STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING _____ B. WING _____	06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

(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 A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 06/02/2021 to 06/04/2021. The facility was found not to be in substantial compliance with 42 CFR 483, Subpart B. Survey Dates: 06/02/2021 - 06/04/2021 Survey Census: 34	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 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	F 550		7/19/21

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

Electronically Signed | 06/27/2021

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F 550	Continued From page 1 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, record review, and interview, the facility did not assure residents were treated with the respect and dignity during meals to promote enhancement of their lives, and in recognition of their individuality. This was evidenced by residents requiring assistance with eating in the dining room were made to wait for limited staff while other residents in the same room began to eat, and/or completed their own meals. In addition, when they did begin eating, the residents requiring assistance with their meals had their meals repeatedly interrupted when staff members were called away. Lastly, one resident (R)29 had a cloth clothing protector placed around her neck prior to each meal, and this was not her choice. As a result of this deficient practice, having been placed at risk of a decline in psychosocial functioning (embarrassment, shame, depression, dehumanization), these residents have been prevented from attaining their highest practicable well-being. This deficient practice has the potential to affect all residents in the facility.	F 550	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The DON will provide in-service training for all nursing staff, activity staff, and the SWD in regards to Dining Room Practices. This will include utilizing trays to deliver food and identifying which residents prefer using a tray while eating. The residents preferences will be identified and updated as needed through their care plans. Large clothing protectors will be discarded and the facility will provide cloth napkins to enhance the dining experience. Food serving will be modified to ensure that staff will be available to provide assistance for residents that require assistance during meals.	

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F 550	Continued From page 2 Cross Reference to F802. Residents requiring staff assistance with meals had to wait for staff to assist while other resident were already dining on their lunch meal. The longest waiting period was 48 minutes, resident was seated in the middle of the dining room with no food. Subsequently, the resident received assistance with her meal; however, staff was continually called away, interrupting her meal. The resident's meal was interrupted three times within a 17 minute period. Findings Include: 1) R29 was an 88-year-old female admitted on 05/11/21 following a right hip replacement. Other diagnoses include anemia, hypertension (high blood pressure), hyperlipidemia (increased lipids), dementia, and a history of falls. On 06/02/21 at 11:25 AM, an observation and interview were done with R29 in the dining room. R29 was observed having her lunch, which was served on a large plastic tray, with a large cloth clothing protector placed around her neck covering her chest and entire front torso. R29 was observed to be fully independent with feeding herself. R29 slowly and carefully cut the stuffed cabbage on her plate into bite-sized pieces without difficulty, then she began to feed herself lunch, with nothing falling off her fork, and not dropping anything. Once she had finished eating, R29 stood up to wipe her table-mate's area clean, as her area was already spotless. When asked if she wanted or had requested to wear a clothing protector, R29 answered, "no, they just put it on me." On 06/03/21 at 11:15 AM, an observation was done in the dining room of R29 sitting and waiting	F 550	How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All current and new residents have the potential to be affected by the same deficient practice. Each resident□s cognitive functioning and physical functioning will be identified through the MDS assessment. Residents identified as needing assistance with meals will be provided with activities until a staff member is available to assist them. The staff member will then bring the resident to the dining room to assist them with their meal. The facility will continue to recruit and train staff to assist residents with meals as identified by the Facility Assessment. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? An annual Dining Room Practices in-service will be provided for all nursing staff, activity staff, and the SWD. How the facility plans to monitor its performance to make sure the solutions are sustained?	

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F 550	Continued From page 3 for lunch. The Activities Director was observed setting R29 up for lunch, placing a large cloth clothing protector around her neck. R29's permission was neither asked for nor given prior to the clothing protector being placed around her neck.	F 550	The SWD will conduct a quarterly audit of dining room experiences. The DON will conduct random checks of dining room practices quarterly. The DON will review and revise the dining room practices and protocol annually or as needed.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the	F 578		7/19/21

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F 578	Continued From page 4 time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review (RR), the facility failed to ensure an Advance Directive and/or discussions regarding Advance Directives was documented in one resident's medical record. As a result of this deficient practice, resident (R)29 was placed at risk of not having her wishes honored for future health care decisions, should she become incapacitated. This deficient practice has the potential to affect all the residents at the facility. Findings Include: On 06/02/21 at 03:09 PM, a RR of R29's hard chart and electronic medical record (EMR) noted a POLST (Provider Orders for Life-Sustaining Treatment), and a selection of a surrogate, but no Advance Directive. Further review noted no social services documentation that it had been discussed with R29 or her surrogate. Advance Directive documentation was requested from the Director of Nursing (DON) on 06/04/21 at 08:48 AM.	F 578	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Licensed Social Worker (LSW) was notified about the deficient practice and updated the Social Services Initial Assessment Form to include Advanced Health Care Directive information. The SWD will be educated on the revised form and AHCD questionnaire. R29 was discharged on June 14, 2021, with the son stating he will continue as the surrogate since R29 has short term memory loss and has been residing with him due to her condition. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	

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F 578	Continued From page 5 On 06/04/21 at 11:42 AM, a brief interview was done with the DON in the Conference Room where she confirmed that R29 had no Advance Directive and it had not been discussed.	F 578	All new and current residents without an AHCD will potentially be affected by the deficient practice. The SWD will utilize the AHCD questionnaire when meeting with the resident or family member upon admission. The SWD will review the code status quarterly, including if an AHCD is present. The Administrator will be given a list of residents and the type of Medical Directives that are available in the EHR. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The LSW will conduct a quarterly review of residents AHCD, with reports and recommendations forwarded to the Administrator. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The LSW will conduct quarterly audits of the AHCDs.	
F 604 SS=E	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity.	F 604		7/19/21

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F 604	Continued From page 6 The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff members, record reviews, and review of the facility's policy and procedures, the facility failed to ensure 2 of 2 residents (Resident 29 and 25) sampled for physical restraints and one add-on resident (Resident 15) were free from physical restraints imposed for the purposes of discipline or convenience. The use of physical restraints	F 604	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? R25 the MDS will be reviewed and the ID Team will reassess the use of a blue pad and upper/top bedrail. The resident□s	

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F 604	Continued From page 7 was employed to restrict residents' movements which had the potential to contribute to a decline in physical functioning and/or affect residents' psychosocial functioning (agitation, shame, depression, dehumanization). This deficient practice has the potential to affect all the residents at the facility. Findings Include: 1) R25 was admitted to the facility on 01/15/20 with diagnoses that include hyperosmolality and hyponatremia, depressive disorder, vascular dementia with behavioral disturbance, and metabolic encephalopathy. Observation on 06/02/21 at 02:10 PM found Resident (R)25 in her room lying in bed. Bilateral upper rails were up, a folded blue floor mat was placed against the rail (extending the length of the upper bed rail) at the head of the bed with a geri chair placed at the foot of the bed, both items were on the left side of the resident's bed. The privacy curtain to the right side was drawn closed. There was a geri chair placed on the outside of the curtain which was placed against the resident's bed. The geri chair blocked the middle portion of the resident's bed. The resident's bed was positioned with her head and legs raised, creating a concave mattress. Second observation on 06/02/21 at 03:50 PM found R25 was out of bed. The folded blue mat and geri chair remained positioned at the head and foot of the bed as observed earlier. Third observation on 06/03/21 at 07:20 AM found the resident was out of bed and the folded blue mat and geri chair remained positioned to the left side of the bed at the head and foot of the bed.	F 604	Broda char will be stored outside of the resident□s room. R29 on June 4, 2021 at 5 PM the DON and Physical Therapy Aide (PTA) discussed the resident□s physical limitations. The DON was updated by the PTA that the resident□s physical strength had improved, her ability to ambulate increased, and the wheelchair was no longer needed as a mode of locomotion. R29 was moved to a regular chair during activities and dining, and the pin alarm was removed. The resident was eventually discharged to home on June 14, 2021. R15 will be offered a regular chair to sit in while awake or during activities to ensure the least restrictive use of restraints or use of the recliner. The resident will be offered meaningful activities to ensure the resident remains free from falls or injuries. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All current and new residents that have a diagnosis of vascular dementia and exhibit restlessness that may require pin alarms or recliners may be potentially affected by the deficient practice. A restraint assessment will be conducted by the ID Team prior to the	

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F 604	Continued From page 8 Record review done on 06/03/21 at 10:30 AM found an annual Minimum Data Set with an assessment reference date of 04/30/21 documenting no use of restraints. A review of the care plan documents interventions for seizure disorder but no interventions to address placing the blue mattress and geri chair along the left side of the resident's bed. The quarterly "Morse Fall Scale" dated 04/15/21 indicates R25 has a history of falls and yielded a score of 55 (resident is a high risk for falling). Interview with the MDS Coordinator (MDSC) and Social Worker Designee (SS) was done on 06/03/21 at 01:54 PM at their desks in the breezeway. The MDSC reported R25 has combative behavior, she will fight staff. Further queried whether R25 ever fell out of bed. The MDSC found an incident on 07/18/20 R25 documenting R25 was awake, restless, and agitated. R25 threw pillows on the floor and slid down but did not fall on the floor. SS reported R25's bed is placed on the lowest position with a floor mattress plus pillows and rolled sheets are placed on the side of the resident as she can move around in her bed. Record review on 06/04/21 at 08:00 AM of progress note dated 07/18/20 at 06:52 AM (referenced by the MDSC and SS) documents R25 was "awake, restless, combative and agitated, calling out all night...shaking the left side rail...resident's head was right next to the rail while she was shaking." R25 was repositioned away from the rails and pillows were applied to both side, resident continued to grab all pillows. On 06/04/21 at 08:10 AM, interviewed Certified	F 604	implementation of pin alarms, bed alarms, and mattresses/pads. A quarterly or as needed assessment will be conducted to ensure a restraint free environment. All RNs will be provided an in-service on the facility□s restraint protocol to ensure all alarms will have a physician□s order. All Certified Nurse Aides and the SWD will be provided an in-service in regards to physical restraints. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? The DON will conduct quarterly, random checks to ensure a restraint free environment. The ID Team will promote a restraint free environment by assessing the appropriateness of physical restraints and the use of the least restrictive measures quarterly. How the facility plans to monitor its performance to make sure the solutions are sustained? The DON will conduct a quarterly restraint audit.	

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Nurse Aide (CNA)3 in the resident's room (resident was not present). Inquired whether the "Broda" chair belonged to R25, CNA3 responded, the chair belongs to R12 (roommate) and was placed next to the bed as she was feeding R12. CNA3 also stated sometimes staff store the chair there. Upon further query CNA3 reported R25 will move about in bed and sometimes the blue folding mat is opened and placed along both sides of the bed should R25 awaken, to make sure resident doesn't go down. CNA3 could not recall resident falling out of bed; however, recalled R25 bumped her head on the rail.

Interviewed the Director of Nursing (DON) on 06/04/21 at 08:29 AM at the nursing station. The DON reported R25 stays up at night and will try to grab staff and move about; however, there is no report of falls. Initially a bed alarm was used and has since been discontinued. The observation of the placement of the folded floor mattress and geri chair along the left side of R25's bed was shared with the DON. The DON acknowledged the placement of these items restricts R25's space and is a physical restraint. A request was made for the facility's policy and procedures on physical restraints.

A copy of the policy and procedures was provided by the DON on 06/04/21 at 10:40 AM. The intent of the policy is for residents to be free from any physical restraints imposed for purposes of discipline or convenience and not required to treat residents' medical symptoms. The procedure includes the following: performing a Restraint Assessment, no less than quarterly; try less restrictive measure such as pillows, bed monitors, anti-slip pads on chairs, wedge cushions, one side rail down, etc; assist resident

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with appropriate exercise to achieve proper body position, balance and adjustment and to prevent contractures; and consult with other health professionals.
2) R29 was an 88-year-old female admitted on 05/11/21 following a right hip replacement. Other diagnoses include anemia, hypertension (high blood pressure), hyperlipidemia (increased lipids), dementia, and a history of falls.

On 06/02/21 at 11:57 AM, an observation was done in the dining room. R29 was noted to have her wheelchair pushed up to a table with the wheels locked, and the footrests positioned at the level of her shins. R29 had just completed her lunch and was trying to stand up. As she struggled to stand, trying to push her chair back and in a crouched position with both shins pushed against the footrests of the wheelchair, R29's "pin" [chair] alarm loudly went off. The noise of the alarm startled R29, and she had an embarrassed look on her face as the Social Worker Designee (SS) rushed over to her and shut off the alarm. The SS then assisted R29 in standing, pushing the footrests out of the way, and walking her to the other side of the table where R29 wiped her table-mates area clean. SS then assisted R29 back to her wheelchair, where the chair alarm was reapplied.

On 06/03/21 at 07:03 PM, during a review of R29's electronic medical record and a copy of her baseline care plan, it was noted that there were no orders for a chair alarm, nor was it a part of her baseline or comprehensive care plans.

On 06/04/21 at 08:48 AM, an interview was done with the Director of Nursing (DON) at the nurse's station. When asked about the chair alarm and

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restricting the movement of R29, coupled with the wheelchair locks and footrests, the DON agreed that although the intention was not to restrain the resident, those interventions together do restrict the resident from standing. The DON also stated that all residents with bed or chair alarms should have an order for them. When asked to present the order for R29's chair alarm, the DON could not find one.
3) R15 was admitted on 1/25/13 with diagnoses that included vascular dementia with behavioral disturbances, hypertension, heart disease without failure, and anxiety disorder.

Multiple observations (06/02/21 at 08:43, 10:49 AM, 11:58 AM, 3:53 PM; 06/03/21 at 09:48 AM, 10:50 AM, 1:15 PM; and 06/04/21 at 10:15 AM and 12:10 PM) were made of R15 in the main dining room, laying in a recliner chair (the back of the chair lowered to an approximate 165 degree angle and footrest elevated which propped up R15's feet) sleeping and watching television (TV). On 06/02/21 at 11:58 AM, during lunch, observed R15 seated in the recliner with the back of the recliner an upright (approximately 90-degree angle) position. R15 stood up from the recliner and the Activities Director (AD) immediately ran over to R15 and told the resident to sit down. R15 sat back down then continued to attempt to stand but was unable to due to the AD standing directly in front of the resident. The AD placed his/her right hand on the front of R15's right shoulder and forcibly pushed R15's upper body towards the back of the recliner. The AD then laid the back of the recliner down, positioning R15 in a supine position on the resident's back. R15 made several unsuccessful attempts to stand from the recliner while in the supine position. After reclining R15, the AD proceeded to assist

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F 604	Continued From page 12 another resident with lunch. On 06/03/21 at 11:18 AM, conducted a record review (RR) of R15's hard chart and electronic health record (EHR) at the nursing station. On 04/10/21 at 2:08 PM, an activity note documented R15 is able to walk using a walker to use the toilet and to monitor R15 for safety because R15 will stand up when the recliner is in an up position. R15's Plan of Care note written on 4/09/21 at 2:26 PM documented R15 is a high risk for falls with no regards to safety. On 06/03/21 at 2:45 PM, inquired with the AD regarding observations of R15 in a supine position in the recliner. The AD stated R15 will stand up from the recliner if it upright and attempt to walk, but the resident is a high fall risk and will fall if unassisted. The AD continued to explain R15 is place in a supine position in the recliner because staff is unable to safely monitor and prevent R15 from falling due to the resident's impulsive behavior and lack of safety awareness.	F 604		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff members, the facility did not assure one of 15 resident assessments accurately reflected the resident's status. Resident (R)25 was erroneously coded for the use of an antipsychotic. Findings Include:	F 641	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? R25 the MDS on assessment dated 04/30/2021 will be modified by the MDSC	7/19/21

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F 641	Continued From page 13 Record review was done for R25 on 06/03/21 at 09:27 AM. Review of the comprehensive/annual Minimum Data Set with an assessment reference date of 04/30/21 documents in Section N. Medications, R25 was coded "7" for the number of days the resident received an antipsychotic in the last 7 days. A review of the physician's order found no documentation of a prescribed antipsychotic. Further review found a care plan for seizure diagnosis but no diagnosis of seizure disorder. The MDS Coordinator (MDSC) and Social Worker Designee (SS) were interviewed on 06/03/21 at 01:54 PM at their desk located in the breezeway. Queried whether R25 is receiving an antipsychotic. The MDSC reviewed R25's physician orders and stated R25 received Divalproex sodium sprinkle for diagnosis of dementia with psychomotor agitation. Follow-up interview was done with the MDSC on 06/03/21 at 02:37 PM at her desk in the breezeway. Inquired whether Divalproex sodium sprinkles is classified as an antipsychotic or an anticonvulsant (anti-epileptic), the MDSC confirmed Divalproex sodium sprinkles is an anticonvulsant and should not have been coded as an antipsychotic. The MDSC stated the Divalproex sodium sprinkles is being used to address R25's behavior and is often used for behavior. The MDSC stated maybe the MDS assessment needs to modified. Further queried whether R25 has a seizure disorder as a care plan was developed to address a seizure disorder. The MDSC replied R25 is diagnosed with metabolic encephalopathy. The MDSC was asked whether R25 has a history of seizures or	F 641	to accurately reflect the resident□s status. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All current and new residents with the diagnosis with dementia with behaviors that have a medication order of divalproex sodium may be affected by the deficient practice. The DON will review the facility□s 802 and 607 quarterly to ensure the MDS coding will be accurate to reflect a resident□s status. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? The facility will conduct a quarterly review of residents who are currently on divalproex sodium to ensure documentation from each resident□s attending physician, and the proper indication for the medication are documented. The DON will conduct a quarterly review of the facility□s 802 and 607 to ensure psychotropic drugs are accurately coded. How the facility plans to monitor its performance to make sure the solutions	

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F 641	Continued From page 14 diagnosis of seizure disorder related to metabolic encephalopathy. The MDSC confirmed, R25 does not have a seizure disorder, the use of the Divalproex sodium sprinkles (anticonvulsant) is being used to address R25's behavior.	F 641	are sustained? The DON will conduct a quarterly review of psychotropic medication use.	
F 656 SS=F	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 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.	F 656		7/19/21

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F 656	Continued From page 15 (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, and interview with staff members, the facility did not ensure that the development and implementation of comprehensive person-centered care plans were done for 7 (Residents 16, 29, 31, 11, 27, 25 and 30) of 13 residents in the sample. Specifically, care plans were not developed for positioning of residents during meals with the potential to result in aspiration. Residents experiencing weight loss did not have care plan interventions to address the problem which may affect residents' nutritional status. Activity care plans were not developed to include person-centered interventions that would engage the resident in meaningful activities. Care plans were not developed or implemented to protect a resident with fragile skin from bruising or skin tears and for a resident with behaviors that include picking at her skin causing skin tears. Care plan interventions (hand roll towel) were not implemented for a resident with hemiplegia to prevent hand contractures or the worsening of contractures. Lastly, care plan interventions were not developed to address communication needs for a resident that did not speak English. As a result of this deficient practice, these residents were placed at risk for a decline in their quality of	F 656	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? R27 on June 22, 2021 the DON notified the MD about the deficient practice and received an order for a PT evaluation and treatment as indicated for safe positioning. In addition, the DON will discuss the risks and benefits of the resident□s preference of positioning during eating with the resident and guardian. R25 the MDSC will revise and update the plan of care to prevent bruising, and interventions will be discussed with the nursing staff. R30 the MDSC will revise and update the plan of care to ensure the prevention of aspiration by utilizing proper positioning. The Certified Nurse Aides have noted an improvement in swallow when R30 is up on her recliner. This new intervention will be incorporated in the revised plan of	

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F 656	Continued From page 16 life, and were prevented from attaining their highest practicable physical, mental, and psychosocial well-being. This deficient practice has the potential to affect all the residents at the facility. Cross-reference to F684. Resident (R)27 is unable to stabilize her head in midline during her meals, her head falls forward and to the right. The facility did not assess and develop care plans to assist R27 with positioning during her meals to prevent aspiration of food and liquids. Cross-reference to F684. R25 has been noted with bruising to upper and lower extremities and chin. Review of the resident's care plan found an intervention for use of protective sleeves. Observations during the survey found the resident was not wearing protective sleeves. Cross-reference to F684. During observations, R30 was unable to position herself and stabilize her head during meals, her head falls forward, chin pointing at her chest. The facility did not assess and develop care plans to ensure R30 is positioned in accordance with professional standards of practice during her meals to prevent aspiration of food and liquids Cross-reference to F835. The facility experienced staffing challenges due to COVID, requiring the Director of Nursing (DON) and Minimum Data Set Coordinator (MDSC) to routinely be taken away from their primary duties to work on the floor. In addition, the DON was tasked with covering the day-to-day administrative duties while the facility Administrator worked remotely.	F 656	care. R16 the MDSC will revise and update the plan of care related to unexplained weight loss as recommended by the RD. R31 the MDSC will revise and update the plan of care to reflect the need of a Japanese interpreter. In the absence of an interpreter, staff will utilize translation applications to communicate with the resident. R29 the current MDSC failed to complete the comprehensive care plan, as noted in the EHR. Assessments are identified with grace periods and highlighted in red text as due dates approach. The MDSC did not prioritize assessments appropriately. The DON will train another MDSC and monitor all scheduled assessments and comprehensive care plans. R11 the MDSC will update and revise the plan of care and provide an in-service for all Certified Nurse Aides and nursing staff about interventions to prevent further contractures. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All current and new residents have the potential to be affected by the same deficient practice.	

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F 656	Continued From page 17 Findings Include: 1) Resident (R) 16 was admitted to the facility on 03/29/2016 with diagnoses of unspecified dementia with behavioral disturbance, age related osteoporosis without current pathological fracture, bilateral primary osteoarthritis of knee, hypertension, and unspecified hyperlipidemia. On 06/03/21 at 02:06 PM, reviewed R16's quarterly Minimum Data Set (MDS) with an assessment reference date of 04/13/21, in Section G. Functional Status, under Eating (how resident eats and drinks, regardless of skill.), R16 requires total dependence-full staff performance every time with one person physical assist. Under Section K. Swallowing/Nutritional Status K.0300.Weight Loss, R16 had a loss of 5% or more in the last month or loss of 10% or more in the last 6 months and is not on a physician-prescribed weight-loss regimen. On 06/04/21 at 01:03 PM, reviewed R16's monthly weight chart from 08/10/20 to 05/04/21, R16 was 164 pounds (lbs.) on 08/10/20 and gradually decreased to 138 lbs. on 05/04/21. In one year, R16 lost 26 lbs. Interview with the Dietician (D1) on 06/04/21 at 08:03 AM, on the phone, stated R16 had unexplained weight loss. D1 was unable to further elaborate due to not having the resident's record in front of her, but stated she believes R16 is taking a supplement. Inquired whether there should be a care plan for R16's weight loss, D1 stated it should be in the care plan. On 06/04/21 at 09:06 AM, reviewed D1's most recent progress note entry dated 05/01/21, " ...April 2021 wt [weight] review for resident w	F 656	The DON will monitor all completed assessments and comprehensive care plans for new admissions. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? All new admission assessments will be reviewed by the DON and the ID Team will review comprehensive care plans for all new admissions. After the ID Team reviews the plan of care, the MDSC will meet with all Certified Nurse Aides to review interventions. All preventative interventions will be placed in the PCC tasks (EHR) for daily monitoring. How the facility plans to monitor its performance to make sure the solutions are sustained? A comprehensive care plan audit tool will be utilized for a quarterly review by the DON.	

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[with]/significant, unexplained ...wt loss within the past 6 months ...Aspiration risk r/t [related to] hx [history of] difficulty swallowing and coughing during meals d/t [due to] advanced dementia: required a mechanically altered diet textured of minced solids. Remains on regular (thin) liquids. No noted problems on present diet, however requires total dependence w/meals d/t advanced dementia." Goals include maintaining R16's weight to prevent further unintended weight loss, no aspirations, maintain adequate hydration, no complains of constipation, and for R16 to consume 50% to 100% of food and fluids. In R16's dietary progress not, D1 recommended to add 4 ounces (oz) of Ensure Plus two times a day with lunch and dinner to prevent further weight loss. "Encourage adequate hydration throughout the day to a goal of 1500ml/day. Continue to provide assistance w/meals to promote improved PO [by mouth] intake. Continue to monitor wt, intakes, diet consistency tolerance, labs as ordered."

Concurrent review of R16's care plan with Director of Nursing (DON) on 06/04/21 at 10:06 AM, at the nurses' station, D1's recommendations were not included in R16's care plan. R16 did not have a care plan for her unexplained weight loss.
2) Resident (R)31 was an 89-year-old female admitted on 05/08/21 with diagnoses of Alzheimer's with Dementia, and a history of frequent falls.

During an observation and attempted interview with R31 on 06/02/21 at 11:45 AM in the dining room, R31 was noted to be sleepy with a flat affect and was not responsive to any greetings or questions.

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On 06/02/21 at 02:11 PM, a phone interview was done with R31's family representative (FR2). FR2 confirmed that R31 does not respond to questions or greetings in English any longer, stating that R31 has reverted to only speaking in and responding to communications given in Japanese. FR2 stated she and other family members had noticed that even with them, R31 is much more directable and agreeable if she is spoken to in Japanese. R31 also stated that she informed the facility of this upon admission and was assured that there were Japanese-speaking staff available.

On 06/02/21 at 08:08 PM, a review of R31's minimum data set (MDS) with an assessment reference date (ARD) of 05/21/21 noted question A1100 A. "Does the resident need or want an interpreter to communicate with a doctor or health care staff?" To which it is documented that the resident answered "yes." The same assessment also documented that the resident's preferred language is Japanese.

On 06/03/21 at 05:30 PM, a record review of R31's comprehensive care plan, initiated on 05/20/21, was done. It was noted that the comprehensive care plan included no Communication Plan or any interventions for interpreter services. It was also noted that despite having potential behavioral problems such as aggression, restlessness, and agitation identified and addressed, the comprehensive care plan contained no interventions that included addressing R31 in her preferred language.

On 06/04/21 at 08:48 AM, an interview was done with the Director of Nursing at the nurse's station. When asked about interpreter services for R31,

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the DON stated that the facility had a certified nurse aide (CNA) that worked full-time on the evening shift, and a physical therapist working full-time that could both speak Japanese. Other than that, the DON stated the facility did not have access to interpreter services. When discussing R31's comprehensive care plan, the DON agreed that communicating with R31 in her preferred language should be a part of any plan addressing behavior.

3) R29 was an 88-year-old female admitted on 05/11/21 following a right hip replacement. Other diagnoses include anemia, hypertension (high blood pressure), hyperlipidemia (increased lipids), dementia, and a history of falls.

On 06/02/21 at 03:09 PM, a review of R29's hard chart and electronic health record (EHR) noted a baseline care plan in the hard chart, but no comprehensive care plan initiated or documented.

On 06/03/21 at 01:29 PM, an interview was done with the MDS Coordinator (MDSC) at the nurse's station breezeway. The MDSC stated that she initiates the baseline care plan, which the facility keeps in the hard chart, then transfers it into the EHR to become part of the comprehensive care plan after 14 days. When asked about R29's comprehensive care plan, the MDSC checked the EHR and confirmed that it had not been initiated yet. The MDSC then stated that R29's comprehensive care plan should have been initiated by 05/24/21, but since she only does MDS duties twice a week and works as a floor nurse three days a week, she had fallen behind.
4) R11 was admitted to the facility on 06/17/19 with diagnoses including dementia with

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F 656	Continued From page 21 behavioral disturbances, hemiparesis and hemiplegia following other cerebrovascular disease affecting the left dominant side, bradycardia, muscle weakness, atherosclerotic heart disease, and hyponatremia and hypo-osmolality. On 06/02/21 at 11:39 AM and 06/03/21 at 09:54 AM and 11:44 AM, observed R11 did not have a hand roll towel or any other type of equipment placed in the resident's hands to prevent contractures. On 06/02/21 at 11:50 AM, conducted a record review of R11's electronic health record (EHR). Review of the resident's care plan documented hand roll towels should be placed in R11's hands as an intervention for the prevention of contractures which was implemented on 06/17/19. On 06/03/21 at 10:00 AM, conducted a simultaneous record review of R11's EHR and interview with the DON. The DON navigated R11's EHR and confirmed R11's care plan includes interventions to place hand roll towels in the resident's hands to prevent contractures. Shared observations made of R11 with no hand roll towels on 06/02/21 and 06/03/21. The DON confirmed hand roll towels should have been implemented for the prevention or worsening of contractures.	F 656		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan	F 679		7/19/21

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F 679	Continued From page 22 and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, interview with staff members, and record review, the facility failed to provide an ongoing program of activities for 1 of 5 residents (Resident 5) that were sampled for activities. Comprehensive person-centered care plans were not developed in accordance with the resident's assessments which had the potential to result in a decline of the resident's psycho-social well-being. The Resident's care plans were not individualized and specific to the resident's preferences and interests. Findings Include: Resident (R)5 was admitted to the facility on 11/27/20. Diagnoses include cognitive, social or emotional deficit; osteoporosis; and Type II diabetes mellitus. Observation on 06/02/21 at 09:01 AM, R5 was lying in her bed awake, asked the resident if she was okay and whether she had eaten her breakfast already. R5 replied she was okay but not sure if she had her breakfast. Subsequent observations on 06/02/21 at 09:28 AM, 11:08 AM, 02:12 PM (asleep), and 03:53 PM found R5 lying in her bed with the privacy curtain drawn across the foot of the bed, not engaged in any activity. R5 was observed eating her lunch at 11:44 AM.	F 679	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The ID Team will proceed to modify the MDS dated 12/10/2020 and the CAA for activities will be corrected to address a comprehensive person-centered care plan to enhance the quality of life. In addition, Section B of the MDS assessment will corrected to reflect the resident□s cognition. The AD will update and revise the resident□s preferences and interests on the activity flow sheet. The DON will collaborate with Bristol Hospice to engage residents in meaningful activities. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All current and new residents who prefer	

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F 679	Continued From page 23 On 06/02/21 at 03:57 PM the television placed at the back wall (to the resident's right side) was on, Travel station. On 06/03/21 at 07:20 AM, R5 was lying in bed awake with no activity. Subsequent observation at 10:10 AM, R5 was lying asleep in bed with an empty cup on her bedside tray. R5 was not observed in dining/activity area and there were no activity materials (books, newspapers) left in her room to engage in an activity of choice. Record review was done on 06/03/21 at 10:15 AM. R5's admission/comprehensive Minimum Data Set (MDS) with assessment reference date of 12/10/20 indicates R5 has a severe cognitive impairment. A review of Section F. Preferences for Customary Routine and Activities, the following items were marked as the resident's preferences: receive shower, bed bath, sponge bath, receiving snacks, family involvement, reading books, newspaper, or magazine, and listening to music. Activities was triggered on the Care Area Assessment (CAA); however, it was noted the interdisciplinary team decided not to develop an individualized care plan for activities. The care plan provided by the facility on 06/03/21 at 02:44 PM notes a care plan for activities with the goal for the resident to attend activities three to five times weekly. Interventions includes: all staff to converse with resident while providing care; invite the resident to scheduled activities; thank resident for attendance at activity function; resident needs assistance with ADLs as required during activity; resident needs 1:1 bedside/in-room visits and activities if unable to attend out of room events; and the resident needs assistance, escort to activity functions. Further review was done on 06/04/21 at 07:40 AM. A review of the "Activity Assessment Form"	F 679	to remain in their rooms will be potentially affected by the deficient practice. The AD will identify all resident□s activity levels and engage residents in an activity of their choice and preference. The activities staff will develop a daily assignment list to offer and provide activities for residents who prefer to stay in their room to ensure all residents have an activity of their preference. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? A monthly meeting with the AD and Assistant Administrator will be held to ensure adequate staffing for the activities department and to prepare necessary materials. An annual in-service for all activities and nursing staff will be conducted that will cover the Hand-in-Hand Dementia Care for All. How the facility plans to monitor its performance to make sure the solutions are sustained? A quarterly activity audit will be conducted by the AD to ensure that the deficient practice will not recur.	

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signed 12/10/20 lists R5's leisure interest as "spectator: watch TV/Movies/Sports; Music listening/plays instruments; and reading/writing/cognitive." There is a space to list specific preferences; however, it is blank. Also noted, resident is under hospice care and upon admission was on 14 day quarantine protocol; she has her own television to watch (likes to watch Korean drama); and newspaper to read or magazines will be offered.

Interview was done with the Activity Director (AD) on 06/04/21 at 08:18 AM in the activity/dining room. AD reported R5 comes out for activities two to three times a week and is able to do memory match cards and puzzles. AD also reported the television in R5's room belongs to R12. Inquired what activities are provided during 1:1. AD responded, they usually visit R5 in the morning and will do orientation (name and day). They also invite R5 to watch television in the activity/dining room; however, AD is not sure of what R5's response is ("not sure what she is saying"). Further queried AD regarding documentation of R5's participation in activities or activities that were provided. AD reported staff will document in the tablet everyday what activities were provided. Requested a copy of R5's activity participation. Documentation/report of R5's participation in activities (day and type of activity) was not provided prior to the survey team's exit on 06/04/21.

On 06/04/21 at 08:28 AM a brief interview was conducted with R5 in her room. R5 was asked what she was going to do today, she did not respond. Asked if she would be going out to activities or prefers to stay in her room. R5 responded it's her preference to stay in the room.

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F 679	Continued From page 25 Further asked R5 whether she is provided with puzzles, books, or newspapers, she replied, "no."	F 679		
F 684 SS=D	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 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 observations, interviews with resident, resident representative and staff members, and record review, the facility failed to ensure two residents (Residents 27 and 30) were positioned to assure safety while eating. This deficient practice had the potential to result in residents aspirating their food or drinks. The facility also did not assure one of two residents (Resident 25) sampled for skin conditions had a care plan that was implemented to prevent bruising or skin tears. Findings Include: 1) Resident (R)27 was admitted to the facility on 05/03/21. Diagnoses include: history of cerebrovascular accident with right sided weakness, kyphosis, and Vitamin D deficiency. On 06/02/21 at 11:50 AM observed R27 in her room eating lunch (entrée was minced). R27 was flat on her bed with her head raised by a pillow.	F 684	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? R27 on June 22, 2021, the DON notified the MD about the deficient practice and received an order for PT evaluation and treatment as indicated for safe positioning. In addition, the DON discussed the risks and benefits with the resident and their guardian. The MDSC updated the resident□s plan of care to address the risk of aspiration. R25 the MDSC will revise and update the plan of care to include interventions to prevent bruising and skin tear. Resident bathing will be modified to prevent injury. All Certified Nurse Aides will be educated on the use of padding on the resident□s gerichair and applying protective sleeves	7/19/21

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F 684	Continued From page 26 R27's head was drooped to the right, her head touching her shoulder. R27's plate was placed on her stomach as she fed herself. R27 was asked whether she was comfortable and ate this way at home. R27 responded that this was the way she ate at home and denied coughing or choking while eating. Second observation in the resident's room on 06/03/21 at 11:05 AM, found Certified Nurse Aide (CNA)10 reposition R27 with the head of the bed raised (approximately 25 degree angle) and placed a kidney shaped pillow around the resident's neck. At 11:24 AM, R27 was eating her meal, the lunch tray was placed on the over bed tray. R27's head was hanging to the front and drooping to the right side. Record review was done on 06/03/21 at 01:44 PM. A review of the admission Minimum Data Set (MDS) with an assessment reference date of 05/16/21 notes R27 yielded a score of 11 (moderately impaired) when the Brief Interview for Mental Status was administered. R27 was noted to require supervision (oversight, encouragement, cueing) with only setup help. In Section K. Swallowing/Nutritional Status, R27 was coded with no signs/symptoms of possible swallowing disorder. Further review found no care plan to address R27's positioning during meals that places her at risk for aspiration. Interview was conducted with the Director of Nursing (DON) on 06/04/21 at 10:52 AM in the breezeway. Inquired why does R27 have difficulty holding her head in midline. The DON reported that R27 has kyphosis and reportedly had a fall which resulted in injury to her neck. The DON also reported R27 has pain related to her neck	F 684	on upper and lower extremities. R30 the MDSC will update the plan of care to address the risk of aspiration, as well as an intervention of seating the resident in her gerichair due to improved intake and decreased risk of aspiration due to positioning. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents with poor posture and residents that exhibit restlessness with fragile skin are affected by the deficient practice. A weekly plan of care updates review will be conducted by the MDSC. Interventions will be monitored by the charge nurse. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? The DON will conduct a random plan of care review on a quarterly basis to ensure that preventative measures are implemented. How the facility plans to monitor its performance to make sure the solutions are sustained? A quarterly plan of care audit will be	

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F 684	Continued From page 27 and can't tolerate sitting up for too long. However, R27 will tolerate sitting for approximately 20 minutes when she has visitors. Inquired about R27's positioning while eating, DON responded R27 will tell staff how much to raise her head during meals and will not tolerate 90 degrees positioning as it hurts her back and neck. DON stated the facility is following her wishes. Further queried whether risks vs. benefits was discussed with the resident or her family representative. The DON agreed to follow-up for documentation that risks vs. benefits were discussed with the interdisciplinary team and resident/family representative. Prior to the survey team exit, documentation was not provided regarding the risks vs. benefits. 2) R25 was admitted to the facility on 01/15/20 with diagnoses that include hypersomality and hyponatremia, depressive disorder, vascular dementia with behavioral disturbance, and metabolic encephalopathy. Resident representative (RR) interview was conducted on 06/02/21 at 09:45 AM. RR reported that he has been notified of his parent having bruises. He further stated R25 has behavior where she thinks that someone is trying to hurt her, staff try to calm her down, however, she becomes combative. Observations on the following days found R25 did not have any bruises or skin tears and did not have geri sleeves applied: 06/02/21 at 11:50 AM seated in a geri chair in the dining room; 06/02/21 at 02:10 PM lying in bed in her room; 06/02/21 at 03:50 PM seated in a geri chair in the dining room; 06/03/21 at 07:20 AM seated in a geri chair in the dining room; and 06/03/21 from 10:44 AM	F 684	conducted by the DON.	

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through 12:27 PM seated in a geri chair in the dining room.

Record review done on 06/03/21 at 10:30 AM found skin assessments from 03/19/21 to 04/16/21 noting ecchymosis to bilateral upper and lower extremities. Subsequent assessment note of 04/23/21 documents a bruise to the right side of the chin. The assessment of 05/07/21 notes the bruise to the right chin fading.

Interview was done with the MDS Coordinator (MDSC) and Social Worker Designee (SS) at their desks in the breezeway. The MDSC reported R25 has combative behavior, usually dangling her legs from the recliner resulting in bruises on her shins. MDSC also noted R25 becomes restless and hits her legs against the recliner. The SS reported the resident always has discoloration of the skin.

The Director of Nursing (DON) was interviewed on 06/04/21 at 08:29 AM at the nursing station. The DON reported that R25 is difficult to bathe, requiring two person assist and will flail her arms during the shower. The bilateral ecchymosis to upper and lower extremities were discovered after a bath. R25 reportedly grabs staff and tries to scratch them so another staff member has to assist to hold the resident in the chair to prevent her from falling. The DON further reported R25 displays the same behavior when provided bed bath and during perineal care.

Further queried whether the facility has developed a care plan to address R25's skin. The DON found a care plan for the resident to be free from skin tears through the review date (08/04/21) which includes intervention for

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"protective sleeves for the arms daily as indicated." The DON reported the sleeves should be applied daily and could not recall whether R25 refuses the sleeves. Informed the DON, R25 was not observed with protective sleeves during the survey. The DON also identified bathing R25 continues to be a problem as the resident becomes combative and the facility has not found a solution to bathing resident without a struggle.

3) R30 was admitted to the facility on 05/07/21 with diagnoses of unspecified epilepsy, intractable with status epilepticus, age-related osteoporosis without current pathological fracture, unspecified hyperlipidemia, and age-related physical debility.

During lunch observation on 06/02/21 at 12:18 PM, observed CNA10 assist R30 with her meals. CNA10 stated CNA1 usually assists R30 with her meals but is helping today. R30's bed was positioned at approximately 25 degree angle and R30's head was positioned forward, chin pointing at her chest. CNA10 used her hand to position R30's head straight prior to feeding R30. CNA10 then released her hand from R30's head without ensuring R30 swallowed and R30's head dropped to a forward position, chin pointing at her chest. Inquired about R30's bed position while eating, CNA10 quickly positioned R30 at a 45 degree angle and stated R30 will sometimes slide down from her bed.

On 06/03/21 at 02:10 PM, reviewed R30's admission Minimum Data Set (MDS) with an assessment reference date of 05/20/21, in Section G. Functional Status, under Bed mobility (how resident moves to and from lysing position, turns side to side, and positions body while in

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F 684	Continued From page 30 bed), R30 requires total dependence-full staff performance every time with one person physical assist. Under Eating (how resident eats and drinks, regardless of skill.), R30 requires total dependence-full staff performance every time with one person physical assist. In Section K. Swallowing/Nutritional Status, R30 was coded with no signs/symptoms of possible swallowing disorder. Interview with CNA1 on 06/03/21 at 11:20 AM, CNA1 stated due to R30's head positioned forward, chin pointing at her chest, CNA1 positions R30's head straight with her hand, prior to feeding R30. CNA1 further stated she waits until R30 swallows her food to prevent aspiration and releases R30's head back to the forward position, chin facing her chest. Interview with the Director of Nursing (DON) on 06/04/21 at 10:12 AM, DON stated while providing R30 assistance with meals, her bed should not be lower than a 45 degree angle. DON also acknowledged that staff should wait until R30 swallows prior to releasing her head back to the forward position, chin facing her chest, to prevent aspiration. Concurrent review of R30's care plan, R30 was not care planned to address R30's bed and head positioning, as well as, person-centered staff practice while providing assistance during meals.	F 684		
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	F 689		7/19/21

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F 689	Continued From page 31 §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, interview, and record review, the facility failed to ensure one resident (R)29 in the sample was free from accident hazards. The use of wheelchair locks and footrests were employed to assist in preventing R29 from standing which placed her at risk of an avoidable accident and/or injury. This deficient practice has the potential to affect all the residents at the facility. Findings Include: R29 was an 88-year-old female admitted on 05/11/21 following a right hip replacement. Other diagnoses include anemia, hypertension (high blood pressure), hyperlipidemia (increased lipids), dementia, and a history of falls. On 06/02/21 at 11:57 AM, an observation was done in the dining room. R29 was noted to have her wheelchair pushed up to a table with the wheels locked, and the footrests positioned at the level of her shins. R29 had just completed her lunch and was trying to stand up. As she struggled to stand, trying to push her chair back from the table with her hands on the wheelchair arms, crouched with both shins pushed against the footrests of the wheelchair, R29 was noted to be at risk of falling forward onto the table, and she placed her hands on the table, using her arms to brace herself. The Social Worker Designee (SS) rushed over to the table when she heard R29's chair alarm going off, and she	F 689	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? R24 on June 4, 2021, the DON and Physical Therapy Aide (PTA) discussed the resident□s current functioning, including no further physical limitations due to her hip replacement. The PTA stated that the resident□s ambulation had improved and a wheelchair was no longer necessary for locomotion. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All current and new residents who have a hip replacement, diagnosis of dementia, or who utilize a wheelchair as their mode of locomotion are potentially affected by the deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? A random monthly check for wheelchair appropriateness will be conducted by the	

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F 689	Continued From page 32 assisted R29 in standing, pulling the wheelchair back from the table and pushing the footrests out of the way. On 06/04/21 at 08:48 AM, an interview was done with the Director of Nursing (DON) at the nurse's station. When informed about R29's positioning in the dining room, with wheelchair locks employed and footrests placed at the level of her shins, the DON stated that the locks were engaged for safety, so that the wheelchair did not move should R29 attempt to stand unassisted, placing her off-balance. The DON continued that coupled with the positioning of the footrests however, she could see how that would place R29 at a greater risk of falling.	F 689	DON. A resident satisfaction survey will be conducted by the SWD after 7 days, which will include the appropriateness of wheelchair use. Physical therapy screenings as needed to assess wheel chair positioning for residents admitted after a hip replacement will be performed as needed. How the facility plans to monitor its performance to make sure the solutions are sustained? A quarterly resident satisfaction audit tool will be utilized by the SWD to ensure the deficient practice will not recur.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI 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	F 690		7/19/21

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F 690	Continued From page 33 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 staff interviews and record reviews, the facility failed to ensure Resident (R)134's record documented the physician's valid clinical indication for the use of a catheter or assessment of the resident for the removal of the catheter for Resident (R)134. R134 did not have a physician's order for the use of a Foley catheter, document of a clinical indication for the use of a Foley catheter by the attending practitioner, or orders for the care and equipment related to the catheter. As a result of this deficiency, R134 is at a potential risk of developing a Catheter-associated Urinary Tract Infection (CAUTI). Findings Include: R134 was admitted with a Foley catheter from the	F 690	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On June 4, 2021, the DON notified the attending physician and obtained an order for the Foley catheter. In addition, the DON contacted the resident□s urologist and received an order on 6/7/2021, to keep the catheter in place for 4-6 weeks related to BPH and possible cancer of the prostate. How will the facility identify other residents having the potential to be affected by the same deficient practice and what	

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F 690	Continued From page 34 hospital on 5/27/21 for strength improvement after a fall at home which resulted in compression fractures the R134's T4, T8, T11, and L1 vertebra. On 06/02/21 at 10:08 AM, observed R134 in his/her assigned room. R134 was isolated in a closed-door room away from other resident's due to the facility's mandatory 14-day quarantine due to COVID-19. Observed R134 had a Foley catheter bag hanging on the side of the bed. On 06/03/21 at 10:58 AM, conducted a record review (RR) of R134's medical hard chart and electronic health record (EHR) at the nursing station documented the Medical Director (MD) is the resident's physician. Review of R134's Physician's Orders, the MD's Admission Note, progress notes, and history and physical (H&P) completed by the MD did not document a clinical indication for R134's Foley catheter. Furthermore, there was no documentation R134 was assessed for removal of the Foley catheter or an indication for its continuing use. On 06/03/21 at 09:29 AM, conducted a simultaneous record review and interview with the Director of Nursing (DON) at the nursing station. The DON confirmed R134 did not have orders for catheter care, type/size of catheter equipment, or valid clinical indication for use of a Foley catheter for R134. The DON could not provide documentation that R134 was assessed for removal of the Foley catheter or a future date during with R134 would be assessed.	F 690	corrective action will be taken? All current and new residents that may require a Foley catheter, or other medical conditions requiring treatment (e.g., tube feeding, IV hydration, ostomies, etc.) may be potentially affected by the same deficient practice. The DON will update and revise the policy & procedure for urinary catheters and provide and in-service for all RNs with the new protocols. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? The DON will post guidelines for obtaining a physician□s order at the nurses□ station. How the facility plans to monitor its performance to make sure the solutions are sustained? The DON will audit physician□s orders for all medical treatments on a quarterly basis.	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		7/19/21

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F 692	Continued From page 35 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide care and services to prevent significant weight loss or to identify the need for dietary evaluation and intervention for one resident (R)31, as evidenced by an unrecognized weight loss of 6% in less than 30 days. As a result of this deficient practice, the facility placed this resident at risk for avoidable declines and injuries. This deficient practice has the potential to affect all residents at the facility. Findings Include: Resident (R)31 was an 89-year-old female admitted on 05/08/21 with diagnoses of Alzheimer's with Dementia, and a history of	F 692	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On June 4, 2021, the DON notified the resident□s attending physician and the RD about the resident□s poor PO intake and weight loss of 6% in less than a month. The DON received an order for Ensure 4 oz 6x/day. The RD recommended to monitor intake and provide high calorie snacks. How will the facility identify other residents	

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F 692	Continued From page 36 frequent falls. On 06/02/21 at 11:34 AM, R31 was observed sitting at a table in the dining room fast asleep, with her lunch sitting on a tray in front of her. Staff made multiple attempts to wake her and get her to eat, but R31 pushed her lunch tray away and refused, returning to sleeping in an upright position. On 06/03/21 at 05:30 PM, a record review was done of R31's electronic health record (EHR). It was noted that R31 was weighed only once since admission with a documented weight of 113 lbs. (pounds) on 05/10/21. A review of R31's meal intake noted documentation that R31 had refused all three meals on 05/30/21, had refused two meals and eaten 0-25% of a third meal on 05/31/21, had eaten 0-25% of all three meals on 06/01/21, and had refused one meal and eaten 0-25% of two meals on both 06/02/21 and 06/03/21. Further review of R31's comprehensive care plan, initiated on 05/20/21, noted the facility was aware of her poor nutritional intake, and was to "monitor/document/report... [R31] refusing to eat." On 06/04/21 at 08:48 AM, an interview was done with the Director of Nursing (DON) at the nurse's station regarding R31's poor intake and potential weight loss. The DON stated the facility protocol for all residents is that nursing should be monitoring resident intake. If there is poor intake documented for three days, then the resident should be weighed at that point, and the Registered Dietician (RD) and Physician should be notified. When informed of R31's poor intake for the past five days, the DON checked the EHR and confirmed that there was no documentation	F 692	having the potential to be affected by the same deficient practice and what corrective action will be taken? All new residents may potentially be affected by the deficient practice. The DON will review and update the policy and procedure for weight loss. The night shift RN will review the intake records and notify the day shift RN of residents who have had poor PO intake over the previous 3 days. The day shift RN will then make a referral or notify the family, RD, and attending physician. All nursing staff (RN and Certified Nurse Aides) will be provided in-service training with the revised weight loss protocol. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? The DON will review and update the policy and protocol regarding the procedure for weight loss. The night shift RN will review the intake records and notify the day shift RN of residents who have had poor PO intake over the previous 3 days. The day shift nursing staff will weigh the resident and notify the attending physician and RD for any new orders or recommendations.	

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F 692	Continued From page 37 that the poor intake had been recognized, reported or acted upon. The DON agreed that R31's weight should have been checked and notification should have been done and stated that she would follow-up on it. On 06/04/21 at 12:50 PM, the DON entered the conference room and stated that R31 had been weighed, and her current weight was 106 lbs., reflecting a 6% weight loss in less than a month. The DON further stated that the RD and Physician had been notified.	F 692	How the facility plans to monitor its performance to make sure the solutions are sustained? The DON will monitor residents□ weights monthly and ensure that any significant weight gain/loss is communicated to the RD and attending physician.	
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--- §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	F 758		7/19/21

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F 758	Continued From page 38 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 interview and record review, the facility failed to monitor the medication regimen for one resident (R) in the sample and ensure that she did not have any "PRN [as needed]" orders for psychotropic drugs (any drug that affects brain activities associated with mental processes and behavior) for longer than fourteen days. As a result of this deficient practice, the resident did not have her medication regimen effectively monitored, placing her at risk for adverse effects related to unnecessary medication. This deficient practice has the potential to affect all the residents at the facility taking psychotropic medications.	F 758	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The DON will review and revise the Psychotropic Drug Protocol and any as needed/PRN psychotropic drug orders will be reassessed for continuation. How will the facility identify other residents having the potential to be affected by the same deficient practice and what	

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F 758	Continued From page 39 Findings Include: R31 was an 89-year-old female admitted on 05/08/21 with diagnoses of Alzheimer's with Dementia, and a history of frequent falls. On 06/02/21 at 02:49 PM, a record review of R31's medication administration record (MAR) noted orders for risperidone (an antipsychotic) " ...0.5 ml [milliliters] by mouth every 24 hours as needed [PRN] for Dementia with behavioral problem and Agitation at bedtime," started on 05/09/21, and trazodone (an antidepressant) " ...25 mg [milligrams] every 6 hours as needed ...Trazodone first, if not working give Risperdal [risperidone]," also started on 05/09/21. The PRN orders were in addition to maintenance doses of both medications that were a routine part of R31's medication regimen. On 06/03/21 at 02:44 PM, a copy of the Medication Regimen Review (MRR) recommendation from PharMerica, dated "5/28/21", questioning the continuation of the PRN psychotropic orders, was received from the DON. It was also noted at this time, upon a second review of R31's MAR that the PRN orders for the trazodone and risperidone had been discontinued earlier that day at 10:50 AM. On 06/04/21 at 08:48 AM, an interview was done with the Director of Nursing (DON) at the nurse's station. The DON explained that although the pharmacy (PharMerica) had dated the MRR 05/28/21, it was not e-mailed to the DON until 05/31/21. Due to having to cover nursing sick calls by working the floor herself on 05/31/21 and 06/01/21, the DON was unable to read the MRR	F 758	corrective action will be taken? All new and current residents who are receiving psychotropic drugs will be potentially affected by the deficient practice. The ID Team will reassess and document the appropriateness of PRN psychotropic drugs after 14 days. All RNs will be in-serviced on psychotropic drug use, which includes the topic, Improving Dementia Care in Nursing Homes: Best Care Practices. The DON will utilize the EHR to monitor which residents have psychotropic drugs ordered and PRN usage to monitor for any possible gradual dose reductions (GDR). The ADON will be provided a copy of the monthly pharmacy consultation report to address all recommendations in a timely manner. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? All RNs will be in-serviced on psychotropic drug use. The ID Team will reassess and document the appropriateness of PRN psychotropic drugs after 14 days.	

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F 758	Continued From page 40 until 06/03/21 when she phoned the physician and had the PRN orders discontinued. The DON stated that since the beginning of COVID, the facility has had problems with receiving the MRRs from PharMerica late, however she should have looked at it sooner than 06/03/21.	F 758	The DON and ADON will utilize the EHR to monitor which residents have psychotropic drug orders and review the pharmacy consultation reports to address all recommendations and assess which residents may be appropriate for a GDR. How the facility plans to monitor its performance to make sure the solutions are sustained? The DON will conduct a psychotropic drug use audit quarterly. The DON will review the facility□s 802/697 quarterly to ensure that the facility is in compliance, and to decrease the use of unnecessary drugs.	
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.	F 761		7/19/21

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F 761	Continued From page 41 §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 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview with staff member, the facility failed to ensure drugs were securely stored. The medication cart was left unlocked for 36 minutes with the potential for residents to access medication or staff members for drug diversion. Findings Include: Observed an unlocked medication cart in the dining room on 06/02/21 at 11:32 AM through 12:08 PM (36 minutes). The cart was parked against the wall in the dining room next to the double doors leading to the corridor for rooms 12 and 13. The cart was unattended and staff were not administering medication. At this time, 15 residents were eating their lunches in the dining room. Concurrent observation of the medication cart was done with the Director of Nursing (DON) on 06/02/21 at 12:08 PM. The DON confirmed the cart was not locked and stated the medication cart should be locked. The DON was walking away from the cart and was stopped and instructed to lock the cart.	F 761	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The DON secured the cart upon notification. On the following shift, the DON notified all RNs about the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All current and new RNs may potentially perform the same deficient practice. All RNs will be reminded about locking the medication cart when unattended. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? The DON will perform an in-service on	

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F 761	Continued From page 42	F 761	proper medication administration protocols with all RNs. The DON will conduct monthly random medication administration checks for all RNs. The pharmacy consultant will conduct medication administration checks on a monthly basis. How the facility plans to monitor its performance to make sure the solutions are sustained? The DON will conduct a monthly medication administration audit.	
F 802 SS=E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the	F 802		7/19/21

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F 802	Continued From page 43 interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to assure there was sufficient staff to serve meals in a timely manner to maintain food safety and palatability of food. Residents that required assistance or dependent on staff members with their meals were observed to wait for staff members to assist them. The residents who dined in their room were also observed to wait for assistance with their meals. Also, observed staff members interrupting residents' meals when they were called away to assist other residents. Findings Include: 1) Observation on 06/03/21 at lunch meal from 11:00 AM in the dining room found 15 residents seated in the dining room. The first tray was served at 11:21 AM. The last tray was served at 12:09 PM to Resident (R)25. Observed there were five residents that required assistance or were dependent on staff to assist in their meals, including R25 who was served 48 minutes after the first tray. R24 was seated in a geri chair, her lunch tray was provided at 11:29 AM, staff member sat with R24 at 11:36 AM to assist her with lunch. The staff member left at 11:42 AM to assist R1 leaving R24 with her lunch tray sitting in front of her. At 12:03 PM, the Activity Director (AD) went to assist the resident. A review of the admission Minimum Data Set (MDS) with assessment reference date (ARD) of 05/11/21 found R24 is dependent on staff for eating with one-person physical assist.	F 802	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All Certified Nurse Aides will be trained using the Hand in Hand Training that covers training for patients with dementia. The facility will modify kitchen serving times into 3 groups to provide sufficient dietary assistance for residents during mealtimes. Residents will be assessed and divided into groups for meals depending upon the level of assistance required during meals. The facility will implement a resident satisfaction survey, which will include questions on dietary staffing levels, staff approaches, and the dining experience. The Administrator is recruiting and training staff to assist with mealtimes. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All new and current residents who require assistance with meals may be affected by the deficient practice.	

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F 802	Continued From page 44 R15 was seated in a geri chair in front of the television. R15's tray was provided at 11:31 AM, placed on an over bed tray. R15 received assistance from Registered Nurse (RN)2 with her lunch at 12:10 PM (39 minutes after resident was provided with her lunch tray). A review of the quarterly MDS with an ARD of 04/06/21 notes R15 required limited assist with one-person physical assist for eating. R25 was observed in the dining room at 11:00 AM. R25 was seated in a geri chair in the middle of the dining room (not at a table or over bed tray provided). At 12:09 PM, staff member was observed to provide a lunch tray to R25 and assisted her with her meal. A review of the annual MDS with ARD of 04/30/21 found R25 requires extensive assistance with one-person physical assist for eating. R10 was observed in the dining room at 11:00 AM. After waiting 42 minutes, RN2 assisted R10 with her lunch meal. A review of a significant change MDS with ARD of 03/22/21 noted R10 required limited assistance with one-person physical assist for eating. 2) Dining observation on 06/02/21 at 11:39 AM in the dining/activities room, observed Resident (R)32 was seated in a geri chair in front of the television with two residents positioned on each side. R32 did not have her lunch tray; however, the residents seated to her side both had their meals and were eating. Second observation at 11:53 AM found R32 still didn't have her lunch tray. At 06/02/21 at 12:09 PM interviewed the AD in the dining room and asked her whether R32 eats food. AD replied she will get R32's meal tray now. On the way to the kitchen, AD was called	F 802	The ID Team will continuously assess residents□ abilities and current needs to determine the level of assistance required during meals, and that there is sufficient staff assistance. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? The DON will monitor the efficacy of the modified meal times during periodic observations. The SWD will conduct resident satisfaction surveys monthly. Annual in-services for CNAs will include dementia specific training, utilizing the Hand in Hand Nursing Home training series. How the facility plans to monitor its performance to make sure the solutions are sustained? A quarterly resident satisfaction audit tool will be conducted by the SS.	

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F 802	Continued From page 45	F 802		

away to assist another resident. At 06/02/21 at 12:19 PM, RN2 was observed to assist R32 with her meal. R32 waited 40 minutes in the dining room while other residents were eating to begin her lunch.

3) On 06/02/21 at 12:01 PM in the dining room, R25 was observed receiving assistance with her lunch. R25's food is pureed. At 12:02 PM, AD was called to assist a resident that stood up (alarm went off). At 12:04 PM, AD returned to continue assisting R25 with her meal. AD was called away again. At 12:12 PM observed another staff member assisting the resident with her lunch. At 12:13 PM, this staff member was called away to help another resident. At 12:15 PM, R25 was observed to continually yell, "hey, hey, hey." No staff responded to her calling out. AD returned at 12:18 PM to continue feeding R25. R25's meal was interrupted three times within 17 minutes, disrupting her meal.

4) During lunch dining observation on 06/03/21 at 11:07 AM, observed kitchen staff prepare the first meal tray, resident (R)32's meal, and dining staff put R32's lunch tray in a brown tray cart. At 11:12 AM observed the last meal tray for residents' rooms 7 through 11 put into the brown tray cart and taken to the rooms' corridor. There are a total of six residents who need extensive assistance with their meals from this corridor and two Certified Nursing Aides (CNA) assigned to provide assistance, CNA10 and CNA1. From 11:12 AM to 12:00 PM, CNA10 was observed to provide set up assistance to residents who need less support, pick up and put away finished meals, and provide meal assistance with the residents who need extensive support.

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F 802	Continued From page 46 At 11:20 AM, observed CNA1 provide assistance to R6 for lunch and was observed to finish lunch at 11:52 AM. At 11:56 AM, CNA1 proceeded to provide R30 assistance with lunch. R30 waited 44 minutes to eat lunch, from 11:12 AM to 11:56 AM. Interview with CNA1 at 11:53 AM in room 11, CNA1 stated she provides assistance with meals for three residents, but one of the three residents, R24, is in the facility dining room today. From 11:24 AM to 11:39 AM, observed CNA10 provide assistance to R16 for lunch. From 11:43 AM to 11:57 AM, observed CNA10 provide assistance to R32 for lunch. R32 was the first meal tray prepared by kitchen staff at 11:07 AM and did not receive her lunch until 11:43 AM. Interview with CNA10 at 11:57 AM in front of room 8, CNA10 stated she provides assistance with meals for three residents. CNA10 was observed to provide assistance to R20 at 12:00 PM. R20 waited 48 minutes to eat lunch, from 11:12 AM to 12:00 PM.	F 802		
F 812 SS=D	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.	F 812		7/19/21

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F 812	Continued From page 47 (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 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility's policy and procedure, and interview with staff member, the facility failed to label and date stored food items in the freezer, refrigerator, and dry goods storage room. Findings Include: During the initial tour of the kitchen with Kitchen Supervisor (KS) on 06/02/21 at 08:05 AM, observed in the refrigerator closest to the dining serving station, pre-packaged grilled eel, with no discard date or received date. KS stated the eel is for a resident from a family member and staff should put a label with a received date on it. Review of the facility's policy and procedure regarding "Food from Outside Sources" received on 06/04/21 at 10:37 AM, states "The nurse or CNA [Certified Nursing Assistant] shall label food brought in for residents from outside ...with the resident's name and date ..." Further observation during the initial tour of the kitchen with KS, observed three plastic storage bags with unidentifiable items in the meat freezer outside of the kitchen without a label or dates. KS was able to identify two of the three items as chicken and swordfish. KS stated there needs to be a label for these items and stated the unidentified item needs to be thrown out when	F 812	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Kitchen Supervisor (KS) disposed of the pre-packaged grilled eel and three items that were not labeled. The dried shiitake mushrooms were placed in a sealed plastic storage with a discard date in 3 months since the original labels were not found. The nursing staff and kitchen staff will be provided with an in-service by the KS on how to receive and store food from outside sources. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All new and current residents that request family to bring food from outside may be potentially affected by the deficient practice. All dry goods with multiple servings may	

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F 812	Continued From page 48 inquired what was in the bag. Observation of the dry goods storage room during the initial tour with KS, observed in a gray bin, 11 plastic storage bags of dried Shitake mushrooms with no label or discard date. Inquired if the dried Shitake mushrooms needed to be labeled, KS proceeded to look around the gray bin and stated there should be a label. Review of the facility's policy and procedure regarding "Food Storage" received on 06/04/21 at 10:37 AM, states "Food service staff shall label food items with a received date. After opening, the items should be labeled with an open or prepared date and a discard date. The expiration date may be used as a discard date for the item."	F 812	not be labeled. The KS will create a food storage checklist, which will be updated monthly. An in-service will be conducted with all current and new Certified Nurse Aides on the proper amount of thickener. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? A monthly food storage checklist will be created and updated monthly by the KS. A random check of foods in the resident refrigerator and storage bins will be conducted by the KS. How the facility plans to monitor its performance to make sure the solutions are sustained? The KS will update the food storage checklist monthly, and all results will be reviewed with the Administrator. All identified problems will be reviewed as part of the QAPI meetings.	
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest	F 835		7/19/21

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F 835	Continued From page 49 practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to use its resources effectively and efficiently during the COVID-19 Public Health Emergency (PHE) to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This was evidenced by late submissions of resident assessments, late comprehensive care plans initiated for residents, staff with expired training and TB tests, no Facility Assessment, no quarterly Quality Assessment and Assurance (QAA) meetings for over a year, the QAA Committee had not been maintained, and the Emergency Preparedness (EP) Plan that had not been reviewed. This deficient practice has the potential to affect all the residents at the facility. Findings Include: On 06/02/21 at 07:50 AM, as the State Survey Team (SA) entered the facility, it was observed that neither the Administrator, Assistant Administrators, nor the Director of Nursing (DON) were present at the facility. Greeted by the Office Manager (OM) and the Social Worker Designee (SS) at the entrance, the OM stated that the Administrator had been working from home for a while, and the DON was scheduled to come in later, but she would call them both to come in as soon as possible. The OM and SS seemed uncertain what to do, walking away repeatedly, leaving the SA alone in the lobby, the COVID screening process of the SA fragmented and unclear.	F 835	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The MDSC will complete the comprehensive care plans. Assessments are identified in the EHR with a grace period and highlighted in red text as due dates approach. The DON will train another MDSC and monitor all scheduled assessments and comprehensive care plans. The Administrator will conduct a facility-wide assessment to determine the necessary resources needed to care for its residents during day-to-day operations and emergencies. This will help to determine the necessary staff needed to meet the needs of the residents. The Administrator will prepare a spreadsheet indicating the dates the Emergency Preparedness Plan (EPP) was reviewed. This will help to serve as a reminder that the EPP should be reviewed annually. The Office Manager will ensure that CPR/First Aid Certification and TB clearances are up-to-date. Quarterly Quality Assessment and Assurance (QAA) and Quality Assurance	

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F 835	Continued From page 50 On 06/02/21 at 08:28 AM, an interview was done with the Administrator in the conference room. The Administrator stated that she had been "working remotely most of the time" since the beginning of the PHE. Without the Administrator physically present, the DON had been tasked to perform the day-to-day administrative duties, however the Administrator stated she stayed in constant communication with the DON by phone. On 06/02/21 at 03:09 PM, a review of Resident (R)29's hard chart and electronic medical record (EMR) noted a baseline care plan in the hard chart, but no comprehensive care plan initiated or documented. It was also noted that R29's Minimum Data Set (MDS) Admission Assessment was incomplete and assessment reference date (ARD) was overdue. On 06/03/21 at 12:00 PM, an interview was done with the Administrator in the front office after receiving an incomplete and undated Facility Assessment. When asked, the Administrator confirmed that the 2021 Facility Assessment had been done "basically some was done yesterday, and the rest today." The Administrator also stated that they had not completed a Facility Assessment for 2019 or 2020 either. On 06/03/21 at 12:17 PM, another interview was done with the Administrator in the front office. When asked when the EP Plan was last reviewed, the Administrator stated, "probably 2017." The Administrator stated that she was aware that the EP Plan should be reviewed annually. On 06/03/21 at 01:29 PM, an interview was done with the MDS Coordinator (MDSC) at the nurse's	F 835	and Performance Improvement (QAPI) meetings will resume. QAA/QAPI meetings will focus on quality deficiencies and performance improvement projects, which will be documented in the meeting minutes. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All current and new residents have the potential to be affected by the same deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? All new admissions assessments and comprehensive care plans will be reviewed by the DON and ID Team. The Administrator will review and update the Facility Assessment annually. The Safety Committee will review and update the EPP annually. QAPI/QAA meetings will take place on the third Wednesday following the end of the quarter. A calendar schedule will be created and maintained to keep all members informed of meeting dates and times.	

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F 835	Continued From page 51 station breezeway. The MDSC stated that she initiates the baseline care plan, which the facility keeps in the hard chart, then transfers it into the EMR to become part of the comprehensive care plan after 14 days. Regarding the MDS Admission Assessments, the MDSC stated that each resident should have an ARD within 14 days from admission. After reviewing R29's EMR, the MDSC confirmed that the comprehensive care plan was overdue, the admission assessment was incomplete, and the ARD was overdue; all tasks she was responsible for. The MDSC explained that the facility had been short-staffed on Registered Nurses (RNs) for a while, and since they had not had many admissions due to COVID, the Administrator had decided to schedule her to do her MDSC duties twice a week, and to work as a floor nurse the remaining three days of the week. This made it challenging for her to keep up with her MDS duties, as quarterly and annual assessments are done year-round, in addition to attending weekly Interdisciplinary Team (IDT) Meetings to remain informed on the entire resident population. On 06/04/21 at 08:27 AM, after receiving staff training and testing documentation from the facility, an interview was done with the Administrator and the OM in the front office. The OM confirmed that out of five randomly selected staff members for whom documentation was requested, there was one Certified Nurse Aide (CNA) that was still working despite having a CPR/First Aid certification that had expired on 05/07/20, and two other staff members who were still working despite having annual Tuberculosis clearances that were overdue. The Administrator stated that monitoring staff credentialing, training, and testing was usually done by an Assistant	F 835	How the facility plans to monitor its performance to make sure the solutions are sustained? The Administrator will resume working in-person at the facility.	

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F 835	Continued From page 52 Administrator (AA)2 who had been working remotely since March of 2020, and that the facility was aware that they had fallen behind. The Administrator also stated that the QAA committee had not been meeting quarterly over the past year due to COVID. On 06/04/21 at 09:05 AM, a confidential interview was done with an anonymous staff member at the nurse's station breezeway. The staff member stated that since the start of the PHE, the Administrator and Assistant Administrators had consistently not been present at the facility but had been "working remotely". This left many of the administrative duties to the DON, who still had her own duties to perform, in addition to covering the MDSC's duties when she was scheduled on the floor, working on the floor as needed for RN coverage, and dealing with the PHE itself, with its constantly evolving recommendations and reporting requirements.	F 835		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:	F 838		7/19/21

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F 838	Continued From page 53 §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing	F 838		

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F 838	Continued From page 54 patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on an interview with the Administrator and a review of the Facility Assessment, the facility failed to conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies for at least two years. As a result of this deficient practice, the facility was unaware if they had sufficient staff to competently meet the needs of their resident population. Cross-reference to F835. Findings Include: On 06/03/21 at 11:55 AM, a review of the Facility Assessment that had been just received from the Office Manager (OM), after requesting it three times, was done. The Facility Assessment was noted to have several pages that were either completely blank, or contained only headings, and none of the pages, including the title page, were dated. On 06/03/21 at 12:00 PM, an interview was done with the Administrator in the front office after receiving the Facility Assessment that was noted to be incomplete and not dated. When asked, the Administrator confirmed that the 2021 Facility Assessment had been done "basically some was done yesterday, and the rest today." The	F 838	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Administrator will conduct a facility-wide assessment to determine the necessary resources needed to care for its residents during day-to-day operations and during emergencies. This will help to determine the necessary staff needed to meet the needs of the residents. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The deficient practice affects all current and new residents. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? The Administrator will review and update the Facility Assessment annually. The Facility Assessment will also be	

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F 838	Continued From page 55 Administrator went on to verify that the facility had not conducted and documented a Facility Assessment for 2019 or 2020 either.	F 838	updated whenever there is, or the facility plans for, any change that would require a substantial modification to any part of the assessment. How the facility plans to monitor its performance to make sure the solutions are sustained? The Administrator will update the Facility Assessment annually. The Facility Assessment will be reviewed during the quarterly QAPI meetings.	
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on an interview with the Administrator and the Director of Nursing, and a review of the facility's Quality Assessment and Assurance (QAA) documentation, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) program continued to be implemented throughout the COVID Public Health Emergency (PHE). As a result of this deficient practice, the facility had no identified quality deficiencies and no distinct performance improvement projects documented for over a year.	F 867	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Quarterly meetings will resume to discuss Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Improvement (QAPI) programs. Meetings will focus on quality deficiencies and performance improvement projects,	7/19/21

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

(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 867	Continued From page 56 Cross-reference to F835. Findings Include: On 06/04/21 at 12:52 PM, an interview was done in the nurse's station breezeway with the Administrator and the Director of Nursing (DON). Concurrently, a review of the facility's QAA/QAPI documentation was also done. The Administrator stated that due to the COVID PHE, the last full QAA/QAPI meeting that had been held (prior to 05/21/21) was on 01/29/20. A review of the documentation from the 01/29/20 meeting noted no quality deficiencies or distinct performance improvements projects identified. A review of the documentation from the first QAA/QAPI meeting in over a year, held on 05/21/21, also noted no quality deficiencies or distinct performance improvement projects identified. This was confirmed by the DON who stated that the recent meeting was to get everyone updated on the facility issues and events since the last meeting. The Administrator stated one of the reasons the QAPI program had not been implemented during the PHE was that several members of the QAA Committee, including herself, had been working remotely since March of 2020.	F 867	which will be documented in the QAPI/QAA meetings. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The deficient practice affects all current and new residents. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? The Administrator will resume working in-person at the facility. QAPI/QAA meetings will take place on the third Wednesday following the end of the quarter. Members who are unable to attend meetings in person will participate virtually via Skype or other electronic methods. How the facility plans to monitor its performance to make sure the solutions are sustained? QAPI/QAA meetings will be reviewed and approved at the following quarterly meeting.	
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)	F 868		7/19/21

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F 868	Continued From page 57 §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on an interview with the Administrator and the Director of Nursing, and a review of the facility's Quality Assessment and Assurance (QAA) documentation, the facility failed to maintain the required QAA Committee members and failed to meet at least quarterly for over a year. Cross-reference to F835. Findings Include: On 06/04/21 at 12:52 PM, an interview was done in the nurse's station breezeway with the Administrator and the Director of Nursing (DON). Concurrently, a review of the facility's QAA/QAPI documentation was also done. The Administrator stated that due to the COVID PHE, the last full QAA/QAPI meeting that had been held (prior to	F 868	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? QAA/QAPI programs will resume quarterly meetings. If the Medical Director is unable to attend the meeting, his designee will be in attendance. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The deficient practice affects all current	

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F 868	Continued From page 58 05/21/21) was on 01/29/20. A review of the documentation from the 05/21/21 meeting noted that the Medical Director or his designee was not in attendance. The DON confirmed that the last meeting the Medical Director had attended was the 01/29/20 meeting. The Administrator stated one of the reasons the QAA Committee had not been meeting quarterly during the PHE was that several members of the Committee, including herself, had been working remotely since March of 2020.	F 868	and new residents. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? The Administrator will resume working in-person at the facility. QAPI/QAA meetings will take place on the third Wednesday following the end of the quarter. A calendar will be created and maintained to inform all members of meeting dates and times. If the Medical Director is unable to attend the meeting, his designee will be in attendance. Members who are unable to attend meetings in person will participate virtually via Skype or other electronic methods. How the facility plans to monitor its performance to make sure the solutions are sustained? QAPI/QAA meeting attendance will be monitored. The Administrator will make changes to the QAPI/QAA meeting schedules if deemed necessary.	
F 880 SS=F	Infection Prevention & Control	F 880		7/19/21

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F 880	Continued From page 59 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 60 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 observation, and staff interviews, the facility failed to ensure appropriate protective and preventive measures for COVID-19 and other communicable diseases and infections. The facility did not conduct thorough or consistent screening of visitors entering the facility for signs and symptoms of COVID-19, and staff did not perform hand hygiene between residents or tasks during dining services. As a result of this deficiency, all residents are at an increased risk	F 880	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The health screening questionnaire was reviewed and updated to reflect current recommendations and restrictions related to COVID-19.	

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F 880	Continued From page 61 of developing and transmitting communicable diseases and infections. Findings Include: 1) On 06/02/21 at 07:57 AM, four (4) surveyors entered the facility. The Office Manager (OM) greeted the surveyors and proceeded to screen all surveyors which included answering a screening form and temperature screening. The screening form documented: -Full legal name -Purpose of visit -Have you/anyone close to you worked at, visited, or resided at any other facility in the last 14 days? IF YES, please provide details: -In the last 14 days, have you traveled to Oahu or spent any amount of time with someone who has traveler to Oahu? Yes No IF YES, DO NOT ENTER FACILITY -In the last 10 days, have you/anyone close to you been tested for COVID-19? (include routine testing). If yes, please provide details- Yes No -Do not enter id you answer yes to any of the following questions to the right-> - Been exposed to individuals with cold or flu-like symptoms - Tested positive for COVID-19 - Had any of the following symptoms - Sore throat (Yes No) - Fever >or equal to 100F (Yes No) - New or worsening cough (Yes No) - Shortness of breath (Yes No) - Chills/Fatigue (Yes No) This surveyor answered yes to Have you/anyone close to you worked at, visited, or resided at any other facility in the last 14 days? IF YES, please provide details. This surveyor and another	F 880	Designated staff were re-trained on the sign-in process for all staff and visitors who enter the facility. The training includes how to properly use the thermometer and how to identify if it is working properly, and the use of the health screening questionnaire. All staff were in-serviced in proper hand hygiene practices. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All new and current residents may be affected by the deficient practices. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? The health screening questionnaire will be reviewed and updated each time the policy & procedures related to COVID-19 are updated. Designated staff will be re-trained on the protocol to sign-in all staff and visitors who enter the facility. Training will also include health screening questions, proper thermometer usage, and when to restrict persons from entering the facility. Annual in-services will include infection control practices, including hand hygiene.	

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F 880	Continued From page 62 surveyor traveled to Hawaii Island on 5/25/21 and returned to Oahu on 5/28/21. The OM then attempted to take the surveyors' temperatures, but the thermometer was not properly working and the OM went and got the Social Worker Designee (SS) to help with the thermometer. The completed screening forms were collected by the SS, who then quickly scanned the forms and placed the forms in a plastic storage container drawer above the screen table with other completed screening forms. The surveyors were not questioned about recent travel or asked to provide details regarding questionable answers to the screening questions. On 06/03/21 only 2 of 4 surveyors were required to fill out the screening form. On 06/04/21, 2 of 4 surveyors were required to fill out the screening form and one surveyor took their own temperature and logged the reading in the facility book. On 06/04/21, 1 of 4 surveyors received a sticker which indicated the surveyor was screened and approved to enter the facility. All surveyors were not aware of or provided stickers post screening on the first and second days of entering the facility. On 06/04/21 at 10:19 AM, conducted an interview with the Infection Preventionist (IP) regarding visitor screening. The IP was informed of the inconsistent screening of the surveyors throughout the survey. The IP confirmed staff did not receive training on how to properly use the thermometer or how to identify if the thermometer is properly working. Inquired what happens to the visitor screening form once it is placed into the plastic storage container drawer above the screening table. The IP stated the drawer is emptied and placed in another container in the office. Inquired if the screening forms are reviewed by the IP or other staff. The IP	F 880	The IP or a designated RN will conduct random monthly hand hygiene audits of all staff and provide feedback or retraining to staff as needed. How the facility plans to monitor its performance to make sure the solutions are sustained? Hand hygiene audits will be reviewed during the QAA/QAPI meetings. The health screening questionnaire will be reviewed and updated each time the policy & procedures related to COVID-19 are updated. The IP will review the updates with the DON and Administrator for approval.	

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F 880	Continued From page 63	F 880		

confirmed the visitor screening forms are not reviewed to ensure the screening was completed thoroughly or correctly.
2) During a dining observation on 06/02/21 at 11:18 AM in the facility dining room, observed Certified Nursing Aide (CNA)5 adjust resident (R) 25's geriatric (geri) chair to an upright position and proceeded to help another staff member adjust R15's geri chair to an upright position by pushing the footrest down without handwashing or using alcohol-based hand rub (ABHR) between residents. After using ABHR, at 11:21 AM, CNA5 then went back to R25 and turned R25's geri chair to the dining table and proceeded to walk to R4 sitting across R25 and rub R4's shoulder to arouse her to wake up for lunch, without performing handwashing or using ABHR between residents.

At 11:29 AM observed Social Worker Designee (SS) touch R4 on the shoulder to arouse her to wake up for lunch, walk to an unidentified resident sitting in a geri chair and adjusted this resident's eyeglasses on her head. SS then walked to R29 and adjusted the puzzle on R29's dining table then walked to R14, announced to R14 it is lunch time and put the Japanese books R14 was reading to the side of her table, then walked to R3 and grabbed a newspaper on R3's dining table. SS did not perform handwashing or use ABHR between residents and tasks.

At 11:31 AM observed CNA5 bring R22's lunch tray to R22, set-up R22's beverages by putting straws in her cups, grabbed the lid covering R22's meal and proceeded to walk to an unidentified resident, touch this resident on the shoulder, grabbed her spoon, encouraged her to eat, then took this resident's knife and cut the stuffed

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F 880	Continued From page 64 cabbage into pieces without performing handwashing or using ABHR between residents/tasks.	F 880		
F 908 SS=F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility's policy and procedure, and interview with staff member, the facility failed to ensure the dishwasher was maintained in a safe operating condition. The facility did not have a system to ensure that proper sanitation temperature of the dishwasher was achieved. Findings Include: During the initial tour of the kitchen with Kitchen Supervisor (KS) on 06/02/21 at 08:05 AM, KS stated the facility's sanitation method for dishes is by heat at 180 degrees Fahrenheit (F). KS demonstrated by turning on the dishwasher, three out of three times during the demonstration the dishwasher did not reach 180 degrees F. The following temperatures were concurrently observed with KS, 177 degrees F, 177 degrees F, and 174 degrees F. Observed written on the dishwasher, "Rinse temperature 180 F ...MIN." Inquired how the facility ensures the dishwasher is operating properly, KS stated a contracted agency comes once a month to maintain the dishwasher and ensure it is operating properly. Review of the facility's policy and procedure	F 908	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The dishwasher temperature will be increased to the required temperature of 180 degrees Fahrenheit. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The deficient practice affects all current and new residents. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? The Kitchen Supervisor (KS) will review and ensure the Dishwater Temperature Log is being utilized correctly.	7/19/21

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F 908	Continued From page 65 regarding "Use of Dishwasher" received on 06/04/21 at 10:37 AM, states "Check rinse cycle at 180 degree F or higher."	F 908	The KS will conduct an in-service to ensure all kitchen staff are aware of sanitation requirements. How the facility plans to monitor its performance to make sure the solutions are sustained? The KS will review and ensure the Dishwasher Temperature Log is being utilized correctly. The KS will contact the contracted agency if temperatures are observed to fall below the required 180 degrees Fahrenheit.	
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview with staff members, the facility failed to safely dispose of a cleaning chemical to ensure a safe environment for 1 out of 7 residents who had access to a shared bathroom. Findings Include: On 06/03/21 at 09:41 AM, observed in a shared bathroom between rooms 10 and 11 a non-acid disinfectant bathroom cleaner in the bathroom trash bin. At 10:02 AM, concurrent observation with Housekeeping (HK)6 of the bathroom	F 921	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Housekeeping Supervisor (HS) will conduct an in-service to review proper disposal of empty chemical bottles. How will the facility identify other residents having the potential to be affected by the same deficient practice and what	7/19/21

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F 921	Continued From page 66 cleaner in the trash bin, HK6 stated he left the bathroom cleaner in the trash and planned to take out the trash after lunch. HK6 further stated there is 1 resident between room 10 and 11 who can ambulate and has access to the bathroom. Interview with Housekeeping Supervisor (HS) on 06/04/21 at 08:13 AM, explained if there is an empty cleaning chemical bottle, staff are to dispose empty chemical bottles in the trash bin outside of the facility building. HS further stated that staff should only dispose of empty cleaning chemicals bottles in resident access trash bins if staff plan to throw away the trash right for resident safety. Interview with Certified Nursing Aide (CNA)1 on 05/04/21 at 08:19 AM, stated there are 3 residents who can use the bathroom on their own when taken. 1 out of the 3 residents can go into the bathroom with just staff stand-by assistance, staff positioned outside of the bathroom door.	F 921	corrective action will be taken? The deficient practice affects all new and current residents who are ambulatory. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? The HS will periodically respect resident trash bins to ensure housekeeping staff are following proper disposal procedures for chemical substances. How the facility plans to monitor its performance to make sure the solutions are sustained? The HS will provide training for all new and current housekeeping staff. The HS will periodically inspect resident trash bins to ensure chemical bottles are disposed of properly.	

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E 000	Initial Comments A recertification survey was conducted by the Office of Health Care Assurance on 06/02/21 - 06/04/21. The facility was found not to be in substantial compliance with §483.73, Requirement for Long-Term Care (LTC) Facilities of Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types, State Operations Manual.	E 000		
E 004 SS=D	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must	E 004		7/19/21

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

Electronically Signed | 06/27/2021

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E 004	Continued From page 1 develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to review and update their Emergency Preparedness Plan at least annually. Findings Include: On 06/03/21 at 11:55 AM, while in the conference room, the facility's Emergency Preparedness (EP) Program binder was received from the Office Manager. A review of the EP Program was done, and it was noted that the EP Plan was not updated to include any information about the COVID-19 Public Health Emergency (PHE), and there was no documentation of when it had last been reviewed. On 06/03/21 at 12:17 PM, an interview was done with the Administrator in the front office. When asked when the EP Plan had last been reviewed or updated, the Administrator stated, "probably	E 004	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Administrator will update the Emergency Preparedness Plan (EPP) to include information about the COVID-19 Public Health Emergency. The Administrator will prepare a spreadsheet indicating the dates the EPP was reviewed. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The deficient practice affects all current	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING _____ B. WING _____	06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 004	Continued From page 2 2017." The Administrator was reminded that the EP Plan should be reviewed and updated at least annually, to which she responded, "I know, and we are trying to improve."	E 004	and new residents. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? All public health concerns will be addressed by the Safety Committee, who will meet monthly to discuss these issues. The Safety Committee will review the EPP annually. How the facility plans to monitor its performance to make sure the solutions are sustained? Safety concerns will be included on the agenda to be discussed during the quarterly QAPI meetings.	