STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125048	A. BUILDING _____ B. WING _____	02/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN PEARL NURSING FACILITY	45-181 WAIKALUA ROAD KANEOHE, HI 96744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

The State Survey Agency (SA) Office of Health Care Assurance (OHCA) conducted a recertification survey from 02/04/21 to 02/05/21 and 02/08/21 to 02/11/21. The Extended Survey was completed on 02/17/21.

The facility was found not to be in substantial compliance with the requirements of §42 CFR 483, Subpart B for Long Term Facilities.

1) The facility was found not to be in substantial requirements of §42 CFR 483.80 Infection Control regulations and had not implemented the Center for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.

On 02/09/21 at 1:06 PM the SA notified the Administrator of Immediate Jeopardy at F880, Infection Control. The facility failed to ensure the protection of its residents as evidenced by not immediately isolating or implementing droplet precautions for a resident who screened positive as a person under investigation (PUI) for COVID-19.

On 02/09/21 at 4:46 PM the facility provided an acceptable plan for removal of the IJ and the survey team validated that the IJ removal plan was operational on 02/11/21 at 09:30 AM.

2) On 02/10/21 at 3:30 PM the SA notified the Administrator of Actual Harm at F684, Quality of Care. The facility failed to ensure a resident received treatment and care in accordance with professional standards following a fall resulting in

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

Electronically Signed | 03/22/2021

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F 000	Continued From page 1 the resident experiencing pain, weight loss, decline in activities of daily living, and surgical repair for a hip fracture. 3) The SA also investigated the following Aspen Complaints/Incidents Tracking System (ACTS) #8322, #8659, #7297, and #8685. Although the allegations were not substantiated, the facility was cited for associated deficient practices at F609 (reporting allegations to adult protective services) and F607 (development and implementation of policy and procedures to report allegations to adult protective services). On 02/11/21, the SA notified the Administrator of Substandard Quality of Care (SQC) at F607 for development and implementation of written policies and procedures that ensure reporting allegations of abuse, neglect, exploitation of residents, and misappropriation of resident property to Adult Protective Services (APS). As a result, the facility failed to ensure the safety of the residents in the facility. This deficient practice has and outcome for more than minimal harm and to affect all the residents in the facility. Survey Dates: 02/04/21 to 02/05/21, 02/08/21 to 02/11/21, and Extended Survey on 02/17/21. Census: 65 residents Sample Size: 20	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and	F 550		3/27/21

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F 550	Continued From page 2 access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations and interview with	F 550	This plan of correction constitutes our	

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F 550	Continued From page 3 resident, the facility failed to treat residents with dignity during dining. Residents who require assistance with their meals were observed to wait for assistance as their meals were set before them. The facility also failed to ensure residents are provided with an environment that is respectful of residents' information as evidenced by staff members communicating via radio regarding residents' personal care. The facility also failed to ensure adequate privacy for residents while using the toilet facilities Findings include: 1) Cross Reference to F725. Interview with Registered Nurse (RN) 1 on 02/10/21 at 09:49 AM stated during dining there are three staff members to help with dining and five residents who need assistance during dining. On 02/09/21 at 11:47 AM observed residents with their lunch in front of them. On this unit, there are five residents that need assistance with meals and two Certified Nurse Aids (CNA) and one reliever staff assisting three residents with lunch. R14 was receiving assistance decided she wanted to go on a walk outside before eating her meal, the reliever staff provided supervision during her walk. Observed R57 waiting for assistance with her meal in front of her, her food was uncovered. At 11:55 AM, observed R57 sitting alone and still waiting for assistance. R57 appeared restless and attempted to use a spoon to scoop her food with several failed attempts.	F 550	written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. F550 Residents 11, 14, 57, and 58 were reassessed for assistance needs with dining. Assistance is being provided as needed to ensure appropriateness and timeliness of meals. Resident 5 was interviewed by Social Services and issues with staff using radios and bathroom with privacy curtains were addressed and resolved. Residents requiring assistance with dining have the potential to be affected by the alleged practice. Facility residents have the potential to be affected by the alleged practices. Staff were re-inserviced on appropriateness of assistance and timeliness of meal service by Staff Development Coordinator / designee (SDC). Inservicing will be ongoing as needed. Facility residents were reviewed for level of assistance by Dietitian / DON /designee. Meal-times were reassessed and addressed as needed. Staff were re-inserviced in the appropriate use of the radios and privacy during toileting by SDC/designee. Inservices will be ongoing as needed.	

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F 550	Continued From page 4 At 12:05 PM, observed R14 return from her walk and sit down at the dining table where her meal was left, the reliever staff offered R14 coffee before leaving the unit. At 12:07 PM, observed a CNA finish assisting R58 with her meal and proceeded to assist R57. R57 waited a total of 20 minutes for assistance while her meal was in front of her. At 12:10 PM, observed RN1 bring R11 into the dining room for lunch and provide R11 assistance. At 12:20 PM, R14 is observed looking around waiting for assistance with her meal. R14's meal was served to her at 11:47 AM and returned from her walk at 12:05 PM. At 12:20 PM, approximately 15 minutes later she was still waiting for assistance. 2) Record Review (RR) of R5's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) on 10/28/2020 documents R5's Brief Interview for Mental Status (BIMS) is a 15, indicating R5's cognition is intact. On 02/04/2021 at 10:45 AM, conducted an interview with R5. During the interview R5 explained there were several situations which occur frequently which caused R5 to feel embarrassed. R5 stated staff use radios to communicate with each other. When staff communicate over the radio, the resident's room and bed number is used to identify residents. R5 stated he/she feels embarrassed and ashamed when staff uses his room and bed number over the radio and discuss care staff is providing, especially care related to incontinent issues,	F 550	Administrator / DON/ designee will monitor/audit dining 3 x weekly x 12 weeks to ensure compliance with appropriateness assistance and timeliness of meals. Administrator / DON/ designee will monitor/audit radio usage and bathroom privacy 3 x weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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F 550	Continued From page 5 because other residents are able to figure out who staff is talking about with the identifiers used by staff. R5 shared he/she is able to identify other residents by their room and bed number and feels uncomfortable with information he/she hears over the radio. Additionally, R5 pointed out that the bathrooms in the rooms do not have doors, instead there are curtains which hang from the ceiling. R5 stated the curtains do not provide enough privacy for both the resident using the bathroom and other residents who share the room, especially, when he/she is able to "hear someone making diarrhea and the smell is bad."	F 550		
F 568 SS=D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with resident and staff members, the facility failed to provide residents with quarterly individual financial statements. The facility's system for disseminating quarterly financial statements does	F 568	Resident 40 was provided his Trust Fund Statement for last quarter ending 12/31/20. R40 signed a receipt for the statement.	3/27/21

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F 568	Continued From page 6 not include documentation to attest residents received their statements. Findings include: Interview with Resident (R)40 on 02/04/21 at 10:43 AM, resident reported that he does not recall getting a copy of a statement regarding how much money he has in his account. Record review found R40 yielded a score of 14 (cognitively intact) when the Brief Interview for Mental Status was administered during the quarterly Minimum Data Set with an assessment reference date of 12/30/20. On 02/09/21 at 01:30 PM telephone interview with Business Office Worker (BOW)1 confirmed R40 has a trust fund which is managed by the facility. Inquired how often are statements provided to residents, BOW1 responded previously it was provided monthly; however, it is now sent quarterly. BOW1 further reported social services informed the business office that R40 has been deemed incapacitated by the physician so statements are not being sent out. BOW1 referred to BOW2 as the staff member responsible for issuing the statements. On 02/09/21 at 01:36 PM interviewed BOW2 via telephone. Inquired who is R40's responsible party, BOW2 replied, bank statements are provided to R40. BOW2 further explained the bank statements are sent interoffice to the facility and hand delivered to the residents at the facility. The last issued statement would be mid-January (01/15/21). Further queried how does the facility ensure residents receive their statements. BOW2 reported this has never been an issue in the past. Therefore, the facility was unable to	F 568	Residents who receive their own Trust Fund Statements have the potential to be affected by the alleged practice. Administrator/designee inserviced the Business Office staff regarding Trust Fund Statement deliveries to residents and obtaining signed receipts. Inservicing will be ongoing as needed. Administrator/designee ensured residents who receive their own Trust Fund Statements have received them as needed for the last quarter. Administrator / designee will monitor/audit Trust Fund Statement deliveries to residents and obtaining signed receipts every quarter x 3 quarters to ensure compliance. The results of these audits will be brought to QAPI quarterly x 3 quarters for review and recommendations.	

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F 568	Continued From page 7 provide documentation R40 received his quarterly financial statements.	F 568		
F 572 SS=D	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is not met as evidenced by: Based on interview with residents and staff member, the facility failed to verbally provide a notice of rights and services prior to or upon admission for a newly admitted resident and the facility also failed to ensure residents were provided with a notice of their rights during their stay. Findings include:	F 572	Residents 16 and 52 were given copies of the resident rights. Resident 54 no longer resides at the facility. Facility residents have the potential to be affected by the alleged practice. Social Services were re-inserviced by Administrator regarding reviewing residents□ rights with new admissions.	3/27/21

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F 572	Continued From page 8 Resident Council interview on 02/08/21 at 12:04 PM, R54, a new admission, admitted on 01/29/21, stated she does not remember anyone going over Resident Rights upon admission. R16 stated he did not receive a copy of the Resident Rights and R52 stated he does not remember. R16 further noted that the facility may have the Resident Rights posted but does not know where it is located. Interview with Social Worker (SW) on 02/10/21 at 11:16 AM, reported that Resident Rights is briefly reviewed during admission " ...because the admission packet is sixty pages ...we show them where it's at and if they have any question ...," they can go over it with them. The admission packet is reviewed by SW or Social Services Aide (SSA) during admission.	F 572	Inservices will be ongoing as needed. Residents were reminded in resident council by the Social service Director of where resident rights are posted on each unit. A copy of residents□ rights were placed at each residents□ bedside and will be provided for new admissions on admission by Social Services / designee. Social Services/ designee will monitor/audit with new admissions and resident council where residents□ rights are posted every month x 3 months to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	
F 573 SS=D	Right to Access/Purchase Copies of Records CFR(s): 483.10(g)(2)(i)(ii)(3) §483.10(g)(2) The resident has the right to access personal and medical records pertaining to him or herself. (i) The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and (ii) The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when	F 573		3/27/21

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F 573	Continued From page 9 such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of: (A) Labor for copying the records requested by the individual, whether in paper or electronic form; (B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and (C)Postage, when the individual has requested the copy be mailed. §483.10(g)(3) With the exception of information described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information described in paragraph (g)(2) of this section may be made available to the patient at their request and expense in accordance with applicable law. This REQUIREMENT is not met as evidenced by: Based on interview with resident and staff members and review of email correspondences between facility staff and the resident, the facility failed to ensure a resident was able to exercise the right to access personal and medical records pertaining to him or herself in a form and format as agreed to by the facility and the individual. Findings include: Interview with Resident (R)5 was done on 02/04/21. R5 reported that he requested to view	F 573	Resident 5 was given access to review his chart. The Health Information Management (HIM)Coordinator assisted resident. A nurse was available nearby in case the resident had questions. Residents wishing to review their medical record have the potential to be affected by the alleged practice. The HIM Coordinator / Administrator / DON were inserviced by the regional	

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F 573	Continued From page 10 his medical record, signed a paper, and was asked to fill out a release form. R5 further reported facility staff would come to review his medical record when he was sleeping. R5 then requested to schedule a date and time; however, is still waiting to have access to his records. On 02/10/21, the Health Information Management Coordinator (HIMC) provided a copy of R5's request which was signed by the resident on 11/16/20. A review of the "Authorization to Request and/or Release Medical Information" documents the following, "Unless otherwise revoked, this authorization will expire on the following date or event: 11/17/20 (handwritten)". Interview with the HIMC found that initially R5 requested to review the entire record. R5 was unable to pay the fees to obtain a physical copy so R5 narrowed down the time frame for May 2016. The facility was agreeable to allow R5 to review his medical record on a computer to avoid fees. HIMC and Director of Nursing (DON) arranged to meet with the resident, two times R5 did not respond and didn't want to speak with the DON and the third time he was asleep. HIMC reported R5 does not want the DON to be present while reviewing the medical record; however, the DON reportedly needs to be present to answer any clinical questions. Following the third attempt to meet with the resident, he did not pursue another meeting. HIMC provided copies of email correspondences with R5. On 11/13/20, R5 requested to review his record for the period of 05/06/16 to 05/25/16. Correspondence from HIMC on 11/23/20 from R5 documents question of why HIMC is refusing to get his records and ignores him. HIMC	F 573	nurse regarding resident□s right to review their medical record. Inservices will be ongoing as needed. Residents may review their records online with written request within 24 □ 72 hours with assistance as needed and a nurse nearby to answer questions as needed. HIM Coordinator / designee will monitor/audit compliance with resident requests to review their medical records every month x 3 months. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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F 573	Continued From page 11 responded on 11/24/20 at 08:26 AM to explain that arrangements have been made to view the records online to avoid charge fee and the DON would be available to review his record. A follow-up to the email of 11/24/20 at 08:40 AM HIMC offers to meet on 11/24/20 at 01:00 PM. On 12/02/20 at 09:44 AM, HIMC reached out to R5 to re-schedule. HIMC documents when they (HIMC and DON) came to meet on 11/24/20 at 01:00 PM, R5 was sleeping.	F 573		
F 577 SS=E	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents.	F 577		3/27/21

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F 577	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation and interview with staff member and residents, the facility did not ensure residents are aware the results of the state inspection are available to read and easily accessible to residents. Findings include: Resident Council interview was done on 02/08/21 at 12:04 PM. Inquired whether residents know where the results of the most recent State survey is located. Residents were unaware of where to find the report to review. Concurrent observation with Social Worker (SW) on 02/10/21 at 11:28 AM regarding the location of the results of the State Agency's last survey. The survey results are in a brown and gold cabinet that is located at the front main entrance (area utilized for adult day health clients). The front of the cabinet is facing away from the area most frequented by residents and not readily visible to them. The survey binder was in the right compartment of the cabinet. The left compartment had a yellow sign on top of the cabinet stating the current survey results were located below. The sign was obscured by the leaves of a large fake plant. Inquired with SW if the plant was blocking the sign, she agreed and moved the plant. SW was not able to say how many residents utilize the space to easily view the sign that tells them where the results are. Interview with Registered Nurse (RN)3 on 02/11/21 at 09:01 AM at Hale Ho'Olu, a locked unit located downstairs, revealed there is no State survey results located in the unit and if there is	F 577	Survey binders were redone and clearly posted on each unit. Social Services / Nursing staff were re-inserviced by SDC/ designee regarding availability of survey results for residents. Inservices will be ongoing as needed. Social Services notified residents during resident council on the location of the survey binders. Residents wishing to review survey results have the potential to be affected by the alleged practice. Social Services/designee will remind residents during resident council of the location of the survey binders at least once a quarter. Social Services / designee will monitor / audit the clear and easily located survey binders 3 x weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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F 577	Continued From page 13 one it may be at the Nurse's station. RN3 confirmed the residents in the locked unit would not have access to the results unless a resident requested to view it because the results are not located on their unit and is located upstairs in front of the main entrance.	F 577		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		3/27/21

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F 584	Continued From page 14 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview with residents, the facility failed to provide comfortable sound levels that do not interfere with residents' resting periods. Findings include: Resident Council interview on 02/08/21 at 12:04 PM, residents expressed concern about the noise levels from staff, especially during the night when they are sleeping. R16 explained " ...the place is noisy, the staff and residents. When you have two staff talking, it is loud ...at nighttime ..." staff are " ...laughing loud and talking loud." R54 stated " ...you would think they would be more soft-spoken." R16 further stated, " ...nurses talking loudly to each other. Sometimes got to say shut up, like when watching TV cannot hear it." R52 hopes the facility " ...shapes up a little bit." On 02/10/21 at 10:26 AM, observed a sign for quiet time between the hours of 8:00 PM and 8:00 AM posted on facility bulletin board near the Ilima wing. The sign included, "Shhhh..... Also if residents are resting during the day."	F 584	Resident 54 no longer resides at the facility. Residents 16 and 52 were offered new rooms. Resident 16 declined and resident 52 moved to another room. Facility residents have the potential to be affected by the alleged practice. SDC/DON/designee re-inserviced staff regarding noise levels in the facility and observing □quiet hours□. Inservices will be ongoing as needed. Social Services / designee will review noise levels with residents during resident council monthly for 3 months or until compliance is achieved. Administrator / designee will monitor/ audit the facility noise levels 3 x weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg	F 637		3/27/21

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F 637	Continued From page 15 CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review (RR) and staff interviews, the facility failed to identify a significant change for 1 (Resident 51) of 20 residents in the sample. Resident (R)51 had two areas of decline in activities of daily living, change in urinary continence and significant weight loss. Findings include: Cross Reference to F657 and F684. RR for R51 documents he/she was admitted to the facility on 08/23/2019 with a diagnoses including L4 vertebral compression fracture with back pain and a history of Schizophrenia, Hypertension, and Cerebral Infraction due to occlusion or stenosis of small artery, anemia, and anxiety disorder (01/08/2021). On the morning of 09/07/2020, R51 had an unwitnessed fall and was found by staff on the ground beside the commode. Upon initial	F 637	Resident 51 had a significant change completed and submitted by the MDS Coordinator. Resident 51□s care plan was updated by the MDS Coordinator. MDS Coordinator was re-inserviced regarding the significant change processes and care planning updating by the SDC/designee. Facility residents have the potential to be affected by the alleged practice. The IDT team was re-inserviced regarding the significant change processes and care planning updating by the SDC or designee. Inservices will be ongoing as needed. Current residents were reviewed for potential significant changes at the weekly risk meeting and submitted as needed. MDS Coordinator / designee will monitor /	

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F 637	Continued From page 16 assessment post fall, staff documented there were no observable injuries. However, R51 did complain of new pain to the left leg. On 09/30/2020 at 11:00 AM, R51 was discharged to the hospital and underwent surgery to repair a left intertrochanteric hip fracture. Post fall documentation described that R51 did not have any visible injuries but did complain of new left leg pain (10/10, severe pain). On 09/07/20, an x-ray was taken, findings documented no hip dislocation, mild hip joint effusion and soft tissue swelling. A second x-ray was done on 09/25/2020 which documented findings of a left hip intertrochanteric hip fracture. Conducted a comparative review of R51's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/23/2020 and quarterly MDS with an ARD of 09/16/2020 for Section G: Functional Status. R51 experienced an overall decline in ability to self-perform activities of daily living (ADLs) and an increase in R51's need for staff support for completing ADLs. For bed mobility and transferring between surfaces R51 required limited assistance with one person physical assist (annual) to increased to extensive assistance with two or more person physical assist (quarterly). R51 required limited assistance with one person assist (annual) for walking in room/corridor to activity did not occur in the quarterly MDS. Locomotion on/off unit, R51 needed supervision only with one person physical assistance (annual) to being totally dependent on staff with one person assist (quarterly). R51 required one person assistance with staff providing only weight bearing assistance with toileting needs (how the resident uses the toilet, commode; transfers on/off toilet; and cleanses self after elimination) to requiring	F 637	audit weekly risk meeting to ensure significant change submissions / care planning updates weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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two person assist.

Review of Occupational Therapy (OT) daily treatment notes document on 09/07/2020, R51 complained of significant left lower extremity pain and completed supine in bed bilateral upper extremity exercise. On 09/10/2020, R51 was cleared for standing and weight bearing exercises and tolerated treatment well for toilet transfer and bedside commode with four-wheel walker (FWW). On 09/11/2020, documents after R51 attempted to sit up and move his/her legs, R51 refused to continue due to back and left leg pain. On 09/14/2020, R51 complained of severe left lower extremity pain sitting at the edge of the bed, but willing to continue with therapy. Patient required total max assist over feet due to pain. Attempted to stand to pull up over hips, but R51 was unable to stand with assistance due to pain and requested to go back to bed. R51 received pain medication and requested for Charge Nurse to discuss pain management options with the doctor. On 09/15/2020, TO documents R51 has difficulty standing with complaints of left lower extremity (LLE) pain, nursing was informed and R51's progress continues to be limited by decreased standing ability due to LLE pain. On 09/16/2020, despite being pre-medicated for pain with Oxycodone 10 mg, but after LE movement, R51 requested to transfer back to bed. On 09/21/2020, R51 continued to compliant of LLE pain and declined therapy from start of care due to fall. On 09/25/2020, TO treatment was withheld due to pending x-ray results.

Review of nursing progress notes on 09/01/2020 at 07:08 PM, prior to the fall, documented R51 was able to ambulate with a steady gait using a four wheel walker (FWW) with supervision, was

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observed by staff to ambulate short distances without a FWW, continent, and able to use the bedside commode and toilet. Nursing progress notes on 09/07/2020, post fall, document R51 became unable to change positions in bed, appearing fatigued, had incidents of incontinence, and refused staff's attempts to provide incontinent care despite educations and encouragement. Nursing progress notes post fall documented R51's decline and increased need for staff assistance with transfers, position changes in bed, and decline of care which would require movement of the left lower extremities (LLE).

Review of Section H: Bowel and Bladder. Review of the Annual MDS with an ARD of 07/23/2020, R51 was always continent of bladder and bowel and did not have any appliances (indwelling catheter, external catheter, ostomy, or intermittent catheterization). However, review of the Quarterly MDS with an ARD of 09/16/2020, documented R51 was intermittently catheterized and had two or more episodes of bowel incontinence and seven or more episodes of urinary incontinence.

Review of R51's physician orders documented an order for a straight catheter, as needed, if no void in 8 hours (started on 07/27/2020, discontinued on 10/07/2020). On 09/09/20, a Foley catheter was ordered due to urinary hesitancy. The Treatment Administration Record (TAR) documented after the fall, R51 needed to be straight cathetered six times (09/09, 09/11, 09/24, 09/25, 09/27, and 09/28).

On 02/10/21 at 01:30 PM, inquired with the Director of Nursing (DON) as to how the facility identifies residents who are at risk for significant

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F 637	Continued From page 19 changes. DON stated the facility holds "At Risk" meetings which consist of the medical director, administrator, nursing staff, social worker, and dietician. The At Risk meetings review residents at risk for nutrition, with significant weight loss or gain, skin, behaviors, falls, and any other clinical concern. The DON stated R51 significant weight loss was identified and was being addressed by the dietician and MD1. Review of the "At Risk" meeting minutes for 09/11, 09/18, and 09/25 primarily focused on R51's significant weight loss and did not address R51's decline in mobility, increased need for physical assistance with ADLs, or the use of a Foley and straight catheter, and increase in bowel and bladder incontinence. On 02/10/21 at 10:33 AM, conducted a telephone interview with Nursing Administration (NA)3, who is the primary MDS coordinator. NA3 simultaneously reviewed R51's chart during the telephone interview. NA3 confirmed R51 did have changes in bowel/bladder continence, performance/assistance with ADLS, and significant weight loss. NA3 stated according to the Resident Assessment Instrument (RAI) Manual, R51 did experience decline in two or more areas of ADLS and a MDS for significant change should have been completed but was not. Review of the Quarterly MDS with an ARD of 09/16/2020 documented V00200B2 was not completed.	F 637		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		3/27/21

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F 656	Continued From page 20 resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review (RR), and	F 656	Residents 6, 41, and 51 had care plans	

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F 656	Continued From page 21 staff interviews the facility failed to ensure a comprehensive person-centered care plan was developed with measurable objectives and individualized interventions for 3 of 20 residents in the sample. (Residents 6, 51 and 41). A care plan was not developed for: a resident that smokes; a resident experiencing dental problems, mood, and cognitive loss/dementia; and a resident with wandering behavior. As a result of this deficient practice, residents are at risk of not attaining or maintaining their highest practicable physical, mental, and psychosocial well-being and potential of a negative impact on the resident's quality of life, as well as quality of care and services received. Findings include: 1) Cross Reference to F689, Free of Accident Hazards/Supervision/Devices. Resident (R)6 was admitted to the facility on 04/15/19 with a diagnoses that includes End stage renal disease, dependence on renal dialysis, peripheral vascular disease, partial traumatic amputation at level between the knee and ankle, and anemia in chronic kidney disease. On 02/02/2020 at 12:37 PM, during an interview, R6 was identified as a resident who smokes. R6 stated staff assist the resident to the smoking area because he often becomes fatigued, especially on the days R6 attends dialysis appointments and needs help with the wheelchair due to below knee amputation. Additionally, R6 prefers to smoke when it is dark outside, between 1:00 AM and 03:00 AM. R6 reported he keeps the lighter and cigarettes in an unlocked drawer next to the bed. R6 later showed this surveyor	F 656	developed □ R6 / smoking care plan, R41 / wandering care plan and R51 / cognition & dementia and dental hygiene. MDS Coordinator was re-inserviced regarding updating care plans by the SDC/designee. Facility residents have the potential to be affected by the alleged practice. The IDT team was re-inserviced regarding care plan updating by the SDC or designee. Inservices will be ongoing as needed. Current residents were reviewed for potential care plan updates at the weekly risk meeting as needed. MDS Coordinator / designee will monitor / audit weekly risk meeting to ensure care plan updates weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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the lighter and cigarettes.

Review of R6's care plan, last reviewed/revised on 02/03/21 at 2:28 PM, did not include a care plan for smoking or interventions related to smoking.

On 02/10/21 at 1:35 PM, inquired with the Director of Nursing (DON) if smoking should be addressed in R6's care plan. The DON confirmed R6's did not have a care plan for smoking and it should have been included. The DON stated nursing stores the resident's lighter and cigarettes and was unaware R6 stored kept his in an unlocked bedside drawer.

Review of the facility's policy and procedure on smoking documents residents who smoke should undergo quarterly reassessment to determine resident's cognitive ability, judgement, manual dexterity, and mobility for safety purposes which will be documented in the care plan to reflect resident's smoking status. Requested copies of all R6's smoking assessments. The DON provided one smoking assessment, completed on 06/07/2020, was not completed within the quarterly timeframe. IN addition, the smoking assessment documented R6 is able to transport self to and from smoking area which is not congruent with R6's reported ability.

2) Cross Reference to F657 Care Plan Timing and Revision and F684 Quality of Care.

R51 was admitted to the facility on 08/23/2019 with a diagnoses including L4 vertebral compression fracture with back pain and a history of Schizophrenia, Hypertension, and Cerebral Infraction due to occlusion or stenosis of small

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artery, anemia, and anxiety disorder (1/08/2021).

Review of R51's most recent quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/16/20, in Section V. Care Area Assessment (CAA) Summary, no care areas were identified. A review of R51's most recent annual MDS with an ARD of 07/23/20, Section V. CAA Summary, documented cognition loss/dementia and dental care were triggered in the CAA and the interdisciplinary team (IDT) decided to develop a care plan for those areas.

Review of R51's medical records documented on 8/28/20, R51's tooth (top front tooth) fell out while eating breakfast. R51 did not have any pain or discomfort.

Review of R51's comprehensive care plan, last reviewed/revised on 02/04/21, documented there is no care plan of individualized interventions for cognition loss/dementia or dental care. Also, there is no no documentation regarding assessments and the facility's rationale for not proceeding with care planning for cognition loss/dementia and/or dental care.

3) On 02/04/21 at 12:19 PM observed R41 finish his meal and leave the dining room after lunch. R41 attempted to enter an all-female room, with a stop banner across the door. Registered Nurse (RN) 1 struggled to redirect R41 and tell him it is not his room. R41 continued to stand in front of the room. At 12:21 PM, while RN1 attended to another resident in the hallway, R41 tore down the stop banner and attempted to go in the room again. RN1 returned to R41 to redirect him again, by reminding him that his room is elsewhere, and she will help him find his room. R41 put his foot

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F 656	Continued From page 24 down on the ground to prevent RN1 from to pushing his wheelchair away from the room. R41 attempted two more times to go in the room with failed redirection from RN1. RN1 called another staff for assistance who asked R41 if he wanted to rest and successfully redirected him to his room. Interview with RN1 on 02/04/21 at 9:13 AM, inquired about the stop banner in front of the female rooms. RN1 stated it is to prevent three of the male residents from wandering into the females' rooms. RN1 included R41 as one of the male residents who wander. Review of R41's quarterly Minimum Data Set (MDS) with an assessment reference date of 12/30/210, Section E 0900. Wandering-Presence & Frequency, behavior of this type occurred daily, wandering in the past 7 days. Review of R41's annual MDS with an assessment reference date of 10/02/20, in Section V. Care Area Assessment, Behavioral Symptoms was triggered for wandering and the interdisciplinary team decided to develop a care plan for wandering. Review of R41's care plan last reviewed/revised on 01/03/21, there is no care plan with interventions individualized and address R41's wandering behavior.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 657		3/27/21

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F 657	Continued From page 25 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review (RR) the facility failed to ensure that six (Residents 25, 164, 58, 126, 51, and 47) of a sample size of 20 had their comprehensive care plans reviewed and revised by an interdisciplinary team (IDT) who had knowledge of the resident and their needs. There was lack of evidence the CP was evaluated for effectiveness and revised following the IDT meetings. As a result of this deficient practice R25 had ongoing negative behavior; R164 was at risk of additional falls; R58 did not have additional interventions implemented to reduce the potential for recurring urinary tract infection (UTI); R51 fell and experienced increased pain, increased weight loss, decrease	F 657	Residents 25, 47, 51, 58, and 168 had care plans developed/updated. Resident 51 had a significant change completed and submitted by the MDS Coordinator. MDS Coordinator was re-inserviced regarding the significant change processes and care planning by the SDC/designee. Facility residents have the potential to be affected by the alleged practice. The IDT team was re-inserviced regarding the significant change processes and care planning by the SDC or designee.	

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F 657	Continued From page 26 in range of movement (ROM) of the left leg and a decline in mobility of the left leg; and R47's decline in eating were not addressed. Also, for R126 there was no participation by nursing in the development of the resident's care plan. There is potential that the lack of CP revisions could affect any resident in the facility and prevent them from reaching their highest practicable physical, psychological and social well being. Findings include: 1) Cross Reference to F726, Competent Nursing Staff and F842, Resident Records. R25 is an 87-year-old with a history of a stroke, intracranial hemorrhage, severe dementia with combativeness and chronic impairment in activities of daily living. He receives anti-anxiety and antidepressant medication for episodes of agitation, crying, yelling, and hitting staff. R25 had impaired decision making related to impaired cognition from the stroke. He required assistance to ambulate and was out of bed daily in a wheelchair for meals and activities. During the survey, there were three observations of R25 spitting. Two occurrences on 02/04/21 and one on 02/10/21. On 02/04/21 at 12:30 PM, observed R25 sitting in a wheelchair with an overhead table positioned over him in the hallway by the nursing station. R25 expelled an inordinate amount of bubbly saliva on the floor which covered an area of the hallways approximately two foot by two foot, as well as on the floor under the overbed table, on the overbed table legs, and the table extension arm. At that time, observed the RN partially clean the bodily fluid up.	F 657	Inservices will be ongoing as needed. Current residents were reviewed for potential significant changes at the weekly risk meeting and submitted as needed. MDS Coordinator / designee will monitor / audit weekly risk meeting to ensure significant change submissions / care planning weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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On 02/05/21 at approximately 01:45 PM during an interview with the Housekeeper (HK)1, inquired if she had cleaned up the spill the previous day, and she said, "Yes, it wasn't a problem, I'm use to it, it happens a lot with him (R25)."

RR of R25's CP revealed the problem "Resident with behavior of coughing and spitting sputum on floors and walls" was added on 11/19/20. The short-term goal with the target date of 12/02/20 was "Spitting behaviors will resolve with treatment." The following approaches were added:
Administer medications as ordered. Update NP (Nurse Practitioner)/MD (physician) if ordered interventions are ineffective: 11/18/20
Glycopyrrolate 1 mg (milligram) PO (oral) q (every) 12 hours x 3 days see T.O. (telephone order) . . . Glycopyrrolate 1 mg po q 12 hours (H) PRN (as needed) dx: Hypersecretion. See T.O.
Attempt non-pharmacological interventions. Treatment as ordered. Update NP/MD if ordered interventions are ineffective:
Oral care TID (three times a day). See T.O.

There were no specific non-pharmacological interventions identified in the CP last revised 12/03/20 for nursing staff to implement to help control the behavior.

RR of the physician (MD)3 progress notes on 11/18/20, revealed that following entry; "Today, staff asked patient (R25) to be seen for excessive spitting and F/U skin rash... Per staff patient recently seen increased spitting onto the facility floor. Per staff patient in a day will spit enough to cover ~ 25% of the wing's floor. Staff constantly cleaning." MD3 documented; "Disturbance of

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salivary secretion. Increased amount of spitting. Plan: -Monitor -Oral care Q (every) shift and PRN -Glycopyrrolate 1 mg PO Q 12H (hours) x 3 days, then Q 12H PRN.

On 02/09/21 at approximately 10:30 AM, during an interview with the RN3, she said she thought R25's spitting was a behavior issue versus hypersalivation. When asked why she felt it was behavioral, RN3 said, "He does it when he gets bored and is left alone. We got an order for medication at one time, quite a while ago. I think the PRN (medication) had a stop date (no longer active order). I don't think it was used a lot." When inquired why, RN3 said, "I don't have an answer for that." RN3 said she thought there were better ways, other interventions that would be better than medication. When asked what these would be, she said, "He likes to sing, be wheeled around. Everyone takes turns when they can." Asked RN3 if she had discussed this with anyone, and she said she had not. RN3 went on to say she thought the family had paid for a 1:1 sitter at one time but could not continue to pay. RN3 said, "There aren't enough staff to get to him as there are other higher priorities."

RR of the care planning meeting documented on the Observation Detail List Report dated 02/02/21 revealed there was no discussion of R25's spitting behavior, or that MD3 saw him at the request of the nursing staff and provided new medication orders with the request to monitor for effectiveness. The attendance at that care planning meeting was not documented, but notes were entered by Dietary, Activities, and Social Services. There were no notes or indication that nursing had a representative at that meeting.

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R25's behavior of spitting continued, yet the frequency and amount had not been monitored and documented by nursing staff. There was no indication the behavior had been discussed at the CP meetings or that the CP had been reviewed or revised. The problem continued without being properly addressed.

2) Cross Reference to F689, Free of Accident Hazards/Supervision/Devices.

RR of R164's CP documented the problem at risk for falls due to generalized weakness and impulsiveness with the start date of 10/22/20 after a fall on 10/16/20. The falls on 11/16/20 and 11/20/20 were documented, but the fall on 02/02/21 was not.

RR revealed the CP had been revised after the 11/16/20 and 11/20/20 falls to include the following interventions:
11/24/20: "PT (Physical Therapy) eval for strength training with transfers" ;
12/04/20: "Trial removing wheelchair from bedside to prevent self-transfer for 3 days (until 12/7/20). If effective, remove wheelchair from bedside permanently.

The CP was not revised after the fall on 02/02/21.

There was no documentation the three-day trial removing the wheelchair had been done with the response/effectiveness of the trial. In addition, there was no documentation the PT evaluation had been completed.

The facility Director of Nursing (DON) said the facility had a weekly meeting they call the "at risk" meeting to discuss residents that are at risk or

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need additional monitoring. She said it included residents with a history of recurring falls, disruptive behavior, and wounds. The DON said the discussions were not documented in the resident's medical record, but the discipline responsible for implementing any new interventions would update the CP.

Review of the "at risk" meeting minutes revealed the following entries regarding R164:
10/16/20; "Fall on 10/13-phone fell on ground, attempting to catch it."
10/23/20; "2nd fall in week; self-transferring back to bed; stated bed wasn't locked. Unsteady on feet; bed alarm added; personal alarm on w/c (wheelchair).
Reminded to call for assistance."
11/23/20; "11/16 Resident self-transferred and had a fall. No injury. Rehab (rehabilitation/PT) screen."

When request was made, the facility was unable to produce documentation the PT screen had been completed.

Review of the facility's policy titled "Falls, Assessing (undated), directed staff to "Update the Resident's care plan and educate staff members as necessary after a fall."

On 02/11/21 the facility provided an updated copy of R164's CP that was revised on 02/09/21 to include the 02/02/21 fall and the intervention "Inhouse PT evaluation submitted."

3) The MDS (minimum data set) forms the foundation of a comprehensive assessment and is completed for all residents. On 02/10/21 during a telephone interview with the MDS coordinator

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(MDSC), she said she relocated to the Big Island in October, and the facility was training a new MDSC. The MDSC went on to say when an assessment is completed, the areas that require in person assessment are done by nursing at the facility. The MDSC reviewed the documentation of R126's care planning meeting on 02/02/21 and confirmed there was no documentation by nursing or notation a nursing representation was present. When asked whose responsibility it was to attend and update the CP, the MDSC said, "It was my understanding the plan was for the DON (Director of Nursing) to do it during the transition."

On 02/08/21 during an interview with the DON, reviewed the CP meeting document (Observation Detail List Report) for R126 dated 12/02/20. The DON agreed the meeting did not have attendance documented or notes from a nursing representative. The DON said she was not familiar with the new care planning template/form and had not used it. The form had an area to indicate the CP was in place and reviewed, which was blank. The form also had areas to document code status reviewed, pain, and restraint use with review of risks/benefits. All these areas were blank. The DON said she would have to "check with RN20, as "she is the one that usually attends those meetings." Inquired how the facility coordinates the meetings with the MDSC not on site, and how she ensures a nursing representative is present and CP's are updated. The DON said they had divided the responsibilities to gather the data for the MDS assessments amongst the nursing administrative team. The DON later provided a document titled "Interim Plan for MDS," which assigned responsibility to individuals to collect assessment data as well as other tasks. The

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interim plan identified the DON responsible to complete the pain assessment, and RN20 was responsible to attend the care planning meetings and "Update Care Plan Meeting form in Matrix (new electronic medical record system)."

The care plan meetings lacked sufficient documentation that comprehensive assessments were coordinated and that all areas were assessed. With the absence of a MDSC on site and the change of computer systems, the interim plan was not monitored to ensure comprehensive assessments, planning and revisions were documented in the medical record and the CP.

4) Cross Reference F689, Free of Accident Hazards/Supervision/Devices

The facility failed to revise the CP, implement and monitor additional measures that had been identified by their "at risk" meetings that could potentially decrease the risk of R164 having another fall. R164 had documented falls on 10/16/20, 11/16/20, 11/20/20 and 02/02/21.

5) Cross reference to F637, Comprehensive Assessment After Significant Change, F656 Development of Care Plan, and F684 Quality of Care.

R51 was admitted to the facility on 08/23/2019 with a diagnoses including L4 vertebral compression fracture with back pain and a history of schizophrenia, hypertension, and cerebral infraction due to occlusion or stenosis of small artery, anemia, and anxiety disorder (1/08/2021).

RR of R51's quarterly MDS with an ARD of 09/16/2020, documented in Section V. Care Area

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Assessment (CAA) Summary, Section V02000A and V0200B, no care areas were triggered, and no care areas were developed in the care plan. Review of R51's most recent annual MDS with an Assessment Reference Date (ARD) of 07/23/20, Section V. Care Area Assessment (CAA) Summary, Section V02000. CAA and Care Plan (CP) decision, documented cognition loss/dementia, urinary incontinence, mood state, falls, nutritional status, dental care, pressure ulcer, psychotropic drug use, and pain triggered and was identified to develop a care plan.

Conducted a RR of R51's care plan (CP), last reviewed/revised on 02/04/21, documented care plans for urinary incontinence, falls, nutritional status, psychotropic drug use, and pain were not developed and implemented on R51's comprehensive care plan with interventions and measurable timeframes within 7 days after the completion of the comprehensive assessment. Urinary incontinence was developed in the care plan on 09/17/20, falls on 09/07/20, nutritional status on 08/28/20, psychotropic drug use on 10/14/20, and pain on 08/04/20.

Requested documentation of R51's care plan conferences for July 2020 to October 2020 from the Director of Nursing (DON). The facility provided the August 2020 Care Conference. Review of the August 2020 care conference, conducted on 08/05/20, did not include documentation of the IDT team's rationale for not developing a care plan for the care areas identified in the annual MDS (ARD 07/23/20). Disciplines which participated in the August Care Conference included social services, activities, dietary, and nursing. The DON stated the facility has weekly "At Risk" meeting which discuss

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residents that are at risk or need additional monitoring. The DON stated it included residents who are monitored changes, residents with history of risk, and residents who experience significant changes. The DON said the discussions were not documented in the resident's medical record, but the discipline responsible for implementing any new interventions and update the CP.

Review of R51's medical records did not document the IDT team's decision to not develop a care plan for the care areas identified in the annual MDS (ARD 07/23/20). Progress notes documented R51 had an unwitnessed fall and was found on the ground beside the bedside commode on 09/07/20. As a result of the fall, R51 had a decline in mobility and range of motion (ROM), significant weight loss of due to loss of appetite, bowel and bladder incontinence, use of a straight and Foley catheter related to new severe left leg pain which started as a result of the fall. On 09/30/20, R51 was subsequently transferred to the hospital for a left hip fracture which required an open reduction and internal fixation (ORIF) with long medullary nail.

Review of R51's Medication Administration Record (MAR) documented an order for Aripiprazole 10 mg, once a day, was ordered on 07/27/20 for diagnosis of Schizophrenia. A care plan for psychotropic drug use was not developed and implemented until 10/14/20. The MAR also documented an order for Tramadol 100 mg, three times a day; Acetaminophen 1000 mg as needed three times a day; Oxycodone 10 mg, every four hours as needed, for moderate/severe pain 8-10/10; Oxycodone 5 mg every 4 hours as needed for mild pain 6-7/10 (all started on

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07/27/20 and discontinued on 10/07/20). Pain was not developed on the care plan until 08/04/20.

Review of the facility policy titled "Care Planning", last updated 01/10/10, documented "The care plan should be developed no later than seven (7) days following the completion of the comprehensive assessment."

6) Cross Reference to F690, Urinary Tract Infection.

Review of R58's progress notes indicated the resident had urinary tract infections (UTIs) on 12/24/20 and 01/05/21.

Review of R58's care plan regarding "Potential for infection r/t (related to) UTI" started on 12/29/20 and last reviewed/revised on 02/04/21, found no revised interventions to prevent or provide treatment for UTI after R58's last UTI on 01/05/21. Intervention included in the care plan starting 12/29/20 is "Offer PO (oral) fluids."

Interview with Infection Preventionist (IP) on 02/08/21 at 03:25 PM, and concurrent review of the resident's care plan, IP confirmed the care plan was not revised after the last UTI on 01/05/21 to include additional interventions and treatment to prevent UTIs. IP also provided suggested interventions that could be incorporated in R58's care plan to provide treatment and prevention, such as encourage fluids, incorporate cranberry juice or use UTI-Stat (A ready-to-drink medical good providing Cranberry Concentrate with added nutrients for UTI health), timely peri care, include Vitamin C, and limit caffeine.

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F 657	Continued From page 36 7) Cross Reference F677, Activities of Daily Living Care Provided for Dependent Residents. R47 was hospitalized on 01/08/21 and readmitted to the facility with hospice services. A comparison of R47's Minimum Data Set (MDS) for significant change with assessment reference date of 01/14/21 and quarterly MDS with assessment date of 10/20/20 notes a decline in eating. R47 went from requiring supervision with set up to extensive assistance with one-person physical assist. Interview with Registered Nurse (RN) 1 on 01/09/21 at 12:20 PM, RN1 stated, R47 refused her food most of the time but does not need assistance with her meals. She " ...needs encouragement or cueing, we sometimes do hand-over-hand ..." assistance. Review of R47's care plan for ADL (Activities of Daily Living) Functional/ Rehabilitation start date 07/27/20 and reviewed/revised date on 01/23/21 does not address R47's change in function, requiring extensive assistance with one-person physical assist with eating. The approach for eating continues to be "Assist of 1 Cue ..."	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677		3/27/21

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F 677	Continued From page 37 Based on observations, record review, and interview with staff member, the facility failed to provide appropriate assistance with meals after a decline in resident's ability to eat to ensure the resident maintains acceptable nutrtional parameters. Findings include: Cross Reference with F657, Care Plan Timing and Revision. The facility failed to revise Resident (R)47's care plan to address the decline in activities of daily living. Review of R47's progress notes on 01/08/21, R47 was hospitalized on 01/08/21, the progress note stated "...resident standing by door making BM, assisted to toilet and noticed clay colored loose stool. Resident noted with increased generalized weakness r/t inability to stand or walk independently. Resident known for refusal of meals and has been strictly consuming supplements only. MD ordered to send resident to an [name of acute facility] for diagnosis hypotension, dehydration, and altered mental status" Review of R47's care plan regarding End-of-Life Care, on 01/09/21, R47 was re-admitted to the facility with hospice services. The hospice diagnosis is senile depression of the brain with behaviors with life expectancy of 6 months or less if disease persists. Review of Resident (R) 47's significant change Minimum Data Set (MDS) with assessment reference date of 01/14/21, in Section G.	F 677	Residents 47 had care plan developed/updated to address ADL declines. MDS Coordinator was re-inserviced regarding care planning by the SDC/designee. Facility residents have the potential to be affected by the alleged practice. The IDT team was re-inserviced regarding care planning by the SDC or designee. Inservices will be ongoing as needed. Current residents were reviewed for changes at the weekly risk meeting. MDS Coordinator / designee will monitor / audit weekly risk meeting to ensure care planning updates weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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F 677	Continued From page 38 Functional Status, R47 needs extensive assistance with one-person physical assist in eating. In comparison to R47's previous quarterly MDS with assessment reference date of 10/20/20, R47 required supervision with set-up assistance in eating. On 02/04/21 at 12:12 PM, observed R47 drinking Boost supplement out of a straw in the dining room, during lunch. At 12:23 PM Certified Nursing Assistant (CNA) 38 noticed R47 not eating her meal and verbally cued her to eat while passing by. R47 did not acknowledge the verbal cue. At 12:34 PM, R47 continued to sit at the dining table without eating her food. Second observation on 02/05/21 at 11:54 AM, observed R47 at the dining room, with her lunch in front of her, not eating her meal or drinking the supplement. At 12:01 PM, R47 leaned back on her wheelchair and caught the attention of CNA39, who is assisting another resident. CNA39 attempted to encourage R47 to drink her supplement. R47 continued to sit at the dining room table without eating her supplement or food. Interview with Registered Nurse (RN) 1 on 02/09/21 at 12:20 PM, RN1 stated, R47 refused her food most of the time and does not need assistance with her meals but needs encouragement or cueing, sometimes hand-over-hand assistance is provided.	F 677		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		3/27/21

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F 684	Continued From page 39 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review (RR) and interviews, the facility failed to identify ensure Resident (R)51 received treatment and care in accordance with professional standards of practice and developed a comprehensive person-center care plan for 1 of 20 residents sampled. The facility did not assure R51 was provided with care to address to post fall needs and as a result of this deficiency, R51 experienced actual harm, hospitalization with surgical intervention, severe pain, decline in ROM (range of motion), loss of mobility, increased weight loss, fatigue and use of urinary catheter. Findings include: Cross reference F637 Comprehensive Assessment After Significant Change, F657 Care Plan Timing and Revision, and F842 Resident Records. R51 was admitted to the facility on 08/23/19 with a diagnoses including L4 vertebral compression fracture with back pain, history of schizophrenia, hypertension, and cerebral infarction due to occlusion or stenosis of small artery, anemia, and anxiety disorder (01/08/21). On 09/07/20, R51 had an unwitnessed fall and was found on the ground next to the bedside commode. R51 did not have any visible injuries but did complain of new left leg pain (10/10,	F 684	Resident 51 had a significant change completed and submitted by the MDS Coordinator. Resident 51□s care plan was updated by the MDS Coordinator. MDS Coordinator was re-inserviced regarding the significant change processes and care planning updating by the SDC/designee. Resident□s weight and overall condition is stable at present. Facility residents have the potential to be affected by the alleged practice. The IDT team was re-inserviced regarding the significant change processes, care planning and pain management by the SDC or designee. Nursing staff were re-inserviced regarding pain management by SDC / DON/ designee. Inservices will be ongoing as needed. Current residents were reviewed for potential changes at the weekly risk meeting. MDS Coordinator / designee will monitor / audit weekly risk meeting to ensure significant change submissions / care planning updates weekly x 12 weeks to ensure compliance. The DON/designee will monitor/audit pain management weekly x 12 weeks to ensure compliance. The results of these audits will be brought	

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F 684	Continued From page 40 severe pain). An initial x-ray (09/07/20) documented mild hip joint effusion, soft tissue swelling, and no hip dislocation. On subsequent days, R51 continued to complain of left leg pain, appeared fatigued, frequently incontinent of bladder and bowel, refused incontinent care despite education and encouragement, required the use of a Foley and straight catheter, increased as needed (PRN) pain medication, loss of range of motion (ROM), significant weight loss due to unmanaged pain, and decreased mobility. On 09/09/20, a Foley catheter is ordered for R51 due to concerns of urinary hesitancy as R51 was refusing to void as a result of left leg pain. R51 had an increased use of as needed (PRN) pain medication and a decline in ability to stand and movement of the left leg. Despite severe left leg pain, R51 participated in occupational therapy (OT) sessions which included weight bearing exercises as tolerated. Review of R51's most recent annual MDS with an Assessment Reference Date (ARD) of 07/23/20, Section V. Care Area Assessment (CAA) Summary, Section V02000. CAA and Care Plan (CP) decision, documented cognition loss/dementia, urinary incontinence, mood state, falls, nutritional status, dental care, pressure ulcer, psychotropic drug use, and pain were triggered and identified to develop a care plan. Record Review (RR) of R51's quarterly MDS with an ARD of 09/16/2020, documented no care areas were triggered or developed in the care plan. Conducted a RR of R51's care plan (CP), last reviewed/revised on 02/04/21. Despite the	F 684	to QAPI monthly x 3 months for review and recommendations.	

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interdisciplinary team's (IDT) decision to care plan for falls and pain during the annual MDS (ARD of 07/30/20), review found no documentation of care plan interventions for falls and pain. Falls were added to the care plan on 09/07/20 after R51 experienced a fall. R51's chronic back pain was addressed in the care plan on 08/04/20.

Review of R51's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/23/2020 and quarterly MDS with an ARD of 09/16/2020 documented significant decline in the extent of R51's ability for activities of daily living (ADLS). The annual MDS documented R51 needed only limited assistance with one-person assist for bed mobility, transfers between surfaces, and walking and for toileting required extensive assistance with one-personal physical assist (resident involved in activity; staff provide weight bearing assistance). R51's Quarterly MDS, dated 9 (nine) days after the fall, documented R51 required extensive assistance with two or more-person physical assistance for bed mobility and transferring between surfaces. R51 did not walk in room or on the unit and was totally dependent on staff with one person assist for locomotion on the unit. Toileting assistance increased requiring two person assist with extensive assistance.

Review of Section H: Bowel and Bladder. Review of the Annual MDS with an ARD of 07/23/2020 noted R51 was always continent of bladder and bowels and did not have any appliances (indwelling catheter, external catheter, ostomy, or intermittent catheterization. Review of the Quarterly MDS with an ARD of 09/16/2020, documented R51 was intermittently catheterized

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and had two or more episodes of bowel incontinence and seven or more episodes of urinary incontinence.

Review of weights documented R51 was 111.2 pounds (lbs) on 09/03/20 and lost 14.4 lbs over the next 8 days. From 09/11/20 to 09/18/20, R51 went from 96.8 lbs to 93.5 lbs, which is a 3.3 lb weight loss in one week (09/11-18/20) and a 15.92% weight loss in 15 days (09/03-18/20). MD2 related the use of two diuretics (Lasix and Bumetanide), however, Lasix 40 mg was discontinued on 09/11/20 and R51 continued to lose weight. During an interview with MD2 on 02/10/21 at approximately 1:55 PM, MD2 stated the continued rapid weight loss, despite discontinuing the Lasix, should have been reevaluated. Furthermore, MD2 was unaware of a progress note, written on 09/19/20 at 09:45 PM, which documented the resident expressed a loss of appetite due to pain.

Review of R51's medical record progress notes documented severe left leg pain and continued back pain. Review of the September MAR document R51's increased use of Oxycodone 10 mg as needed (PRN) in addition to regularly scheduled Tramadol 100 mg three times a day. No comprehensive care plan was developed for pain and thus no interventions which were consistent with R51's needs and goals were identified.

A second x-ray was done on 09/25/30 in preparation for an orthopedic appointment on 09/30/20 showed an acute left intertrochanteric hip fracture. The decision was made to not transport R51 to the hospital for immediate treatment and wait for the scheduled orthopedic

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appointment on 09/30/20. On 09/29/20, the orthopedic appointment was rescheduled to 10/05/20. MD2 made the decision to wait for the orthopedic appointment on 10/05/20 and not transport R51 to the hospital. That evening staff documented R51's left leg noted to be contracted, with guarded behavior and refusing to extend the left leg. The progress note of 09/30/20 at 10:35 AM, documents the Charge Nurse, MD and DON were at R51's bedside and noted she was unable to extend her left leg and the left hip was warm to touch and swollen.

On 02/10/21 at 10:33 AM, conducted a telephone interview with Nursing Administration (NA)3, who is the primary MDS coordinator. NA3 simultaneously reviewed R51's chart during the telephone interview. NA 3 confirmed R51 did have changes in bowel/bladder continence, performance/assistance with ADLS, and significant weight loss. NA3 stated according to the Resident Assessment Instrument (RAI) Manual, R51 did experience changes in two or more areas of decline and a MDS for significant change should have been completed, however, the significant changes were not identified.

Review of all Fall Risk Assessments provided by the facility for R51, a fall risk assessment dated 09/07/2020 documented R51 was at moderate risk for falls. R51 continues to appear fatigued and now has incidents of incontinence and refuses care despite staff implementing non-pharmacological interventions, education, and encouraging R51 on the importance of incontinent care.

Requested documentation of R51's care plan conferences for July 2020 to October 2020 from

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the Director of Nursing (DON). The facility provided the August 2020 Care Conference. Review of the August 2020 care conference, conducted on 08/05/20 did not include documentation of the IDT's rationale for not developing a care plan for the care areas identified in the annual MDS (ARD 07/23/20). Disciplines which participated in the August Care Conference included social services, activities, dietary, and nursing. The DON stated the facility has weekly "At Risk" meetings which discuss residents that are at risk or need additional monitoring. The DON stated it included residents who are monitored for changes, residents with history of risk, and residents who experience significant changes. The DON said the discussions were not documented in the resident's medical record, but the discipline responsible for implementing any new interventions will update the CP. Review of the "At Risk" meeting documented the IDT team was not aware of R51's significant weight loss, but attributed the loss to the administration of two diuretics. However, R51 continued to lose weight despite the discontinuation of one diuretic medication, the addition of nutritional supplements and R51 stating a loss of appetite due to pain. Furthermore, the At Risk meeting did not include documentation which addressed R51's pain, extensive decline in left leg ROM (range of motion) and mobility, bowel and bladder incontinence, and urinary retention.

On 02/10/21 at approximately 1:55 PM, conducted a telephone interview with Medical Doctor (MD)2 regarding R51's fall and subsequent physical decline, post fall. MD2 stated R51's admitting diagnoses included L4 vertebral compression fracture, schizophrenia,

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and dementia. MD2 stated after R51's fall an x-ray was done and there was no evidence of a fractured hip. MD2 contributed R51's pain to chronic back pain, stating R51 always has pain. Asked MD2 what steps were taken to manage R51's new left leg pain. MD2 stated Ibuprofen was added to the pain medication management regime, with minimal effectiveness. Inquired about R51's UTI, implementation of a Foley catheter, and R51 experiencing bowel and bladder incontinence. MD2 stated R51's UTI and incontinence issues were related to a neurogenic bladder issue due to the L4 vertebra compression fracture and not related to R51's decline in ROM and mobility related to the fall. Inquired if R51 still experienced incontinence and urinary hesitancy post-surgery. MD2 stated after the surgery R51's neurogenic bladder issues "spontaneously resolved." Asked MD2, given R51's decline and continuous reports of left leg pain, were any other diagnostic test considered? MD2 replied, "there was swelling present, but to get an MRI approved by insurance is a whole other story." Inquired if R51's severe left leg pain was an indicator that something more was going on than the x-ray showed. MD2 stated the increase in pain was not identified as anything more than chronic back pain, due to R51 continuous pain. Inquired if MD2 was aware a nursing progress note documented R51 reporting a loss of appetite due to the severe left leg pain. MD2 was not aware of the progress note.

R51 had an unwitnessed fall on 09/07/20. Following the fall, R51 experienced pain which affected her activities of daily living (bed mobility, transferring, walking and toileting). R51 also experienced pain resulting in significant weight loss due to loss of appetite. The pain also

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F 684	Continued From page 46 prevented R51 from toileting and refusing incontinence care requiring intermittent catheterization. After 18 days, R51 received a second x-ray that revealed acute left intertrochanteric hip fracture. On the 23rd day (09/30/20) after the fall, R51 was sent to an acute facility and received an ORIF (open reduction interval fixation).	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview with staff member, the facility failed to ensure a resident with limited range of motion services received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for 2 of 2 residents (Residents 15 and 19) sampled for	F 688	Residents 15 and 19 were reassessed by therapy for splinting needs. Care plans updated to reflect splinting schedules. Nursing staff were re-inserviced regarding splinting schedules by SDC/ designee. Residents with splints have the potential	3/27/21

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F 688	Continued From page 47 limited range of motion. Findings include: 1) Resident (R)19 was admitted to the facility on 08/06/15. Diagnoses include unspecified dementia without behavioral disturbance; type 2 diabetes mellitus without complications; hemiplegia and hemiparesis followed by unspecified cerebrovascular disease affecting left non-dominant side; cerebral infarction, unspecified; peripheral vascular disease, unspecified; anxiety disorder; and metabolic encephalopathy On 02/04/21 during the initial tour, observed Resident (R)19 in bed watching television, her left hand was clenched in a fist. At lunch on 02/04/21, R19 was observed in bed with her meal tray (did not observe application of splint/hand roll). On 02/05/21 at 07:40 AM, R19 was being wheeled out of the shower room, observation found there was possible limited range of motion to bilateral lower extremities. On 02/08/21 at 11:00 AM, R19 was observed in bed without a splint/hand roll. Observation on 02/09/21 after breakfast found R19 in bed without a splint. A review of the quarterly Minimum Data Set with assessment reference date (ARD) of 11/12/20 found R19 was coded with functional limitation in range of motion to the upper extremity (impairment on one side) and lower extremity (impairment on both sides). In Section O. Special Treatment and Program, the coding for Restorative Nursing Program found R19 was coded 0 (zero) for the number of days each of the following restorative programs were performed for at least 15 minutes a day in the last 7 (seven)	F 688	to be affected by the alleged practice. Current residents with splints had care plans and schedules reviewed and updated as needed. Nursing staff were re-inserviced regarding splinting schedules by SDC / DON/ designee. Inservices will be ongoing as needed. Current residents were reviewed for potential changes at the weekly risk meeting. The DON/designee will monitor/audit splinting / schedules/care plans 3 x weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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calendar day, passive range of motion, active range of motion, and splint application.

A review of the care plan notes contractures to left knee, shoulder, elbow, and lower extremities. The interventions include apply splints as ordered, monitor skin around splints for bruising or pressure, range of motion as tolerated, and therapy evaluation/screening as indicated.

R19 has the following physician order: apply left elbow splint and hand roll on at 0900 and off at 1500, twice a day at 0900 and 1700; apply splint left elbow, left resting hand splint on at 1500 off at 1900; apply splint left knee at 0830 and off at 1130; and apply left knee splint one time daily, on at 0830 and off at 1130.

On 02/08/21 following observation of resident at 11:00 AM without a splint, an interview was done with Registered Nurse (RN)40 regarding application of splints. RN40 reported physician order for application of splint include left hand and elbow splint on at 09:00 AM and off at 03:00 PM, left elbow on at 03:00 PM and off at 07:00 PM, and knee splint on at 08:30 AM and off at 11:30 AM. RN40 reported R19 does not like the knee splint. RN40 reported the Certified Nurse Aides (CNA) will document application of splints in their software.

During the interview, CNA6 was walking by and was asked when is R19's splint applied. CNA6 replied the splint should be on at 11:00 AM to 02:00 PM (this is not congruent with the physician's order). Subsequently observed CNA6 attempt to apply R19's hand splint. R19's fingers were tightly fisted as CNA6 attempted to extend the resident's fingers to place the splint in her

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palm, R19 was observed to yell "ouch".

On 02/10/21 with the assistance of CNA40, R19's record was reviewed. CNA40 reported entries are made when R19's splints are applied. Inquired whether the software includes documentation for refusal. CNA demonstrated that they are able to document refusal. Requested for CNA40 to check on 02/09/21 to see whether there is documentation that the splint was applied. CNA40 confirmed there is no documentation of splint application. Further queried whether there is documentation that R19 refused application of splint. There was no documentation of refusal.

On 02/09/21 at 02:38 PM, requested documentation from Director of Nursing (DON) of splint application or range of motion was performed for R19. The DON did not provide documentation; therefore, on 02/10/21 at 11:25 AM, a request was made to the Infection Preventionist (IP) of CNA documentation of splint application and or range of motion was done for R19. No documentation was provided by the DON or IP prior to the team's exit.

2) R15 was admitted to the facility on 02/06/2020 with diagnoses which include cerebral infraction, and hemiplegia and hemiparesis of the left non-dominant side.

On 02/04/21 at 10:00 AM and 12:15 PM and on 02/05/21 at 09:47 AM and 10:20 AM, observations were made of R15 with no splint applied to the left hand. Inquired with R15 regarding not wearing the splint. R15 stated the splint is in the personal storage located approximately 3-4 feet away from R15's bed and

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F 688	Continued From page 50 needs staff to get the splint. R15 was aware the splint should be applied and stated they don't always put it on. A sign located on the wall near R15's bed read, Apply splint to L hand. A review of the quarterly Minimum Data Set (MDS) with and Assessment Reference Date (ARD) of 11/06/2020, notes in Section O. Special Treatments and Programs R15 was coded zero for the number of days the restorative program was performed in the last 7 calendar days for splint or brace assistance, active range of motion (ROM), and passive ROM. On 02/08/21 at 08:05 AM, conducted a review of the physician orders. The physician orders documents an order to apply compression stocking (left arm) with special instructions for Occupational (OT) to provide left hand splint on at 07:00 AM and off at 1:00 PM was ordered on 07/27/20 and discontinued on 02/06/21 due to R15 being transferred to the hospital.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record reviews (RR), the facility failed to assure each resident's environment remains free of accident	F 689	Resident 6□s cigarettes and lighter are being stored at nursing station. Resident has been inserviced regarding signing in	3/27/21

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F 689	Continued From page 51 hazards and each resident receives adequate supervision for 2 (Residents 164 and 6) of 5 residents reviewed for accidents. The facility did not assure a resident's care plan interventions for falls (PT screen/evaluation and trial of removing the wheelchair from bedside to prevent self-transfer) were implemented and a resident at high risk for falls was placed in a closed door room which limited staff monitoring. Additionally, the facility failed to safeguard a resident's smoking paraphernalia (cigarettes and lighter) to ensure safety of all residents. The lack of implementing and monitoring measures to prevent accidents has the potential to affect all residents and puts the residents in the facility at risk of harm. Findings include: 1) R164 was a 73-year-old male with Type 2 diabetes, chronic kidney disease on dialysis, with long-term current use of insulin. He had peripheral vascular disease, left below the knee amputation, and an unhealing wound on the right great toe. R164 was hospitalized from 01/01/21-01/23/21 for necrosis/gangrene of the right great toe and had an amputation of the toe on 01/19/21. Post-surgery, R164 was discharged back to the facility on intravenous antibiotics. R164 required assistance or supervision for mobility/transfer to his wheelchair and had an unsteady balance. He had documented unwitnessed falls on 10/16/20, 11/16/20, 11/20/20, and 02/02/21. When R164 returned to the facility he was placed on the unit (Pikake) designated for residents diagnosed with COVID-19, person under investigation (PUI), and new admissions. The	F 689	and out the supplies by the SDC/designee. Inservices will be ongoing as needed. R164 has been moved to a green zone and his door is open for easier observation. Both resident care plans have been updated. Nursing staff were re-inserviced regarding smoking safety and high-risk fall assessment / observations while on isolation by SDC / DON / designee. Inservices will be ongoing as needed. Residents who smoke and / or is a high fall risk on isolation have the potential to be affected by the alleged practice. Residents who smoke were reassessed to ensure smoking supplies were at nursing station and being signed out/in. Residents on isolation who are at risk for falls were reassessed to ensure observation signage / process was in place. Nursing staff were re-inserviced regarding smoking safety and high-risk fall assessment / observations while on isolation by SDC / DON / designee. Inservices will be ongoing as needed. The DON/designee will monitor/audit smoking supplies and high fall risk residents on isolation 3 x weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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facility had implemented additional infection precautions that included closed doors to reduce the potential of transmission of any infection. On observation, it was noted that the doors on the unit did not have a window to observe the residents. During survey, there were no COVID-19 positive or PUI in the facility, and the only residents on Pikake were new admissions who were kept on the unit for a 14 day quarantine. Due to the fact that R164 had a history of multiple falls and identified as high risk for falls, the facility should have conducted a risk/benefit analysis to determine if the door should be closed, or additional measures were needed to reduce the potential for a another fall.

RR revealed R164's most recent "Fall Risk Assessment Tool" dated 02/02/21 described him as; "Altered awareness of immediate physical environment, impulsive and lack of understanding of one's physical and cognitive limitations."

RR of R164's care plan (CP) documented the problem he was at risk for falls due to generalized weakness and impulsiveness with the start date of 10/22/20. The falls on 11/16/20 and 11/20/20 were documented on the CP, but the 02/02/21 fall was not.

RR revealed the CP had been revised after the 11/16/20 and 11/20/20 falls to include the following interventions:
11/24/20: "PT (Physical Therapy) eval for strength training with transfers"
12/04/20: "Trial removing wheelchair from bedside to prevent self-transfer for 3 days (until 12/7/20). If effective, remove wheelchair from bedside permanently.
The CP was not revised after the fall on 02/02/21.

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There was no documentation the three-day trial of removing the wheelchair had been done with the response/effectiveness of the trial. In addition, there was no documentation the PT evaluation had been completed.

The facility Director of Nursing (DON) said the facility had a weekly meeting they call the "at risk" meeting discuss residents that are at risk or need additional monitoring. She said it may include residents with history of recurring falls, disruptive behavior, and wounds. The DON said these discussions are not documented in the resident's medical record, but the discipline responsible for implementing any new interventions would implement the intervention and update the CP.

Review of the "at risk" meeting minutes revealed the following entries regarding R164:
10/16/20; "Fall on 10/13-phone fell on ground, attempting to catch it."
10/23/20; "2nd fall in week; self-transferring back to bed; stated bed wasn't locked. Unsteady on feet; bed alarm added; personal alarm on w/c (wheelchair). Reminded to call for assistance."
11/23/20; "11/16 Resident self-transferred and had a fall. No injury. Rehab (rehabilitation/PT) screen."

When request was made, the facility was unable to produce documentation the PT screen had been completed.

On 02/11/21 the facility provided an updated copy of R164's CP that was revised on 02/09/21 to include the 02/02/21 fall and the intervention "In-house PT evaluation submitted."

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F 689	Continued From page 54 Review of the facility policy titled "Falls, Assessing (undated)," directed staff to "Update the Resident's care plan and educate staff members as necessary after a fall." 2) Cross Reference to F656, Develop/Implement Comprehensive Care Plan On 02/04/2021 at 12:37 PM, conducted an interview with R6 who was identified as a smoker. During the interview, R6 stated he stores his lighter and cigarettes in a drawer next to his bed. Observed R6 open a drawer (no locking mechanism installed) and show this surveyor a functioning lighter and a pack of cigarettes. R6 confirmed he attends outside dialysis appointment every Tuesday, Thursday, and Saturday from 4:00 PM to 9:30 PM during which the lighter and cigarettes are unattended, RR of R6's care plan (CP) documented R6 did not have a care plan for smoking. Thus, there were no goals or interventions which identified a R6's capabilities and deficits related to the smoking assessment which was conducted on 06/07/2020. Review of the facility Smoking policy and procedure states the resident/guest will be required to return smoking material (lighter/cigarettes) to the Charge Nurse or designee upon returning from the smoking area. In an interview on 02/08/2021, the Director of Nursing (DON) confirmed R6's lighter and cigarettes should be not be stored in an unsecured drawer in R6's room and should be turned into staff for safety.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI	F 690		3/27/21

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F 690	Continued From page 55 CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff	F 690	Resident 58 care plan was updated to	

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F 690	Continued From page 56 members, the facility failed to provide interventions and treatment to prevent urinary tract infections (UTI) for resident (R) 58. Findings Include: Cross Reference to F657. The facility failed to revise R58's care plan to include interventions for UTI prevention. Review of R58's progress notes indicated the resident had a UTI on 12/24/20 and 01/05/21. Interview with Registered Nurse (RN)1 on 02/08/21 at 02:00 PM stated, R58's last UTI was on 01/05/21. RN1 further explained, R58 has a history of UTI and has frequent orders for urinalysis (UA), " ...whenever she has increase agitation, we check to rule it out ..." When asked what type of UTI prevention care is used for R58, RN1 replied, good peri care, frequent toileting, and encourage 1440 milliliters (mLs) of fluids daily. RN1 was not able to confirm if changes were made to R58's care plan after R58's last UTI on 01/05/21 because she stated she does not know how to navigate the care plan. Interview with Infection Preventionist (IP) on 02/08/21 at 03:25 PM, inquired about interventions used for R58 to prevent UTIs, IP stated that staff encourages R58 to drink at least 1200 ml of fluids daily and to also provide standard peri care. Concurrent review of the resident's care plan, IP confirmed the care plan was not revised after the last UTI on 01/05/21 to include additional interventions and treatment to prevent UTIs. IP also provided suggested interventions that could be incorporated in R58's care plan to provide treatment and prevention,	F 690	reflect the current interventions for UTI. MDS Coordinator was re-inserviced regarding care planning by the SDC/designee. Facility residents with chronic UTIs have the potential to be affected by the alleged practice. Residents with chronic UTIs care plans were reassessed. The IDT team was re-inserviced regarding care planning by the SDC or designee. Inservices will be ongoing as needed. Current residents will be reviewed at the weekly risk meeting. MDS Coordinator / designee will monitor / audit residents with chronic UTIs and residents at the weekly risk meeting to ensure care planning weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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F 690	Continued From page 57 such as encourage fluids, incorporate cranberry juice or use UTI-Stat (A ready-to-drink medical food providing Cranberry Concentrate with added nutrients for UTI health), timely peri care, include Vitamin C, and limit caffeine.	F 690		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview with resident and staff members, the facility failed to ensure residents who require dialysis receive such services consistent with professional standards, including ongoing assessment and communication of the resident's condition and monitoring for complication before and after dialysis treatments related to the condition of the resident's access site for one (Resident 54) of one residents sampled for dialysis of six residents receiving dialysis from an outside dialysis facility. Findings include: Resident (R)54 was admitted to the facility on 01/19/21. Diagnoses include: infection following a procedure, unspecified, subsequent encounter; iron deficiency anemia secondary to blood loss (chronic); type 2 diabetes mellitus with diabetic nephropathy; hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease; dependence on renal	F 698	Resident 54 no longer resides at the facility. Dialysis residents have the potential to be affected by the alleged practice. Current dialysis residents were reviewed for compliance and updates were made as needed. Nursing staff were re-inserviced on documentation and assessment for dialysis residents by the SDC or designee. Inservices will be ongoing as needed. DON / designee will monitor / audit dialysis residents documentation weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	3/27/21

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F 698	Continued From page 58 dialysis; major depressive disorder, recurrent, unspecified; and atherosclerosis of coronary artery bypass graft(s) without angina pectoris. Interviewed R54 on 02/05/21 at 09:23 AM. R54 reported she goes to an outside dialysis facility for hemodialysis on Tuesday, Thursday, and Saturday. The facility arranges transportation and there is a communication binder for the facility and the dialysis entity. Subsequent interview with R54 on 02/10/21, R54 reported her access site is not assessed upon her return to the facility. The facility provided copies of the "Dialysis Communication Record" forms from 01/23/21 through 02/06/21. A review found the dialysis nurse did not complete the documentation related to the access site condition after treatment for the following dates, 01/26/21, 01/28/21, 02/04/21, 02/06/21 and one record that is not dated. Interview with Registered Nurse (RN)40 on 02/10/21 at 01:30 PM inquired what happens when the resident returns and the communication record is not completed. RN40 responded, the facility will call the dialysis entity and request to complete the form and fax it back. RN40 also reported the resident's access site is assessed upon return to the facility. Further review found no documentation the resident's access site was assessed on 01/28/21 (this is the same treatment day that the dialysis entity did not document the resident's condition of access site upon completion of treatment).	F 698		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2)	F 710		3/27/21

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F 710	Continued From page 59 §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff member, the facility failed to ensure a resident's physician supervised and evaluated weight loss for 1 (Resident 59) of 5 residents sampled for nutrition to assure a resident maintains acceptable parameters of nutritional status. Findings include: Cross Reference to F725, Sufficient Nursing Staff. Resident (R)59's initial admission to the facility on 06/15/16. Diagnoses include unspecified dementia without behavioral disturbance, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side; chronic obstructive pulmonary disease, unspecified;	F 710	Resident 59□s weight is stable at present. Resident has been reassessed for meal assistance, weight loss and care plan updated as needed. Physician inserviced regarding documentation by DON/designee. Inservices will be ongoing as needed. Residents with weight loss have the potential to be affected by the alleged practice. Current residents with weight loss were reviewed for compliance and updates were made as needed. Nursing staff were re-inserviced on documentation and physician notification by the SDC or designee. Inservices will be ongoing as	

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F 710	Continued From page 60 cognitive social or emotional deficit following cerebral infarction; and dysphagia. Observation on 02/04/21 at 01:56 PM found R59 seated in the hall with her lunch tray. Tray consisted of pureed entree, rice, fruit, cranberry juice, water, and milk. Staff member approached R59 and asked if she wanted to try the beef curry, R59 nodded her head yes, R59 provided a spoonful to the resident and asked whether she liked the curry. R59 smiled and staff member offered to provide rice as it is more neutral in taste; however, the staff member was called away to assist another staff member. R59 was provided with built-up utensil handles. Second observation on 02/05/21 at breakfast found R59 seated in a wheelchair, which was placed in the hall, eating a sandwich. Her breakfast tray consisted of papaya, hot cereal, sandwich, water, milk, coffee, and juice. Record review found on 08/05/2020, the resident weighed 130 lbs. and on 02/03/2021, the resident weighed 114 pounds which is a 12% weight loss in six months. A review of the quarterly Minimum Data Set with an assessment reference date of 01/21/21 found R59 requires extensive assist with one-person physical assist for eating. R59 was also coded with a weight loss of 5% or more in the last month or 10% or more in the last six months. A review of the physician's order found Boost Plus, 120 ml at breakfast and lunch was ordered on 09/14/20. Further review found no documentation that R59's physician evaluated and addressed medical and nutritional issues related to the weight loss.	F 710	needed. DON / designee will monitor / audit physician notification and physician documentation for weight loss residents weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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The quarterly Nutrition Assessment (01/26/21) notes the following nutrition problem: nutrition risk related to significant weight loss, dysphagia, variable PO intake as evidenced by weight loss >10% in six months, requires mechanically altered diet and consumes 25-75% of meals. Of note, R59 had acute admission from 09/05/20 to 09/14/20 due to sepsis secondary to e. coli bacteremia and experienced a significant weight loss of 17 pounds (13%) in approximately three months (07/02/20 to 10/22/20). Registered Dietitian (RD) notes R59's weight has been stable since 10/22/20. RD has informed R59's Durable Power of Attorney (DPOA) "multiple times" regarding weight loss; however, DPOA declines need for nutritional supplement as previously R59 was overweight. The DPOA was agreeable to Boost supplement twice a day due to ongoing weight loss.

On 02/09/21 at 04:04 PM telephone interview was conducted with RD. RD reported initially family was not agreeable for a supplement but later was agreeable. RD also reported R59's BMI (Body Mass Index) is within normal limits, the weight has been stable and most recent lab results in January 2021 showed albumin levels went up. Inquired whether R59's physician was consulted regarding the weight loss. RD responded nursing will usually communicate with the physician.

On the morning of 02/11/21 requested documentation that R59's physician was notified of the weight loss and whether the physician reviewed and evaluated R59's weight loss and nutritional issues. On 02/11/21 at 09:49 AM, DON reported that she contacted R59's physician and he confirmed that he was aware of the weight loss. However, DON could not find

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F 710	Continued From page 62 documentation of notifying R59's physician of weight loss and whether he had suggestions for further evaluation or change in orders.	F 710		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff members and resident representatives, and record reviews, the facility failed to provide	F 725	Staffing and unit assignments were reviewed to ensure sufficient staff are available to meet residents□ needs.	3/27/21

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F 725	Continued From page 63 services by sufficient nursing staff to assure: residents received assistance with their meals to promote a dignified dining experience and prevent weight loss; residents received their medications on time to prevent medication errors; residents are monitored to prevent infection control breeches and the spread of COVID-19; and residents receive care for pain and personal care to attain/maintain their highest practicable physical, mental and psycho-social well being. Findings include: 1) Cross Reference to F710, Resident's Care Supervised by a Physician. R59 had a significant weight loss, greater than 10% in six months. Observation found the staff member assisting resident with her meal was called away to assist a fellow staff member. There are two certified nurse aides assigned to this unit of 22 beds. 2) Observation of the dining room on 02/04-/21 at 12:30 PM found R28 and R18 seated in the dining room on different tables. R28 walked over to R18 and took a bowl of rice from R18 and proceeded to eat it. There was no staff supervising the dining room. Concurrent observation and interview with kitchen staff confirmed, the bowl of rice belonged to R18 and R28 should not be taking food from others. 3) A resident representative interview was done on 02/05/21 at 10:39 AM. Inquired whether there are enough staff to provide care to the residents. The representative replied that the facility could probably use a little more staff and observe residents calling out for help but the staff	F 725	Dining room assignments were updated to provide additional coverage. Phone calls were rerouted during med pass to allow nurses to concentrate on medication administration. Facility residents have the potential to be affected by the alleged practice. Administrator / DON / designee will review staffing daily to ensure compliance. Administrator / DON / Regional Nurse will have a weekly recruiting call with HR to hire additional staff. Administrator / DON / designee will monitor / audit staffing weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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members are always busy.

4) On 02/10/21 at 09:19 AM, observed Registered Nurse (RN)6 begin to pass medications on the Pikake unit. The 08:00 AM medication (med) pass was completed at approximately 10:40 AM. During the med pass, RN6 had to answer and manage the following six phone calls:
09:32 AM, Pharmacy called with a question.
09:36 AM, Call about a resident going out that needed paperwork (transport waiting)
09:41 AM, MD called and inquired if RN6 had called him. RN6 had to stop preparing medications and made two calls on the portable radio to find out who called the physician.
09: 50 AM, Call regarding authorization for a resident consult.
10:15 AM, Resident's family member called
10:40 AM, Ilima called regarding a resident.
Throughout the med pass, RN6 had to multitask with phone calls and other tasks. During the med pass, a resident self-propelled into the hallway without a mask. Interruptions during medication preparation and administration increase the risk of error and should be minimized.

On 02/10/21 during the medication pass, RN6 said, "Need two nurses, One can not handle." When inquired why all the phone calls came to portable phone she carried, RN6 said they don't have any unit secretaries and she was the only RN for the two units (Pikake and Ilima). She went on to say when the RN leaves Ilima, the phone is transferred to the portable.

On 02/11/21 at 10:00 AM, observed RN11 preparing medications outside the Ilima nursing station. When inquired who she was preparing

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the medications for, she said one of the residents on Pikake. Asked RN11 if the medications were the 08:00 AM medications and she said they were. RN11 said since they opened Pikake as the COVID unit, they were often late passing the meds because one RN covers both Pikake and Ilima and the medications on Ilima are passed first..

5) On 02/10/21 at 01:29 PM during an interview with the Director of Nursing (DON), inquired how the staff were handling the changes with the Pikake unit and transmission precautions. The DON said the staff had expressed concerns about the staffing in the Yellow Zone (Pikake) because it is a bit heavier load with the logistics of being in a different area and closed doors.

6) Cross reference F880, Infection Control
On 02/09/21 at 01:14 PM observed R32 self propel himself in his wheelchair through an unsecured door in the middle of the unit (Pikake) designated for COVID-19, Persons Under Investigation (PUI's) and new admissions. This unit required additional transmission precautions. There were no Pikake staff in sight to see R32 enter the restricted area. The unit had two CNA/NA's (Certified Nursing Assistant/Nurse Aide) on duty at the time, who were working with residents behind closed doors. The RN assigned to the unit works between the Ilima unit and Pikake unit, and was not physically on the unit at the time.

7) Interview with Resident Council on 02/08/21 at 12:04 PM, R16, who shares a room with R52, stated that there is "...only one nurse per shift, who has to put a lot of things on her mind and forgets things..." that are requested. For example,

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R16 stated, that R52 has a Tylenol request from this morning but has not received it. R52 confirmed this. R16 further stated his thoughts about overnight staff, "...they come in and sleeping, so it takes a long time when calling for help." Another example given by R16, after R52 uses his call light for assistance, he "...has to wait, but staff are real slow, sometimes he already walked himself to the bathroom by the time someone comes to assist...Getting staff attention is difficult."

8) Observation on 02/10/21 at 10:22 AM, R51 was heard calling from her room, "I want to go bathroom!" about five times. At 10:24 AM Certified Nursing Assistant (CNA) 37 walks by R51's room as she is requesting for assistance. CNA37 uses her walkie talkie radio and says "going on break" without investigating where the cry for help was coming from or asking a Registered Nurse (RN) or another CNA to investigate.

9) Cross Reference with F550, Resident Rights/Exercise of Rights.

On 02/09/21 at 11:47 AM observed residents with their lunch in front of them in the dining room and activity room at Hale Ho'Olu unit. There were also residents who chose to eat in their room or slept during lunch. There were two CNA's in the dining room assisting two residents with their meal. At 12:10 PM, R11 wakes up and RN1 brings her to the dining room for lunch and proceeds to provide her assistance with her meal. Interview with RN1, confirmed there are two CNA's and one RN assigned to Hale Ho'Olu unit and there are five residents that needs assistance with their meal. Two of the five residents who need assistance

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F 725	Continued From page 67 were waiting for staff to assist them with their meal. No staff available or present during dining in activity room or hallway near resident rooms. Interview with RN1 on 02/10/21 at 09:49 AM regarding staffing, stated " ...sometimes there are times where we need more help but when we have the activities coordinator, she is able to help out." RN1 explained, during dining, there are three staff members to help with dining and five residents who need assistance during dining. "When we are finished with assisting a resident, we will go to other resident to help." RN1 confirmed there are residents who will have to wait to be assisted during meals.	F 725		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not	F 726		3/27/21

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F 726	Continued From page 68 limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review (RR), the facility failed to assure the nursing staff had the competency and skill set to provide nursing care to two (Residents 25 and 15) of a sample size of 20 residents. The nursing staff did not demonstrate competency for: cleaning up bodily fluids; implementing a resident's care plan, including the use of prn medication to address spitting behavior; adequately monitoring and documenting resident's spitting behavior; safely prepare medications for residents; and documenting administration of prn medication (Tylenol). Finding include: 1) Observed R25 sitting in a wheelchair in the hallway by the nursing station positioned adjacent to the medication cart where RN3 was standing in front of the cart. R25 spit a large amount of saliva on to floor which projected and covered approximately a two foot by 2-foot area. RN3 pulled some wipes from the purple container (Sani cloth germicidal disposable wipes) on the medication cart, put on gloves, and proceeded to clean up some of the saliva on the floor and throw the wipe into the trash can. RN3 pulled a rolling	F 726	Residents 15 was treated for a UTI and recovered. Resident 25□s care plan was updated regarding his □spitting□. Nurses involved were re-inserviced regarding infection control, cleaning bio spills and following the mitigation plan by the SDC/designee. Inservices will be ongoing as needed. Facility residents have the potential to be affected by the alleged practice. Nursing staff were re-inserviced regarding infection control, cleaning bio spills and following the mitigation plan by the SDC/designee. Inservices will be ongoing as needed. SDC / DON / designee will observe and review infection control practices weekly to ensure compliance. DON / designee will audit infection control weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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chair through some of the remaining fluid on the floor and positioned the chair in front of R25. Prior to sitting, to assist with feeding, she threw a wipe on the floor and with her foot moved it back and forth several times in attempt to clean up the remainder of the fluid on the floor. RN3 did not move R25 from the area for a thorough cleaning and did not notice the significant amount of visible saliva under the overbed table on the floor, on the legs of the overbed table and on the extension bar.

Saliva is a bodily fluid and should be considered potentially infectious. Any bodily fluid spill should be cleaned up immediately and decontaminated. RN25 did not demonstrate competency in infection control and did not clean up the fluid utilizing current standards of practice of infection control.

2) During an interview with RN3 discussed R25's behavior of spitting. RN3 said, "He use to have PRN (as needed) medication for it, but I don't think he has it anymore. RN3 was unaware R25 had a current order for medication as needed for the behavior of spitting, or that the medication was an intervention in his care plan (CP). RN3 did not demonstrate competency to provide care and respond to R25's individual needs as identified in his CP.

3) Cross Reference F842, Resident Records.

The nursing staff did not demonstrate competency in accurately documenting R25's progress toward the CP goals in the medical record. R25's medical record did not reflect the ongoing behavior of spitting, frequency, amount or interventions. The record did not contain

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sufficient information to reflect his progress or lack of progress toward the CP goal of decreased behavior of spitting.

4) On 02/09/21, observed RN3 had just completed preparing some medications. Inquired what the medications were and who was to receive them. RN3 reviewed the medication orders with surveyor for the two residents in Room 106 (R13 and R40). RN3 had a small tray she placed the two medicine cups on, took the tray into the resident's room, and administered the medications. It was noted neither of the medication cups were labeled with resident's name. This is an unsafe practice and does not current standards of nursing practice.

On 02/10/21 at approximately 02:00 PM, during an interview with the Infection Preventionist (IP), inquired what the practice was at the facility for medication administration and if it was considered standard of practice to prepare two residents' medications at the same time. The IP said it was the facility policy to prepare and administer one resident's medication at a time, and it would not be considered standard of practice to do more than one at a time.

On 02/11/21 at 10:27 AM, observed RN11 preparing a resident's medication utilizing the cart outside the Ilima nursing station. When inquired who the medication was for, she said it was for a resident on the Pikake unit, but that she does not take the medication cart to that unit due to the transmission precautions. Inquired if she prepares one at a time or prepares all of the medications for Pikake and then goes to the unit. RN11 said, it takes more time, but she would never prepare more than one medication at time.

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F 726	Continued From page 71 5) Cross Reference to F880, Infection Control and F842, Resident Records. On 02/06/2020 at 08:46 AM, observed R15 awake in bed. R15 complained of not "feeling good" and reported an episode of emesis. Review of R15's physician orders documents an order for "Acetaminophen 650 mg, twice a day as needed, for pain, do not exceed 3 grams APAP in 24 hours." Nursing progress notes documented staff administered Acetaminophen 650 mg for fever of 100.9 F, not for pain. Additionally, nursing staff did not document the administration of Acetaminophen 650 mg on the Medication Administration Record (MAR). On 02/09/2021 at 09:15 AM, conducted an interview with Nursing Administration (NA)2 and the Director of Nursing (DON). The DON and NA2 confirmed medications should be administered as ordered and documented on the MAR.	F 726		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758		3/27/21

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F 758	Continued From page 72 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview with resident and staff members, the facility failed to ensure: target symptoms for a resident receiving psychotropic medication had been identified	F 758	Resident 40□s documentation was updated to include a proper diagnosis for medication usage and a behavior monitoring sheet was put in place.	

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F 758	Continued From page 73 resulting in no monitoring of the symptomatic behaviors to re-evaluate the efficacy (i.e. need for reducing or discontinuing) of the prescribed medication; a psychotropic medication was necessary to treat a diagnosed condition; and a physician's rationale for exceeding 14 day limit of a PRN (pro re nata/as needed) psychotropic medication was documented for 2 (Residents 40 and 58) of 5 residents reviewed for psychotropic medication usage. Finding includes: 1) Record review on 02/05/21 at 02:37 PM found Resident (R)40 was admitted to the facility on 08/26/19. Diagnoses include the following: major depressive disorder, recurrent; benign prostatic hyperplasia with lower urinary tract symptoms; neuromuscular dysfunction of bladder, unspecified; and infection and inflammatory reaction due to indwelling urethral catheter. R40 was interviewed on the morning of 02/04/21. R40 reported that he is concerned that he is losing his memory and requested ice cream as it makes him feel better. Further review found a physician's order for Cymbalta (delayed release) for diaphoresis and decreased mentation. A review of the monthly medication review for 01/29/21 found notation from the pharmacist to nursing to "add a behavior monitor sheet for this resident" and to "record specific behaviors and any side effects noted with use of psychoactive medications given". The pharmacist further instructs to "record all behaviors noted, even if medication is not given as the intervention".	F 758	Resident 58□s documentation was updated to reflect reason for medication usage past 14 days. Residents on psychotropic medication have the potential to be affected by the alleged practice. Licensed nursing staff were inserviced regarding proper diagnosis and documentation for psychotropic medication by SDC or designee. Inservices will be ongoing as needed. Current residents on psychotropics were reviewed for compliance and updated as need. DON / designee will monitor / audit residents on psychotropics weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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F 758	Continued From page 74	F 758		

Also found "Note to Attending Physician/Prescriber" from the pharmacist dated 01/28/21 notifying the physician R40 receives antidepressant therapy and to provide an appropriate diagnosis for use of Cymbalta. The physician provided, major depression, late onset Alzheimer dementia with behavioral disturbance.

A review of the Medication Administration Record (MAR) for February found no identified target behavior related to the use of Cymbalta. The instruction notes: at the end of each shift mark frequency, how often behavior occurred and intensity, how resident responded to redirection (intensity code: 0 = did not occur; 1 = easily altered; and 2 = difficult to redirect).

On 02/08/21 at 09:40 AM concurrent record review and interview was conducted with the Director of Nursing (DON) and Infection Preventionist (IP). Staff members confirmed the start date for Cymbalta was 11/14/20. The IP confirmed the MAR does not identify the targeted behaviors (symptoms for staff to monitor) related to the use of Cymbalta.

2) Review of R58's records noted a physician's order dated 09/18/20 for Trazodone, 25 mg PRN, PRN every 6 hours for 6 months with a diagnosis of non-redirectable anxiety. The PRN order of the psychotropic medication exceeded 14-day limit. Rationale was not documented by attending physician or prescribing practitioner for the PRN order to be extended beyond 14 days.

Interview with Registered Nurse (RN) 1 on 02/08/21 at 01:51 PM stated the Trazodone 25 mg PRN is administered when staff are unable to redirect R58's behavior such as yelling.

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F 758	Continued From page 75 Concurrent review of the physician's order indicated diagnosis used for the PRN of Trazodone is to treat unspecified dementia without behavioral disturbance. Interview with Infection Preventionist (IP) on 02/08/21 at 03:11 PM, IP reviewed R58's medical record and was not able to find documentation of the prescribing practitioner's rationale for extending the Trazodone 25mg PRN order beyond 14 days.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 761		3/27/21

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F 761	Continued From page 76 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with staff members, the facility failed to ensure one of the medication storage rooms was locked. The Illima medication room was observed to have the door wide open and not secured. This allowed access to medications not stored in the locked refrigerator or cabinet to unauthorized individuals. As a result of this deficient practice medications are accessible to unauthorized individuals including residents who potentially may ingest medications that could cause significant adverse consequences. The facility also failed to ensure an inhaler was labeled with an open (first usage) and expiration date. Findings include: 1) On 02/08/21 at 03:15 PM observed the Ilima nursing station door open with no staff in the station. On entry to the nursing station, observed the medication room door wide open, which allowed access to all unlocked medications as well as supplies in the room, which included syringes and intravenous fluids. The medication room contained bins of multiple bottles of medication on both counters visible on entry to the room. The room had a small refrigerator with medications that was also not locked and accessible. After approximately 5 minutes, RN5 entered the station and noticed surveyor inside the medication room. At that time asked RN5 if he had forgotten to lock the medication room. RN5 said he thought the other nurse was there. RN5 said he was unaware that both the nursing station and medication room	F 761	Medication room door was secured. Albuterol inhaler was discarded. New one was opened and dated. Nurses involved were in-serviced by DON or designee. Inservices will be ongoing as needed. Residents receiving medications have the potential to be affected by the alleged practice. Licensed nurses were re-inserviced on medication labeling and med room security by the SDC or designee. Inservices will be ongoing as needed. DON / designee will monitor / audit medication labeling and med room security weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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F 761	Continued From page 77 doors had been left open. 2) On 02/10/21 at 10:10 AM observation of the medication cart was done with RN1. The cart contained albuterol sulfate inhaler with no documentation of date it was opened. RN1 confirmed the inhaler had been used and was not labeled with an open date. RN1 reported this resident was recently transferred to the unit. Further queried after first usage, how long before medication expires. RN1 agreed to follow-up. On 02/11/21 at 08:48 AM, interviewed RN3 regarding labeling albuterol sulfate inhaler with an open and expiration date. RN3 reported the pharmacy will usually put a label on the medication to document the date of first use and a discard date. Inquired how many days after first use is albuterol sulfate to be discarded. RN3 checked a grid that was stored on the medication cart; however, was unable to locate the information related albuterol sulfate. RN3 demonstrated the label on another inhaler which was affixed by the pharmacy that documents the open date and number of days before expiration date. On the afternoon of 02/10/21, RN1 reported that medication can be kept and used up until the expiration date; however, should be labeled when first used/administered.	F 761		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care.	F 790		3/27/21

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F 790	Continued From page 78 §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on observations, record review (RR), and interviews, the facility failed to provide documentation of routine dental services for one	F 790	Resident 9 had an oral assessment completed and referral to dentist made. Nurses involved were re-inserviced	

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F 790	Continued From page 79	F 790		

resident (R)9. In addition, the facility failed to identify a change in dental status (loss of several natural teeth), discuss dental services with her, or help to set up an appointment and transportation if needed. As a result of this deficiency, the facility did not thoroughly assess R9's risk and/or underlying causes to the extent possible of R9's change in dental /oral condition and the impact on her. The assessment of dental needs and follow up could affect any resident in the facility.

Findings include:

R9 is an 84-year-old admitted to the facility on 07/23/18 after a stroke that affected her right dominant side. Her medical history included dysphasia, Type 2 diabetes mellitus and hypertension. R9's diet order was "chopped solid," food cut into bite-size smaller pieces. Her most recent comprehensive assessment Minimum Data Set (MDS) dated 01/21/21 revealed a Behavioral Interview for Mental Status (BIMS) score of 14 (range from 0-15). The higher the score, the lower the cognitive impairment.

On 02/05/20 at 08:50 AM, during an interview with R9, asked if she had any dental concerns. R9 said she had "recently" lost some of her teeth. She was not able to provide a specific time, but that it "happened in the past couple of months." R9 said she was still able to eat and currently did not have any pain. R9 said she thought she may be waiting for her son to be available to take her to the dentist, but no one had discussed it with her. When inquired when she had last seen a dentist, R9 replied, "It's been a long time."

Observed R9 had her natural teeth and was missing several upper teeth as well as a lower

regarding follow up with dental referrals by SDC/designee. Inservices to be ongoing.

Facility residents have the potential to be affected by the alleged practice.

Licensed nursing staff were re-inserviced regarding dental assessments and follow up with physician and dental appointments by SDC or designee. Inservices will be ongoing as needed. Current residents will receive dental assessments annually with their annual MDS.

DON / designee will monitor / audit dental assessments weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.

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F 790	Continued From page 80 front tooth. RR of progress notes, care plan and care plan meetings revealed no documentation that R9 had recently had a dental change and lost several of her natural teeth. RR revealed a physician order dated 07/25/20; "Dental, special instructions: consult and treat." On 02/10/21 at 02:39 PM during an interview with the Clinical Specialist (CS), she said the dental consult order was a routine annual order that was entered into the electronic medical record (EMR) when they implemented the new system, and not related to the missing teeth. A request was made for a copy of R9's dental exams for the past two years. On 02/10/21 at 11:25 AM, the CS reported she was unable to locate any documented dental exams.	F 790		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on interview with a cognitively intact resident and record review, the facility failed to assure palatable food was provided Resident 40	F 804	There has been no changes in food, production or dietary staff. Dietary manager met with resident 41 to review	3/27/21

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F 804	Continued From page 81 to assure he maintains acceptable nutritive parameters. Finding includes: Resident interview was done on 02/04/21 at 10:48 AM. Resident (R)40 reported that the food used to be good at the facility; however, finds that it is not as good as it used to be. R40 clarified the food seems to have been frozen, thawed, and reheated. Record review of a quarterly Minimum Data Set with an assessment reference date of 12/30/20 found R40 yielded a score of 14 (cognitively intact) when the Brief Interview for Mental Status was administered.	F 804	likes and dislikes. Facility residents have the potential to be affected by the alleged practice. Administrator / Dietary Manager / designee will meet with resident council to discuss food preferences, palatability, taste monthly for the next quarter. Administrator / Dietary Manager / designee will monitor / audit meals 3 x weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		3/27/21

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F 812	Continued From page 82 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and review of the facility's policy and procedure the facility failed to ensure food products were discarded before the expiration date as evidence by an expired bottle of salad dressing and two plastic bags of expired food. The facility also failed to ensure cold food was held at appropriate temperature. Findings include: 1) On 02/04/21 at 08:58, conducted an initial survey of the kitchen with the Food Service Supervisor (FSS). Observed an opened bottle of salad dressing with an expiration date of 12/26/2020 in the main refrigerator. The FSS confirmed the bottle of salad dressing was expired and discarded the bottle. Observed approximately twenty plastic bags with cooked food in the freezer. The FSS stated the bags of food are previously cooked food which are frozen and reheated as an alternative meal for residents. Observed a plastic bag labeled Ham 11/13 and Stuffed Chicken 12/26. Inquired with the FSS regarding expiration of the bag of ham and stuffed chicken. The FSS confirmed the bag of ham and stuffed chicken should have only been kept for a month after the date written on the bag and the food should have been discarded. 2) On 02/10/21 at 09:40 AM observed kitchen staff preparing lunch. There was a covered metal pan containing cooked pot roast and a smaller plastic container with cubed cooked pot roast. Dietary Staff (DS)5 reported the meat was from the refrigerator and would be heated in the oven	F 812	Expired products were discarded. Pot roast was discarded. Dietary manager re-inserviced the involved dietary staff. Inservices will be ongoing. Facility residents have the potential to be affected by the alleged practice. Dietitian / Dietary manager / designee re-inserviced the dietary regarding expired food products, labeling and maintaining food temperatures. Inservices will be ongoing as needed. Dietitian / Dietary manager / designee will monitor / audit food products and supplies and food temps 3 x weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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F 812	Continued From page 83 for lunch. At this time, there was a pan of scalloped potatoes being heated in the oven. DS5 explained the cubed meat would be used for pureed diets. Requested DS5 to take temperature of the meat. The temperature of the whole pot roast piece and the cubed pot roast was 53 degrees Fahrenheit. Interview with Dietary Supervisor (DS) was done on 02/10/21 at 10:15 AM. The observation of the pot roast sitting out at room temperature and measuring at 53 degrees Fahrenheit was shared. DS responded DS5 usually brings out the meat, chops for puree then heats in a half pan. Inquired whether the expectation is that food items goes from refrigerator to the oven. DS replies, it usually does and was agreeable to follow-up with DS5.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 842		3/27/21

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F 842	Continued From page 84 (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services	F 842		

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F 842	Continued From page 85 provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interviews and record review (RR), the facility failed to maintain complete, accurate and readily accessible medical records of four residents (R)25, R65 R15 and R51 of a sample size of 20. The documentation of the quarterly care plan (CP) meeting on 12/02/20 for R25 was incomplete, and the nursing progress notes did not contain sufficient information to reflect his progress toward the goal of decreased behavior of spitting. In addition, R65 was discharged on 12/24/20 and did not have a discharge summary accessible in the medical record. R15 and R51's records did not accurately reflect medication management. Findings include: 1) RR revealed the documentation (Observation Detail List Report) of R25's CP meeting on 12/02/20 was incomplete. Although the template form included a specific section with common problems (i.e., behavior, pain, falls, oral/dental) to check if the care plan was in place and reviewed, there was nothing marked. The attendance at the meeting was left blank, and there were no notes documented by a nursing representative, or indication that a nursing representative attended. On 02/11/21 at 08:50 AM, the Director of Nursing	F 842	Resident 15 on longer resides at the facility. Resident 25□s care conference notes were updated. Resident 25□s Behavior monitoring sheet was updated for targeted behavior and medication monitoring. Resident 51□s MD notes have been corrected to reflect the correct treatment. Resident 65□s discharge summary is now in the medical record. Facility residents have the potential to be affected by the alleged practice. HIM Coordinator, licensed nurses and physicians were re-inserviced regarding appropriate documentation by the DON or designee. Inservices will be ongoing as needed. HIM Coordinator/ DON / SDC / designee will monitor / audit medical records weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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provided a one-page typed document she said was prepared by RN20. The document was titled "Care Conference Observation Note 12/02/20." The note included "11/16 resident with new behaviors of spitting observed, given orders for glycopyrrolate for hypersecretion with nurses charting intermittently on effectiveness of interventions." The note also included a list of the five times the medication was given for the behavior of spitting as needed (PRN). At 09:00 AM RR of the work history in the electronic medical revealed the care conference nursing note was entered into the medical record 02/11/21 at 08:03 AM.

2) RR of Medical Doctor (MD)3's progress notes encounter date 11/18/20, revealed the following entry; "Today, staff asked patient to be seen for excessive spitting and F/U skin rash... Per staff patient recently seen increased spitting onto the facility floor. Per staff patient in a day will spit enough to cover ~ 25% of the wing's floor. Staff constantly cleaning." MD3 documented the; "Disturbance of salivary secretion. Increased amount of spitting. Plan: -Monitor -Oral care Q (every) shift and PRN (as needed)
-Glycopyrrolate 1 mg PO (oral) Q 12H (hours) x 3 days, then Q 12H PRN.

RR revealed no documentation of R25 spitting in nursing progress notes prior to 11/18/20 when he was seen by MD3 for the behavior. After MD3's visit and direction to monitor the behavior, the progress notes revealed the following entries related to spitting:
11/18/20 at 09:32 AM: "Telehealth visit done this morning with MD3. Updated MD re: . . . and resident noted with increased spitting. Received new orders: 1. Glycopyrrolate 1 mg (milligram)

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PO (orally) q (every) 12h (hours) x 3 days 2. Glycopyrrolate 1 mg PRN q 12h PRN (as needed) dx (diagnosis) hyper secretions."
11/19/20 at 10:34 PM: "Resident compliant with taking Glycopyrrolate for hypersecretions . . ."
11/20/20 at 02:13 AM: "glycopyrrolate 1 mg: Resident continues glycopyrrolate 1 mg for hypersecretions.
11/20/20 at 06:48 PM: "Resident compliant with taking Glycopyrrolate for hypersecretions, tolerating well. Will continue to monitor."
11/21/20 at 01:34 AM: ". . . Resident continues on glycopyrrolate 1 mg for hypersecretions."
11/21/20 at 11:27 PM: "Resident given Glycopyrrolate for hypersecretions, resident still spitting."

There were no further progress notes documenting the frequency or amount of R25's behavior of spitting after the initial three days the new medication was given.

R25 was observed to spit on the floor by the survey team three times during the survey, twice on 02/04/21, and once on 02/08/21. On 02/04/21 at 12:20 PM observed R25 sitting in a wheelchair with overbed table in front of him. At that time, he spit large amounts on the floor, which covered an area approximate two feet by two feet around him extending into the hallway. RR of nursing progress notes revealed no entries documenting the observed behavior on 02/04/21 or 02/08/21.

On 02/04/21 at 01:45 PM during an interview with Housekeeping Staff (HK)1, she said R25, "Does it all the time."

The medical record did not contain an accurate representation of the actual experiences of R25's

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F 842	Continued From page 88 behavior and did not include enough information to provide a picture of his progress or lack there of. 3) R65 was discharged home from the facility on 12/24/20. His physician at the facility was MD1. RR revealed there was no physician discharge summary available in the electronic medical record. Request was made for the discharge summary, which was printed by the facility Medical Director (MD2) on 02/10/21 and provided to surveyor. The discharge summary was electronically signed by MD1 on 12/26/20 but was not readily available in the record. 4) Cross reference to F880 Infection Control and F726 Competent Staff Review of R15's progress notes for 02/05/21 documented staff administered Acetaminophen 650 mg at 08:30 PM for fever. However, the administration of Acetaminophen was not documented on R15's MAR. On 02/09/21 at 09:15 AM, the Director of Nursing (DON) confirmed all medications administered should be documented on the MAR. 4) Cross reference to F684 Quality of Care Conducted a review of R51's medical records. Physician notes written by Medical Doctor (MD)1 on 09/21/20 and 10/07/20 documented R51's "Edema has been under good control with Lasix and Bumetanide...". Review R51's of the Physician Order Sheet and MAR documented the order for Lasix (Furosemide) 40 mg, twice a day, was discontinued on 09/11/20.	F 842		
F 880 SS=L	Infection Prevention & Control	F 880		3/27/21

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F 880	Continued From page 89 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 90 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to establish a prevention control program to provide safety and protection for the residents of the facility. Immediate Jeopardy (IJ) was identified on 02/09/21 at 01:06 PM, the facility failed to isolate and place a resident on droplet precautions when the resident presented with signs and symptoms (fever, nausea, vomiting, and chills) of COVID-19 and screened positively for a person under	F 880	Resident 15 and roommates were tested for COVID and all were negative. Facility staff and physician were inserviced regarding following the mitigation plan by the DON/SDC/designee. Resident 32 did not enter the yellow zone. Residents are redirected from entering yellow zone by any staff member as needed. Staff were inserviced regarding not allowing entrance into yellow zones by	

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F 880	Continued From page 91 investigation. The facility's noncompliance could result in serious adverse outcomes (spread of COVID-19 to facility staff and other residents and possibility of COVID-19 related deaths). The need for immediate action was required to prevent a COVID-19 outbreak. The facility also failed to assure: residents were prevented from entering the yellow zone (unit reserved for newly admitted residents or residents under investigation for COVID-19; staff members did not don and doff appropriate personal protective equipment while on the yellow zone; staff member did not demonstrate proper technique for cleaning of bodily fluids; staff member utilized proper hand hygiene practices; proper set up of room for resident on contact isolation (the biohazard bin for doffing personal protective equipment was placed outside of the room); storing activity item in an unsanitary location; and storing scoopers in powder. Findings include: 1) R15 was admitted to the facility on 02/26/20 with a diagnoses which include cerebral infarction with hemiplegia and hemiparesis affecting the non-dominant side, dysphagia, Type 2 diabetes mellitus with hyperglycemia, hyperlipidemia, and hypertension. On 02/05/21 at 07:55 AM, observed Certified Nurse Aide (CNA)23 exiting R15's room with an emesis basin. CNA23 later confirmed R15 had vomited and was not feeling well. During the observation, this surveyor noted there were no isolation precaution or droplet precaution signs posted outside of R15's room. In addition, staff did not don the personal protective equipment	F 880	the DON/SDC/designee. RNs 3 and 6 were counseled and re-inserviced regarding infection control measures, PPE, and cleaning up spills by the DON/ SDC. Resident 25□s activity supplies are now stored appropriately. Resident 30□s trash bins were relocated. Administrator and Social Services were re-inserviced by the regional nurse regarding appropriate locations for resident council. Thickener was discarded and replaced with individual serving packages. Facility residents have the potential to be affected by the alleged practice. Facility staff were inserviced regarding infection control practices, mitigation plan, zoning for isolation, donning and doffing PPE, appropriate PPE, and cleaning of spills by the SDC/DON/designee. Inservices will be ongoing as needed. Administrator / DON / SDC / designee will monitor and audit infection control practices and adherence to the mitigation plan daily x 12 weeks. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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(PPE) while assisting R15 and roommates and no PPEs located outside of R15's room for staff use.

On 02/08/21 at 09:00 AM, reviewed R15's medical record. It was documented in the progress notes on 02/05/21 at 07:36 AM, R15 first presented with two (2) episodes of emesis, a temperature of 99.6° Fahrenheit (F), nausea, and chills. At 7:30 PM, R15 had emesis, temperature of 100.9°F, staff administered Acetaminophen 650 mg, and rechecked R15's temperature (99.5°F). At 11:45 PM, R15 had a fourth episode of emesis and a temperature of 101°F. Nursing staff administered a COVID-19 test on 02/06/21 at 00:29 AM which was negative.

On 02/09/21, conducted a review of R15's COVID-19 Screening Tool, completed by the Infection Preventionist (IP) on 02/05/21, due to R15's elevated temperature, vomiting, nausea, and chills. The screening tool evaluates four (4) clinical features and epidemiological risk, which includes other symptoms associated with COVID-19 and at risk for severe disease. The IP circled chills and nausea/vomiting as other symptoms. According to the evaluation instructions R15 should have been considered a positive screen for a person under investigation (PUI). If the screen is positive, staff is prompted to first report findings the primary care physician (PCP), IP, Medical Director (MD), and the Director of Nursing (DON) to determine if criteria is met for PUI, then isolate the resident.

On 02/09/21 at 09:15 AM, conducted an interview with the DON and the IP. It was initially explained to this surveyor the screening tool includes a dialogue with the MD and PCP then they use the tool to decide if the resident is a PUI. However,

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later in the interview, the IP stated the screening tool is used to assist nursing staff with reporting to the physician in an SBAR (Situation, Background, Assessment, Recommendation) format. Inquired if there is a process for completing the COVID-19 Screening Tool in the facility's COVID-19 Mitigation Plan. IP stated the COVID-19 Screening Tool is just a tool used to identify if the criteria for a PUI is met. If they are identified as a PUI then they are isolated for suspected COVID-19. Inquired if staff should immediately isolate a resident who presents with signs and symptoms associated with the COVID-19 virus, prior to calling the MD, PCP, IP, and DON to immediately contain the potential spread of the COVID-19 virus to staff and other residents. The IP and DON confirmed R15 was not immediately isolated and had R15 tested positive for the virus, there was the potential for an outbreak of the COIVD-19 virus throughout the facility.

On 02/09/21 at 10:39 AM, conducted an interview with the Medical Director (MD)2. Inquired with MD2 the process used to identify a potential PUI. MD2 stated staff report a resident's symptoms to the resident's PCP and the MD, then it is determined if the resident is a potential PUI. Inquired how the MD uses the facility's COVID-19 Screening Tool in determining a potential PUI. MD2 stated that prior to the surveyor mentioning the COVID-19 Screening Tool, MD2 was unaware the facility had implemented a COVID-19 screening tool or that staff was using it to evaluate residents. Inquired about identifying R15 as a potential PUI, MD2 stated R15 was not initially identified as a potential PUI because R15 did not have any respiratory symptoms and was not immediately concerned that R15's fever,

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vomiting, nausea, and chills are associated with the COVID-19 virus. MD2 stated the presence of respiratory symptoms is an important symptom when evaluating a resident for COVID-19. Inquired regarding the decision to test for the COVID-19 virus almost seventeen (17) hours after the onset of R15's symptoms. MD2 stated R15 had two (2) recorded temperatures over 100°F which prompted the testing to rule out COVID-19. MD2 also stated although COVID-19 was considered at first, maybe it should be considered initially for all residents, due to the wide range of different signs and symptoms a resident could experience. Additionally, MD2 stated, maybe a COVID-19 test should be implemented as a routine response to immediately rule out COVID sooner than later. If R15 had tested positive for the COVID-19 virus, it could have meant a facility wide outbreak. MD2 confirmed a resident should be isolated and droplet precautions implemented prior to contacting the doctors to evaluate if a resident is a PUI.

Review of the facility's COVID-19 Risk Mitigation Plan (revised 12/30/2020) documented a resident is only isolated and droplet precautions implemented once a resident is identified as a PUI. Additionally, the COVID-19 Screening Tool was not in the mitigation plan.

The facility was notified of the Immediate Jeopardy (IJ) on 02/09/21 at 1:06 PM. The facility provided an acceptable plan for removal of the IJ on 02/09/21 at 4:46 PM to the survey team. The corrective measure included: 1) Inservice for nursing staff regarding COIVD-symptoms, testing, isolation and reporting on 02/09/21. Inservice will be ongoing as needed. Nurses will

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not be allowed to work until training is completed; 2) Residents will be assessed every shift for signs/symptoms (s/sx) of COVID. If temperature is greater than 100°F or two or more other symptoms are present, residents will be given a point of care (POC) test and isolated as indicated by testing. Other symptoms include: Temperature greater than 100, chills, muscle/body aches, headaches, sore throat, nausea/vomiting, new loss of taste, fatigue, congestion/runny nose, and diarrhea. If positive resident has roommates, other roommates will be isolated for 14 days and will be tested every 4-5 days while quarantined. If asymptomatic and negative on the 14th day, then isolation will be terminated; 3) DON/IP/RCM will monitor for compliance through auditing vital sign sheets, medical record documentation and COVID-19 screening tools daily for a minimum of 12 weeks or until compliance is achieved; and 4) Audits will be a part of the Quality Assurance Performance Improvement Committee for a minimum of 3 months or until substantial compliance is achieved.

2) The facility developed a COVID-19 plan that would immediately isolate a positive COVID resident from the other residents. The plan was to utilize room 126 in the designated COVID unit area, Pikake (rooms 125-127). The plan included, "If needed to expand the COVID unit, we would relocate the residents from rooms (122-124) . . ." One of the strategies to prevent transmission was to place new/readmissions and PUI's under observation (quarantine) in these rooms to be monitored for signs and symptoms of COVID-19. When the unit does not have any positive COVID-19 residents, it is designated as a "Yellow zone" which required additional

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transmission-based precautions and was considered a restricted area to authorized staff only. No resident or visitor were to enter the area without face shield/eye protection and mask.

The facility had a Courtyard accessible to residents to go outside. Some residents were assisted to the Courtyard area by staff and others had the ability to self-propel in the wheelchair or ambulate. The Courtyard had two walkways that had a door at each end. Two of the doors opened into the recreational lanai area and the other two open directly into the hallway of the Pikake unit.

On 02/09/21 at 01:14 PM, observed R32 entering the Pikake unit through one of the Courtyard doors. R32 was in a wheelchair unaccompanied and self-propelled himself to the door, opened it and was preparing to enter the unit. There were no unit staff visible in the area. A dietary staff member saw R32 trying to get in and assisted him. On entry, R32 did not appear familiar with his surroundings and the dietary staff realized he was in the wrong unit, assisted him back through the courtyard door and to the other side of the facility.

3) The IP said the facility requirement for transmission-based precautions for personal protective equipment, (protective items or garment) to prevent cross contamination in the yellow zone included gown, mask, face shield and gloves when entering the resident room. PPE equipment was available outside each room on the Unit and the staff had been provided with face shields.

On 02/10/21 at observed RN6 pass the morning medications to the residents on Pikake. RN6 did

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not put on a gown when she entered the rooms to administer medications. When RN6 administered meds to Room 124, she was within approximately 2 feet and did not have her face shield down. This practice did not follow the facility policy or CDC guidelines.

On 02/10/21 at 01:05 PM during an interview with the IP, she said it was the expectation the RN's wear face shields and put on gowns when entering the room.

4) On 02/04/21 at 12:30 PM, observed R25 sitting in a wheelchair with an overhead table positioned over him in the hallway by the nursing station. RN3 was standing in front of the medication cart within sight. R25 had expelled (spit) an inordinate amount of bubbly saliva on the floor which covered an area of approximately two foot by two foot which included under the overbed table, on the table legs, the table extension arm and extended into two different hallways. RN3 did not immediately respond. When she did, she pulled some wipes from the purple container on the med cart, put on gloves, bent over, and proceeded to clean up some of the saliva and throw the wipe into the trash next to the nursing station door. She then pulled a rolling chair through some of visibly remaining saliva on the floor and positioned it so she could assist feeding R25. Prior to sitting, RN25 threw a wipe on the floor and with her foot moved the wipe back and forth to clean up the remainder of the fluid on the floor.

The housekeeper (HK)1 walked toward the area, and said, "Oh, there's a spill," and immediately pulled a yellow safety cone from the holder on the wall next to the nursing station and placed it to warn others of a wet floor. When surveyor left the

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area, there was still visible saliva under the table and on the table leg and extension while RN3 was assisting to feed R25.

On 02/05/21 at approximately 01:45 PM during an interview with the HK1, inquired if she had cleaned up the spill the previous day, and she said, "Yes, its not a problem, I'm used to it, it happens a lot with him (R25). HK1 went on to say she moved R25 in his wheelchair to another location so she could clean the area and the overbed table.

Review of the facility Isolation Policy's dated 01/11/20 included the statements:
page 3: "spills of blood or other body fluids should be removed, and the area decontaminated using the facility-approved spill kit.
Page 6: "resident/guest care equipment and environmental surfaces can become contaminated. Proper cleaning/disinfecting is important in the prevention of spreading infections. . . Environmental surfaces (to include floors and tabletops) will be cleaned on a regular basis, if spill occurs, and if visibly soiled.

5) On 02/08/21 at 11:30 AM the resident council interview was held. The surveyors were escorted through double doors on the Pikake Unit to Room 127. On arrival, the residents were already seated in the room. Room 127 is located across the social services office. The residents were escorted out of the room, through the double doors.

On the facility map, the Pikake unit has been designated as a COVID-19, yellow unit for newly admitted residents and for residents under investigation. This unit is also designed to

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transform into a red COVID unit with the use of zip walls to cohort positive COVID residents. At the time of entrance (02/04/21) the facility had a census of six residents on the Pikake unit.

On 02/08/21 at 03:00 PM,interview with the Infection Preventionist (IP) confirmed residents should not have been taken on the Pikake unit. The IP stated the interview would have been better if it was held outside.

6) During lunch meal on 02/05/21, observed R25 being assisted with his meal by Registered Nurse (RN)3. RN3 was wearing gloves and was handed a face shield. RN3 did not remove the gloves and put on the face shield which had a drawstring at both ends of the band that needed to be pulled to tightly affix the face shield. RN3 did not change her gloves/hand sanitize and continued to assist R25 with his meal.

7) On 02/08/21 at 01:51 PM observed a red trash bin, lined with a clear bag outside of R30's room (next to the door). Concurrent observation and interview with RN1 confirmed R30 is on contact precaution. RN1 also confirmed the red trash bin should be placed in the resident's room to doff personal protective equipment (gloves, gown) before exiting the resident's room.

Interviewed the IP on 02/08/21 at 03:00 PM. The IP reported R30 is on contact precaution for MRSA in a wound. The IP confirmed the red trash bin should be placed in the resident's room. Further queried whether the facility utilizes red trash liners to indicate the contents are biohazard materials. The IP replied the facility does not utilize red bags to indicate contents are biohazard materials. Biohazard materials/waste are double

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F 880	Continued From page 100 bagged then these bags are disposed in the designated bin for biohazard materials. 8) On 02/10/21 at 08:20 AM observed a colorful round disk stored in the excess catcher of the alcohol-based hand sanitizer dispenser. RN40 stated the disk, with a manufacturer's label Simon Says is for R25. Inquired whether the disk should be stored on the waste catcher of the ABHS gel dispenser. RN40 responded, no and agreed to return it to activities. 9) Medication storage observation was done on 02/10/21 at 10:10 AM. Concurrent observation with RN1 found a container of thickener with the scoop stored in the powder. Second observation at 10:40 AM with RN40 found no scooper in the container of thickener, RN40 reported the scooper has been missing so disposable spoons are used as a scoop. The scooper was stored in the fiber powder.	F 880		

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F 000	INITIAL COMMENTS	F 000		

The State Survey Agency (SA) Office of Health Care Assurance (OHCA) conducted a recertification survey from 02/04/21 to 02/05/21 and 02/08/21 to 02/11/21. The Extended Survey was completed on 02/17/21.

The facility was found not to be in substantial compliance with the requirements of §42 CFR 483, Subpart B for Long Term Facilities.

1) The facility was found not to be in substantial requirements of §42 CFR 483.80 Infection Control regulations and had not implemented the Center for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.

On 02/09/21 at 1:06 PM the SA notified the Administrator of Immediate Jeopardy at F880, Infection Control. The facility failed to ensure the protection of its residents as evidenced by not immediately isolating or implementing droplet precautions for a resident who screened positive as a person under investigation (PUI) for COVID-19.

On 02/09/21 at 4:46 PM the facility provided an acceptable plan for removal of the IJ and the survey team validated that the IJ removal plan was operational on 02/11/21 at 09:30 AM.

2) On 02/10/21 at 3:30 PM the SA notified the Administrator of Actual Harm at F684, Quality of Care. The facility failed to ensure a resident received treatment and care in accordance with professional standards following a fall resulting in

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F 000	Continued From page 1 the resident experiencing pain, weight loss, decline in activities of daily living, and surgical repair for a hip fracture. 3) The SA also investigated the following Aspen Complaints/Incidents Tracking System (ACTS) #8322, #8659, #7297, and #8685. Although the allegations were not substantiated, the facility was cited for associated deficient practices at F609 (reporting allegations to adult protective services) and F607 (development and implementation of policy and procedures to report allegations to adult protective services). On 02/11/21, the SA notified the Administrator of Substandard Quality of Care (SQC) at F607 for development and implementation of written policies and procedures that ensure reporting allegations of abuse, neglect, exploitation of residents, and misappropriation of resident property to Adult Protective Services (APS). As a result, the facility failed to ensure the safety of the residents in the facility. This deficient practice has and outcome for more than minimal harm and to affect all the residents in the facility. Survey Dates: 02/04/21 to 02/05/21, 02/08/21 to 02/11/21, and Extended Survey on 02/17/21. Census: 65 residents Sample Size: 20	F 000		
F 607 SS=F	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that:	F 607		3/27/21

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F 607	Continued From page 2 §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on a review of the facility's policy and procedures, review of reported allegations of abuse, and interview with staff members, the facility failed to include in their policy and procedure that as mandated reporters, all alleged violations involving abuse, neglect, and exploitation of residents and misappropriation of resident property are reported to Adult Protective Services (APS). The facility did not assure that APS is contacted to determine whether their agency would open and conduct an independent investigation. This deficient practice has the potential for more than minimal harm and is a systemic failure that has the potential to affect a large portion of the facility's residents. The facility did not report two of four allegations of abuse. Findings include: Cross Reference to F609. The facility did not report two allegations of sexual abuse to APS for independent investigation. Review of the facility's investigation of an allegation of sexual abuse for Residents 58 and 19 found no documentation of the facility	F 607	Reports on Residents 19 and 58 were called into APS (Adult Protective Services) Both reports were not accepted by APS. Abuse Prevention Policy was updated to include reporting to APS. The Interdisciplinary team (IDT) was inserviced on updated Abuse policy by the Administrator. Facility residents have the potential to be affected by the alleged practice. Facility staff were inserviced on updated abuse policy by SDC/designee. Inservicing will be ongoing as needed. Social Services / designee will monitor / audit incident reporting to ensure APS reporting 3 x weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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F 607	Continued From page 3	F 607		

reporting the allegations to Adult Protective Services (APS). A review of the policy and procedure entitled "Abuse Reporting and Investigation" found under the section entitled "Reporting and Timely Investigations", "Any alleged violations should be reported immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious injury or abuse, or not later than 24 hours if the events that cause allegation do not involve abuse and does not result in serious bodily injury. Any alleged violations will be thoroughly investigated as well as ensuring the prevention of any further abuse". Furthermore, "The results of the investigation and all reports of abuse must be reported to the Administrator, State licensing agency, resident/guest's physician, as well as the resident/guest's representatively immediately, within 24 hours of the occurrence of such an incident".

A review of the Abuse and Neglect power point used for training staff members notes to report to: Administrator/executive Director or Assistant Administrator, Director of Nursing, immediate supervisor, and social service manager or social worker/designee. And if abuse is committed, report to the Professional Licensing Bureau and Attorney General's Office. The training did not include information to report to APS.

Interview with the Social Worker (SW) on 02/09/21 at 02:10 PM, the SW reported the facility reports to APS when their investigation results in findings. Further requested a copy of the facility's abuse/neglect policy and procedure that addresses the following: screening, training; prevention; identification; investigation; protection;

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F 607	Continued From page 4 and reporting/response. On 02/09/21 at 03:31 PM, the Social Worker provided a policy and procedure entitled "Elder Justice Act and Abuse Prevention Policy". Review of the policy and procedures found no procedure to report allegations to adult protective services to determine whether an investigation will be pursued by their agency. On 02/11/21 at 03:00 PM concurrent review of the policies and procedures related to abuse/neglect provided by the facility were reviewed with the Administrator. The Administrator confirmed the policy and procedure did not include reporting allegations to adult protective services. Further queried whether the facility contacts APS for consultation to determine whether they will open an investigation. Administrator shared the facility doesn't report all allegations to APS. On 02/17/21 during the extended survey, the Administrator provided an updated policy and procedure entitled "Elder Justice Act and Abuse Prevention Policy" which was revised to include for reporting: "Should the investigation reveal that suspected or actual abuse occurred, the Administrator, or appointed designee, must report such findings to the resident/guest's representative, and as required by current State and Federal Laws, to such agencies as the local police department, Ombudsman, APS and the State licensing agency".	F 607		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		3/27/21

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F 609	Continued From page 5 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of the facility's policy and procedures and staff interview, the facility failed to immediately report allegation of abuse to the adult protective services (APS) in accordance with State Law for two of four facility reported incidents related to allegations of abuse. Findings include: Cross Reference to F607. As it is not the facility's practice to report allegations of abuse, neglect, exploitation of residents and misappropriation of	F 609	Reports on Residents 19 and 58 were called into APS (Adult Protective Services) Both reports were not accepted by APS. Abuse Prevention Policy was updated to include reporting to APS. The Interdisciplinary team (IDT) was inserviced on updated Abuse policy by the Administrator. Facility residents have the potential to be affected by the alleged practice.	

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F 609	Continued From page 6 resident property, the facility's policy and procedure was reviewed. The review found that the policy and procedure does not include reporting the APS. 1) The facility submitted an Event Report to the State Agency regarding an allegation of sexual abuse. On 11/30/19 at 03:20 PM, Resident (R)19 reported a Portuguese guy opened her brief, wiped, and touched her "private part", stating she got "raped" last night. The facility completed an investigation and was unable to substantiate the allegation. A review of the facility's documentation found a thorough investigation was completed. A review of the facility's "Incident Report" and "Event Report" submitted by the facility found this allegation was not reported to APS. A review of the facility's policy and procedure for abuse and neglect entitled "Abuse Reporting and Investigation" found the policy and procedure does not include reporting allegations to APS. On 02/09/21 at 02:59 PM interviewed the Social Worker (SW). SW confirmed a report was not made to APS regarding this allegation. Inquired whether the facility has another policy and procedure for abuse and neglect that includes requirements for screening employees, training of employees, prevention, investigation, protection of resident, and reporting/response. The SW was agreeable to follow up. On 02/09/21 at 03:31 PM, the SW provided a policy entitled "Elder Justice Act and Abuse Prevention Policy". A review of the policy found the facility will encourage residents, families, and	F 609	Facility staff were inserviced on updated abuse policy by SDC/designee. Inservicing will be ongoing as needed. Social Services / designee will monitor / audit incident reporting to ensure APS reporting 3 x weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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F 609	Continued From page 7 staff to immediately report any knowledge of allegations of abuse to Administrator, Director of Nursing, Immediate Supervisor and/or Social Service Director. Also included reporting to law enforcement agency if there is a reasonable suspicion of a crime against a resident (Elder Justice Act of 2010) and reporting to the State Agency. There is no documentation of reporting to APS. 2) Cross reference to F607 On 02/09/21 at 02:19 PM, interview with Social Worker (SW) confirmed that APS was not called for the sexual abuse allegation incident on 06/08/20 regarding R58. SW explained that during their investigation "...there were no findings, that is the reason we did not report it." SW would usually be the person to call APS and if she is not available a Nursing Manager would assist.	F 609		

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E 000	Initial Comments A recertification survey was conducted by the Office of Healthcare Assurance (OHCA) on 02/04/21 to 02/05/21 and 02/08/21 to 02/11/21. An extended survey was conducted on 02/17/21. The facility met the requirements for Appendix Z, Emergency Preparedness, §42 CFR 483.73 for long term care facilities.	E 000		

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

Electronically Signed | 03/22/2021

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.