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NUUANU HALE	**2900 PALI HIGHWAY HONOLULU, HI 96817**

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 08/10/2021 - 08/17/2021. The facility was found not to be in substantial compliance with 42 CFR 483, Subpart B, and has not implemented the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. An Immediate Jeopardy (IJ) was identified on 08/12/21 in Infection Control at F880. The Administrator was informed of the IJ on 08/12/21 at 03:26 PM. The State Agency (SA) Medicare Certification Officer was also notified of the IJ on 08/12/21. The facility's IJ Removal Plan was reviewed and approved by the survey team on 08/12/21 at 06:00 PM, and the IJ was determined to be removed on 08/13/21 at 03:16 PM. Survey Dates: 08/10/2021 to 08/13/2021 and 08/16/2021 to 08/17/2021 Survey Census: 73	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	F 550		

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

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promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to promote the enhancement of quality of life for 3 of 22 residents in the sample (Resident (R)12, R380, and R65), by ensuring that they were treated with respect and dignity. Specifically, the facility failed to prevent one resident from being singled out with large disposable absorbent underpads

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(chux) routinely placed next to her wheelchair in the hallway, in full view of other residents, failed to ensure residents were not placed in areas with their adult disposable briefs and bodies visible to fellow residents and other passers-by, and failed to treat a resident with respect when requesting assistance. As a result of these deficient practices, these residents had their dignity routinely compromised and were placed at risk of a decreased quality of life. These deficient practices have the potential to affect all residents in the facility.

Findings include:

1) On 08/10/21 at 10:19 AM, an observation was done of R12 sitting in her wheelchair which was lined up in the second-floor hallway outside her room, along with four other residents. There were chux placed on the floor directly in front, and to both sides, of her wheelchair. None of the other residents in the hallway were observed with chux near their chairs.

On 08/10/21 at 11:15 AM, an interview was done with Registered Nurse (RN)6 at the second-floor nurses' station. RN6 stated that the chux on the floor surrounding R12 was intentionally placed there, "for sanitary reasons, because she spits." When asked to clarify what R12 spits, saliva or fluids that she drank, RN6 stated that "she spits all the time, everything."

On 08/10/21 at 12:30 PM, after completing a dining observation of lunch for the residents on the second floor, it was noted that there was no spitting behavior observed from R12, and the chux surrounding her chair were entirely clean.

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On 08/11/21 at 08:03 AM, after completing a second dining observation of breakfast for the residents on the second floor, it was noted that there was no spitting behavior observed from R12. No spitting behavior was observed from R12 in any of the remaining observations made throughout the survey on 08/12/21, 08/13/21, 08/16/21 and 08/17/21, but the chux were observed consistently placed on the hallway floor around only her wheelchair on all of those days.

On 08/12/21 at 09:07 AM, an observation was done of R12 sitting in her wheelchair which was lined up in the second-floor hallway outside her room, along with four other residents. R12 was observed wearing her own shirt, a light jacket, an adult disposable brief, and non-skid socks. The blanket that should have been covering her lap was falling off her knees, exposing that R12 had no shorts or pants on.

On 08/16/21 at 10:38 AM, another observation was made of R12 sitting in a high-back wheelchair in the second-floor hallway along with five other residents, clearly wearing an adult disposable brief with no shorts or pants on, and a folded blanket barely covering her lap.

On 08/17/21 at 09:54 AM, a record review of R12's comprehensive care plan (CP), last updated 08/13/21, noted extensive care planning for spitting behaviors, initiated on 09/09/20. "Place disposable chux around her to contain her spits," was added to the CP by the Infection Preventionist (IP) on 10/16/20. A record review of all progress notes from 05/04/21 to 08/17/21 revealed spitting behavior documented only twice, on 06/19/21 and 08/12/21.
2) On 08/10/21 at 08:45 AM on entry to Room

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F 550	Continued From page 4 206, immediately observed R65 lying in her bed sleeping. She was lying on her right side facing the window. The sheet was on the bed, but was not covering her body and her gown was open in the back exposing her diaper and chux. The chux had some feces on it. On 08/11/21 at 02:00 PM, R65 was again observed to have her diaper and back exposed while lying in bed. On 08/12/21 at 02:45 PM observed R65 lying in bed with a gown and pajama bottom shorts that concealed the diaper, maintaining her dignity. On 08/13/21 at 09:00 AM observed R65 lying in bed wiith her diaper and chux exposed. 3) Interview with R380 on 08/10/21 at 01:17 PM, resident reported waiting a long time for staff members to respond to his call light. R380 was unable to ascertain how long he waits for a response. He reported it is the staff members' attitude that they don't want to help him or he is being ignored.	F 550		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health	F 561		

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care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.

§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.

§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.

§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to identify, support, and honor the preferences of four of four residents in the sample (Resident (R)74, R7, R2 and R48). Specifically, the facility failed to identify and support the bathing preferences of R7, R2 and R48 and failed to respect R74's wishes to not have a bed alarm. As a result of these deficient practices, these residents did not have their needs met and one resident (R74) experienced great psychological distress. This deficient practice has the potential to affect all the residents at the facility.

Findings include:

1) R74 is an alert and oriented, cognitively intact, 78-year-old female, admitted on 07/23/21 for short-term rehabilitation and strengthening

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following a cerebral infarction (stroke). R74's admitting diagnoses include disorientation, and adjustment disorder with mixed anxiety and depressed mood.

On 08/10/21 at 01:45 PM, an observation was done of R74 in her room on the second floor. R74 was upset and anxious, yelling at the certified nurse aide (CNA)9 who had entered the room in response to R74's bed alarm going off. R74 loudly stated she wanted the bed alarm taken off her bed and expressed how frustrated she was that she had a bed alarm, at times raising her voice to the point of yelling. CNA9 left the room and returned with Registered Nurse (RN)6, who was also the Charge Nurse for the day. RN6 and CNA9 both proceeded to attempt to convince R74 to keep the bed alarm for her safety. R74 loudly stated that the bed alarm did not do any good when she got up the previous night; no one responded to the alarm, and she ended up falling. R74 was visibly agitated, grimacing, gesturing, her voice was shaking, and she was near tears as she explained how anxious and frustrated the bed alarm made her, and that it kept her up at night. After several minutes of arguing, R74 gave up in defeat stating she was exhausted and did not care any longer, "I can't talk about this anymore, I have too much anxiety right now." RN6 and CNA9 left the room with the bed alarm still on R74's bed.

On 08/17/21 at 11:54 AM, a record review of R74's electronic health record (EHR) noted a progress note documented on 8/2/21 at 10:06 PM by RN7 where R74 verbally refused a bed alarm. Another progress note documented on 08/10/21 at 11:20 PM by licensed practical nurse (LPN)1 noted, "alert and oriented X3 ...bed alarm kept

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intact and functioning well ..." After continued review of the EHR did not reveal documentation of when the bed alarm was applied and discontinued, or the informed consent, the Assistant Director of Nursing (ADON) was asked to locate the documents.

On 08/17/21 at 04:16 PM, an interview was done with the ADON in the conference room as she delivered what bed alarm documentation she could find. The ADON produced an informed consent for the bed alarm dated 07/28/21 that documented telephonic consent was received by R74's daughter on her behalf. The ADON agreed that R74 was and is, capable of making her own decisions, giving informed consent, and refusing services, and that the verbal refusal given by R74 on 08/02/21 superseded any prior consent. The ADON also reported that there was no informed consent signed by R74 for a bed alarm, and there was no clear documentation of when the bed alarm was applied or removed. Further record review of R74's EHR revealed a late entry progress note on 08/15/21 by RN6 documenting that the bed alarm was removed on 08/11/21, however, point-of-care documentation of treatment administration noted the bed alarm was in place and functioning for all three shifts on 08/14/21.

2) R7 is a 64-year-old female admitted on 01/11/20 for long-term care with diagnoses that include traumatic cervical spinal cord injury with central cord compression and intractable neuropathic (nerve) pain. As a result of these diagnoses, R7 requires extensive assistance with her activities of daily living such as dressing, oral hygiene, and showering, and total assistance with transfers.

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On 08/11/21 at 08:15 AM, an observation and concurrent interview was done with R7 in her room on the second floor. R7 was observed lying flat in her bed wearing a wrinkled gown, with her hair unwashed and uncombed. R7 stated she was last showered three days ago but usually receives a bed bath daily. R7 continued saying she would like to shower every day, but staff often tell her they have no one to transfer her. R7 also stated that when she showers, that is usually the only time her clothes are changed, and someone assists her with brushing her hair.

On 08/12/21 at 09:22 AM, an interview and concurrent review of the shower schedule was done with certified nurse aide (CNA)9 at the second-floor nurses' station. CNA9 indicated that the shower schedule had just been introduced and implemented by the Director of Nursing (DON) that morning. After reviewing the shower schedule, CNA9 confirmed that R7 had been scheduled for showers on Tuesdays and Fridays, and bed baths on all other days.

On 08/13/21 at 08:50 AM, an observation and concurrent interview was done with R7 in her room on the second floor. R7 was observed lying flat in her bed wearing a clean gown, with her hair unwashed and uncombed. R7 stated she did not receive, nor was she offered, a bed bath or shower yesterday, but did receive a bed bath this morning. When she asked the CNA3 if she could have a shower instead, CNA3 told her she was by herself today so she couldn't get resident up to the shower.

On 08/13/21 at 08:57 AM, an interview was done with CNA3 in the hallway outside room 216.

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When asked about staffing, CNA3 stated CNA7 was her partner today but had come in late this morning, so when she cared for R7 she was by herself and could not transfer her to the shower chair alone. When asked whether she knew how often R7 liked to be showered, CNA3 stated she did not know.

3) Interview with Resident (R)2 on 08/10/21 at 09:30 AM, it was reported that showering is not up to his standards. R2 further reported he would like to have a shower once a week, presently he receives bed baths. R2 explained he has bad skin and showering would rinse off the soap that is used during bed baths. R2 stated he only receives bed baths as staff are nervous about having him sit upright during showers.

On 08/12/21 at 09:25 AM, a shower schedule was provided. R2 is marked with "D" for Wednesday and Sunday. Interviewed Certified Nurse Aide (CNA)9 to inquire what does "D" indicate on the schedule. CNA9 responded this indicates the day shift, so residents will be showered on the day shift. CNA9 reported based on the shower schedule, R2 receives showers twice a week, on Wednesdays and Thursday. Further asked whether residents can receive daily showers, CNA9 responded she thinks residents are asked on admission about showers and can receive daily showers.

4) Resident Council interview was done on 08/11/21 at 01:00 PM. Residents were asked whether they have a choice of how often they shower. R48 stated showers are done by "first come, first served, gotta stand in line". R48 further stated he would like to shower every day, but can't, "it's already been set up." R48 reported

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F 561	Continued From page 10 sometimes residents are notified in advance that there is a water shortage because of something going on in the building and showers are shut down.	F 561		
F 574 SS=E	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but	F 574		

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not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.
(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)
(iii) Information regarding Medicare and Medicaid eligibility and coverage;
(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;
(v) Contact information for the Medicaid Fraud Control Unit; and
(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.
This REQUIREMENT is not met as evidenced by:
Based on observation and interview with residents and staff member, the facility did not assure information and contact information for the State Agency (SA) and Ombudsman were

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provided to residents to ensure they are able to exercise their rights to file a complaint or contact the SA and Ombudsman.

Findings include:

On 08/11/21 at 01:00 PM an interview was conducted with resident council representatives. Residents were asked whether they are aware of where to find the contact information for the Ombudsman and how to formally complain to the SA.

Resident (R)19 reported she is not aware of how to contact the SA to file a complaint. R211 stated she is unaware of where to locate the Ombudsman's contact information.

Observation of the facility's bulletin board postings on 08/12/21 at 07:05 AM found no posting of contact information for the SA in the lobby and Ewa unit. The posting on Diamond and Pali units were not at eye level for residents in wheelchairs. Also, the listing of the SA was documented with other agencies on an 8-1/2 x 11-inch sheet of goldenrod colored sheet of paper. The size of the printed information may be difficult for residents with visual impairment to see/read.

The posting of the Ombudsman information on the Pali unit was placed at the top of the bulletin board making it difficult for residents in wheelchairs to see.

On 08/15/21 at 12:13 PM concurrent observation and interview was conducted with the Ward Clerk (WC). The WC confirmed postings were too high for residents in wheelchairs and too small for

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F 574	Continued From page 13 residents with visual impairment.	F 574		
F 577 SS=E	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview with staff members and residents, residents are not aware of their right to examine the results of the most recent survey conducted by State surveyors and any plan of correction in effect. Findings include:	F 577		

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F 577	Continued From page 14 Interview was conducted with resident council representatives on 08/11/21 at 01:00 PM. Residents were asked whether they can read the results of the State Agency (SA) surveyors' findings. Resident (R)211 responded that they can read the previous survey results. Further queried whether she was aware of where the report is kept. R211 responded, it's probably in the office. Observation was done on 08/12/21 at 07:05 AM throughout the facility of bulletin boards postings on the units and lobby of the facility. Observation found posting of the survey results in the lobby and Pali unit. The SA survey results posted in the lobby and Pali unit were affixed with binder clips at the top of the bulletin board, preventing residents in wheelchairs from reaching the report or accessing it to read while affixed to the bulletin board. There was no posting of the SA survey on the Ewa unit bulletin board. On 08/16/21 at 12:13 PM concurrent observation of the bulletin boards on Pali, Diamond, Ewa units was done with the Ward Clerk (WC). The WC acknowledged residents would have difficulty reaching the report to read and would also have difficulty removing it from the bulletin board.	F 577		
F 578 SS=E	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	F 578		

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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 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 record review, and interview, the facility failed to ensure that for a resident (R) who does not have an advance directive (AD), the resident was informed of his or her right to

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develop one, aided in doing so, or was periodically reassessed in his/her decision-making capacity to do such, for 5 of 9 residents (R12, R230, R380, R2 and R78) in the sample. As a result of this deficient practice, the residents were placed at risk of not having their wishes honored for future health care decisions, should they become incapacitated. This deficient practice has the potential to affect all the residents at the facility.

Findings include:

1) R12 had no AD found in her electronic health record (EHR) or hard chart. On 08/11/21 at 03:21 PM, a record review (RR) revealed that on 02/12/19, R12's family representative (FR) had indicated that he would like to develop an AD for R12. Further review revealed that at the Interdisciplinary Care Conference Meetings on 01/29/21 and 04/14/21, at which R12's FR participated via phone, it was determined that FR did not have the authority to make such decisions for R12 because he had not been designated as R12's Health Care Surrogate yet. It was documented at the end of both meetings that Social Services would send surrogacy information to FR. No documentation was found that this had been done.

2) R230 was a 59-year-old female admitted on 08/05/21 for Hospice care with admitting diagnoses that include liver disease and chronic kidney disease. On 08/11/21 at 03:48 PM, a RR revealed that R230 had no AD found in her EHR or hard chart. In addition, no documentation was found that information or assistance had been offered to her FR/health care surrogate regarding an AD.

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On 08/13/21 at 09:37 AM, an interview was done in the conference room with the Social Services Designee (SSD). Regarding an AD, the SSD stated, "Upon admission we have a short admission meeting, one item reviewed is an advanced directive, the advanced directive checklist is offered. It would be indicated on that form if the family elected an AD or not." Despite the admitting registered nurse (RN)3 documenting in her progress note on 08/05/21 at 02:13 PM that R230's FR was present at admission and was able to answer questions, the SSD stated that he had not had the chance to discuss an AD with her yet and had been having difficulty contacting her.

3) Record review was done on 08/11/21 at 09:16 AM for Resident (R)380. R380 was admitted on 07/19/21 with diagnoses of end stage renal disease (hemodialysis) and left leg below knee amputation. Review of the resident's medical record (hard copy) found no documentation of an advance directive.

A request was made to the Social Services Designee (SSD) for a copy of R380's advance directive on 08/15/21. On 08/16/21 at 07:34 AM reviewed the document that was left by the SSD, the SSD provided a copy of a signed Physician Orders for Life-Sustaining Treatment (POLST). A second request was made to the SSD. Prior to exit on 08/17/21, the facility did not provide documentation of an advance directive or an offer to formulate an advance directive.

4) R2 was admitted to the facility on 03/22/21. Record review was done for R2 on 08/11/21 at 07:55 AM. Review found no documentation of an

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advance directive. As requested, the facility provided a copy of R2's POLST. The POLST was prepared on 03/22/21. Further review done on 08/17/21 at 08:27 AM found a form entitled "Advance Directive" which was signed by the resident on 03/22/21 noting R2 had an existing advance directive and wished to complete a POLST. Further review found no documentation of the advance directive as documented in the resident's record.

A second request was made to the Social Services Designee (SSD) of advance directive and/or documentation of discussion regarding the formulation of an advance directive. The SSD provided a copy of the "Interdisciplinary Care Conference Summary and Resident Status Update" dated 03/31/21 which has a handwritten note R2 has a power of attorney in place. There was no documentation of the POA in the record or provided by the facility for surveyor review.

Surveyors requested SSD provide copies of residents' advance directives as copies of residents' POLSTs were provided. Following review of the documentation provided, a follow-up interview was conducted with the SSD on 08/13/21 at 09:37 AM. SSD reported based on training, advance directives are comprised of many forms and the POLST is one of the forms. However, SSD acknowledged a POLST does not replace an advance directive. SSD explained upon admission the facility will discuss advance directives and document whether resident has an advance directive or declines to formulate an advance directive or asks for assistance to formulate an advance directive. Advance directives are discussed with the resident or the resident's representative. The SSD further

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explained during quarterly meetings advance directives are discussed with participants. Requested SSD provide documentation of discussion related to advance directives with resident or resident representative to formulate an advance directive on admission or quarterly documentation of resident's advance directive status.

5) R78 is a 94-year-old admitted to the facility on 07/29/21 under Hospice care, has dementia and chronic kidney disease. On 08/16/21 RR revealed R78 had a POLST in the medical record signed by her daughter on 07/16/21 as the legally authorized representative and agent designated as Durable Power of Attorney for Healthcare (DPOA). The POLST orders included "do not attempt resuscitation, comfort measures only and no artificial nutrition by tube."

On 08/16/21 reviewed the Admission Agreement signed by R78's daughter dated 08/03/21 which included Page 1/1 "Advance Directive." This page said; "This is to inform you that a Federal Regulation effective December 1, 1991 requires every hospital and nursing home to inform their patients/residents on admission that they have the right make decisions concerning their medical care. This includes the right to accept or refuse medical or surgical treatment and the right to formulate an Advanced Directive or a Durable Power of Attorney for health care as recognized by State law. Please inform us of the current status of your Advance Directive and your wishes by checking one or more of the boxes below. We will assist you in updating your documents.
The boxes checked included "I have an existing Advance Directive; I have a Medical Power of Attorney and I have a POLST document."

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F 578	Continued From page 20 Review of the facility undated policy titled "Advance Directives" included the procedure; "Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff. The medical record did not contain a copy of the DPOA and did not include a copy of the AD despite R78 being on hospice care. The facility was unable to provide documentation identifying R78's medical decision-maker, the AD, or that requests had been made to provide the documents.	F 578		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other	F 583		

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than a postal service.

§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.
(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.
(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
Based on observation, and interview, the facility failed to respect the right to personal privacy for 2 of 22 residents in the sample (Resident (R)34 and R380). Specifically, the facility failed to provide visual privacy for R34 during her bed baths, and for R380 after being assisted to the toilet. As a result of these deficient practices, both residents had their privacy compromised and were placed at risk of a decreased quality of life. This deficient practice has the potential to affect all the residents at the facility.

Findings include:

1) On 08/11/21 at 09:04 AM, an observation was done of R34 in her room on the second floor. Certified nurse aide (CNA)2 had just finishing giving R34 a bed bath. R34 was observed completely naked on her bed, and while the privacy curtain was drawn, it was not closed all the way. Surveyor attempted to close the privacy curtain further, but it would not extend any more, leaving at least a four-inch gap between the end of R34's privacy curtain and the curtain

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F 583	Continued From page 22 surrounding bed two. Through the gap in the privacy curtain, R34 was in full view of her roommate in bed 3 as she lay there naked. 2) Resident (R)380 is independent in cognitive skills for daily decision making. R380 requires extensive assistance with one-person physical assist for using the toilet. Interview with R380 on 08/10/21 at 01:18 PM, it was reported staff members sometimes leave the door open while he is on the toilet. R380 reported he has experienced people walking by his room with a view of him sitting on the toilet. R380 further reported this is embarrassing.	F 583		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		

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and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to ensure a comfortable environment for residents and staff at the facility, as evidenced by elevated environmental temperatures on the second floor, particularly in room 206. As a result of this deficient practice, the residents and staff unnecessarily experienced uncomfortable heat. This deficient practice has the potential to affect all the residents and staff at the facility.

Findings include:

1) On 08/10/21 at 08:50 AM, an observation was done in room 206. Resident (R)34 was noted to be lying in bed with no covers, wearing a gown, unresponsive to greetings or questions. The room felt uncomfortably warm. It was observed that the windows in the room were open, but thick, heavy curtains were closed over the

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windows, not allowing any airflow. There was a window air conditioner (a/c) unit observed, but it was not on.

On 08/11/21 at 07:48 AM, an observation was done of R47 in her bed next to the window in room 206. R47 was sitting high in bed, with certified nurse aide (CNA)9 assisting her with breakfast. R47's covers were kicked off and bunched at the foot of her bed, and she was dressed in her own clothes. The surveyor commented how hot it was, and CNA9 agreed, stating that room 206 felt hot every day. All windows in the room were open, but blocked with thick, heavy curtains, and the a/c unit in the window was off.

On 08/11/21 at 08:56 AM, room 206 was entered and surveyor immediately felt uncomfortably warm. R47 was observed lying in bed wearing an adult disposable brief and her own top, with her covers kicked off and bunched at the foot of the bed. The a/c unit in the window was off. Surveyor tested the air conditioner, and it turned on immediately, with the digital reading displaying the temperature was set at 60 degrees. Cool air began flowing out, indicating that the unit was operational.

On 08/11/21 at 11:09 AM, an interview was done with the Maintenance Supervisor (MS) in room 206. The MS had come in "to check the ac [a/c]." When questioned about the current room temperature, the MS stated that he did not know, and he left to get a thermometer. At 11:10 AM, the MS returned with a manual refrigerator thermometer, hung it on the privacy curtain near bed two, and read it after a few minutes. The MS stated that the thermometer read "40 degrees."

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Surveyor asked to look at the thermometer, noting that the numbers only went up to 60 degrees, but the thermometer scale lines continued past where the 80 degrees would be. The temperature indicator (red line) went to the last scale line on the display. Surveyor indicated to the MS that it appeared the thermometer read past 80 degrees, to which the MS took another look and agreed. Asked the MS if he had another thermometer that could give an accurate room temperature. The MS left the room and returned at 11:34 AM with a digital infrared thermometer gun. Room temperature recorded at 83 degrees when pointed towards bed 1 (away from the window), and 86 degrees when pointed at bed 3 (right next to the window). The MS confirmed that these temperatures were "too high."
2) On 08/10/21 at 12:00 PM entered room (Rm) 206 to observe R65 at mealtime. The room temperature was noted to be very warm and uncomfortable. Room 206 had four residents in the room and R65 was in the bed (206-4) located by the door away from the windows. Observed R65 to have the sheet off and diaper exposed.

On 08/11/21 at 09:00 AM noted the temperature again to be uncomfortably warm in the hallway (Pali wing, Rm. 206-201) on the second floor, and in room 206. R65 was not interviewable and again observed the sheet to be off and her diaper exposed. The hallway of the unit was also noted to be very warm.

On 08/11/21 at 09:45 AM a phone call was made to the MS and request made to check the temperature on the unit and in the room 206. The MS was informed the a/c was not on and asked to take the temperatures prior to turning it on. At approximately 11:10 AM returned to the

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F 584	Continued From page 26 unit where the MS was checking the temperature in room 206. When asked him what the temperature was he replied; "83 to 86 (degrees Fahrenheit)." At that time, MS measured the temperature at the doorway to be 86.2 F. Accompanied the MS while several additional temperatures were taken down the hallway. Three temperatures were measured to be over 82 F. On 8/12/21 a request was made for a copy of the temperatures taken on 08/11/21. MS provided a copy of temperatures taken in all resident rooms on 08/12/21, but said he had not recorded the temperatures he took the previous day.	F 584		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.	F 585		

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§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident

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right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on interview with residents, the facility did not assure residents are aware of how to file a grievance or complaint. This deficient practice has the potential for residents of the facility not being able to exercise their rights to file a grievance or complaint to the facility or an

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F 585	Continued From page 29 advocacy agency. Findings include: Interview was conducted with the resident council representatives on 08/11/21 at 01:00 PM. Residents were asked whether they know how to file a grievance. Resident 211 stated they do not really know how to file a grievance. The other residents did not respond to the question.	F 585		
F 635 SS=D	Admission Physician Orders for Immediate Care CFR(s): 483.20(a) §483.20(a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on record review (RR) the facility failed to ensure that one resident (R)65 of a sample size of 21 had the required minimum admission physician orders needed to provide essential care consistent with her physical status upon admission to the facility. Specifically, R65's admission orders did not include a dietary order. As a result of this deficiency there was the potential that R65 would have been provided a meal or diet that was not medically appropriate or safe for her medical condition. This has the potential to affect all new admissions to the facility. Findings include: R65 was transferred to the facility from an acute care hospital on 06/25/21. Her pertinent medical history (Hx) included malignant neoplasm of the	F 635		

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F 635	Continued From page 30 colon, weakness, major depressive disorder, paranoid schizophrenia, hypertension, anemia, and Hx of stroke. A review of R65's medical record was completed on 08/16/21 which revealed the following: On 06/25/21 admission orders were written by R65's physician (MD)1. The orders did not include a dietary order. On 06/30/21 there was an entry (not timed) on the "Recommendations & Communication from R.D. (Registered Dietician) to Nursing (LN) & Dietary Manager (DM)" form that read; "R65-Adm Assess (admission assessment)/CP (care plan) completed. 1) No diet order in chart, give regular diet, fine chop solid, thin liquids." On 07/01/21 MD1 wrote a dietary order for R65; "Regular, Fine chopped Special instructions: Per ST (speech therapy) continue current diet fine chopped, thin liquids."	F 635		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders.	F 655		

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(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review (RR), the facility failed to develop a baseline care plan that provided effective and person-centered care for 2 of 22 residents (Residents 230, and 78) in the sample, that ensured continuity of care. Specifically, despite identifying the residents' immediate medical needs, the facility failed to develop, implement, and modify resident-specific interventions that thoroughly addressed those needs. As a result of

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these deficient practices, the facility placed these residents at risk for avoidable declines and injuries. This deficient practice has the potential to affect all new admissions to the facility.

Findings include:

1) Cross to findings at F692 Nutrition. Despite an admitting weight of 49 pounds (lbs.), a secondary diagnosis of protein-calorie malnutrition (PCM), and a documented history of weight loss, the facility failed to develop and implement a baseline care plan that addressed the dietary needs of resident (R)230. As a result, R230 experienced a loss of 2.1 lbs. within three days after admission, reflecting a weight loss of 4.3%.

2) R78 is a 94 year old female transferred to the facility for admission from another long term care facility on 07/29/21. R78 has a history of dementia, a fracture of the right wrist, and is receiving hospice care. R78 is non-ambulatory and requires assistance for dressing, transfer and personal hygiene.

On 08/10/21 at 12:00 PM, when observed R78 in the dining room, noted she had a straight supportive splint on her right arm with ace bandage wrap.

Record review (RR) on 08/12/21 revealed the following:
R78's baseline care plan was completed on 07/29/21. The baseline care plan documented R78 had the potential for pain due to "right wrist (fracture)." The designated area of the baseline care plan form was marked "no" for "splints/prosthesis."

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F 655	Continued From page 33 R78's "Resident Admission orders," and "Admission Medication & Treatment Orders" dated 07/29/21 did not include the diagnosis of right wrist fracture and did not include an order or instructions for the wrist splint. R78's admission records included "Dx ICD -10 (International classification of Diseases) diagnosis Unspecified fx of the lower end of right radius, subsequent encounter for closed fx with routine healing." On 08/13/21 at 11:00 AM, MD1 provided a phone order to "keep wrist splint in place. Check for skin abnormalities and circulation."	F 655		
F 656 SS=E	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).	F 656		

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(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and interview with staff members, the facility did not ensure that the development and implementation of comprehensive person-centered care plans were done for 8 of 22 residents (Residents 59, 35, 380, 74, 7, 47, 12, and 78) in the sample. Specifically, care plans were not developed and/or were not person-centered related to the use of antidepressants for two residents. Care plans were not personalized to the needs of a resident admitted with a pressure ulcer. Care plans were developed and implemented without the resident's consent, resulting in anxiety and frustration for the resident before being discontinued. A resident with contractures did not have a care plan to include prevention of further contractures, and her dental care plan was not

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implemented. A care plan was not developed to monitor for adverse effects of taking a blood thinner despite the resident having a documented history of bleeding. Lastly, a care plan was not developed to monitor for circulation and conduct skin assessments for a resident admitted with a splint. As a result of these deficient practices, these residents were placed at risk for a decline in their quality of life, and were prevented from attaining their highest practicable physical, mental, and psychosocial well-being. These deficient practices have the potential to affect all the residents at the facility.

Findings include:

1) Cross Reference to F578. Resident (R)59 receives routine antidepressant medication (trazodone). The facility did not assure a person-centered care plan was developed related to the use of the antidepressant (monitoring for adverse effects, signs and symptoms of depression) and did not develop non-pharmacological interventions to use in conjunction with medication.

2) Cross Reference to F578. Resident (R)35 receives routine antidepressant medication (mirtazapine). The facility did not assure a person-centered care plan was developed for the use of the antidepressant to either address loss of appetite or depression. The care plan did not include non-pharmacological interventions to use in conjunction with medication.

3) Cross Reference to F686. Resident (R)380 was admitted to the facility with a Stage 2 pressure injury to his coccyx. The pressure injury healed. R380 is at high risk for developing

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pressure injuries and/or reopening of pressure injury to the coccyx and the facility did not assure a person-centered plan of care was developed for the prevention of pressure injuries.
4) R74 is an alert and oriented, cognitively intact, 78-year-old female, admitted on 07/23/21 for short-term rehabilitation and strengthening following a cerebral infarction (stroke). R74's admitting diagnoses include disorientation, and adjustment disorder with mixed anxiety and depressed mood.

On 08/10/21 at 01:45 PM, an observation was done of R74 in her room on the second floor. R74 was upset and anxious, yelling at the certified nurse aide (CNA)9 who had entered the room in response to R74's bed alarm going off. R74 loudly stated she wanted the bed alarm taken off her bed and expressed how frustrated she was that she had a bed alarm, at times raising her voice to the point of yelling.

On 08/17/21 at 11:54 AM, a record review of R74's electronic health record (EHR) noted that "Bed alarm-check placement and functioning" had been added to R74's Falls Care Plan on 07/26/21. No documentation of R74's informed consent was found.

On 08/17/21 at 04:16 PM, an interview was done with the ADON in the conference room as she delivered what bed alarm documentation she could find. The ADON produced an informed consent for the bed alarm dated 07/28/21 that documented telephonic consent was received by R74's daughter on her behalf. The ADON agreed that R74 was and is, capable of making her own decisions, giving informed consent, and refusing services, and could not explain why the bed alarm

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was added to the care plan, and implemented without the resident's consent.

5) R7 is a 64-year-old female admitted on 01/11/20 for long-term care with diagnoses that include traumatic cervical spinal cord injury with central cord compression and intractable neuropathic (nerve) pain. As a result of these diagnoses, R7 requires extensive assistance with her activities of daily living such as dressing, oral hygiene, and showering, and total assistance with transfers.

On 08/11/21 at 08:10 AM, an observation and concurrent interview was done with R7 in her room on the second floor. R7 was lying flat in bed with her hair uncombed, contractures noted to all the fingers of her right hand and the middle finger of her left. R7 stated she does have a splint for her right hand, but no one ever assists her to put it on, so she keeps it in the drawer of the nightstand by her bed. R7 further stated that she was not receiving any rehabilitation services but felt she really needed it. When asked about oral care, R7 stated she could not remember the last time staff assisted her in brushing her teeth, and that "sometimes" she was offered mouthwash, but not regularly. R7's dental status appeared to be in an advanced state of decay, with several teeth missing, and what teeth remained were brown in color.

On 08/17/21 at 09:00 AM, during a review of R7's comprehensive care plan, the following was noted in R7's Dental Care Plan: "Offer and assist with oral hygiene at least 2x/day." Also noted in the review of R7's comprehensive care plan was that there was no plan to address her contractures or splint.

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On 08/17/21 at 11:24 AM, during an interview with the Assistant Director of Nursing (ADON) in the conference room, the ADON reported that there was no splint or RNA program refusal signed by R7 found in her chart, and acknowledged that the contractures, splint, and related interventions should have been added to R7's comprehensive care plan.

6) R47 is a 70-year-old female admitted on 02/10/20 for long-term care with diagnoses that include dementia, hypertension (high blood pressure), contracture of muscle and abnormal posture. On 08/10/21 at 10:19 AM an observation was done of R47 as she sat in a high-backed geri-chair in the hallway of the second floor. R47 had both knees drawn up to her chest with her body leaning to the left. At 02:31 PM, R47 was observed in the same position in the geri-chair. An interview with certified nurse aide (CNA)9 in the second-floor hallway confirmed that contractures in both legs prevented R47 from extending them much farther from the knee-to-chest position.

On 08/16/21 at 10:07 AM, a review of R47's hard chart on the second floor revealed that R47 was on the restorative nurse aide (RNA) schedule to have therapeutic exercises for bilateral (both sides) contracted knees done. A physical therapy (PT) Discharge (D/C) Summary, dated 03/11/21, was also found with a PT recommendation for R47 to wear bilateral knee splints. It was noted that no observations of R47 wearing knee splints were made since entering the facility on 08/10/21.

On 08/16/21 at 11:00 AM, during a review of R47's comprehensive care plan it was revealed

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that there was no care plan to address R47's contractures, knee splints, or RNA needs.

On 08/17/21 at 11:16 AM, an interview was done with the ADON in the conference room. The ADON agreed that there should be a care plan to address R47's contractures, knee splints, and RNA needs. At 14:39 PM, the ADON confirmed that there was no signed refusal for the knee splints documented from either the resident or her representative.

7) R12 is an 89-year-old female admitted on 03/19/19 for long-term care with diagnoses that include dementia, stroke, and history of hematuria (blood in the urine). R12 is on clopidogrel, a blood thinner used to prevent stroke, heart attack and other heart problems.

A review of R12's electronic health record (EHR) on 08/11/21 at 03:14 PM noted that R12 had her clopidogrel held for three days, from 08/06/21 to 08/09/21 due to observations of blood clots in her adult incontinence briefs. The original order was to hold the clopidogrel for one week, however due to R12's family representative's stroke concerns, the physician resumed the medication. A review of R12's comprehensive care plan revealed that despite her history of hematuria, monitoring for side effects (such as bleeding) of taking the clopidogrel was not a part of her care plan.

8) R78 is a 94 year old female transferred to the facility for admission from another long term care facility on 07/29/21. R78's medical history included Alzheimer's disease, dementia, chronic kidney disease and a fracture of the right wrist, R78 is receiving hospice care. She is non-ambulatory and requires assistance for dressing, transfer, and personal hygiene.

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F 656	Continued From page 40 On 08/10/21 at 12:00 PM, observed R78 in the dining room. it was noted she had a straight supportive splint on her right arm with an ace bandage wrap. A review of R78's active comprehensive care plan (CP) was conducted on 08/13/21. The CP was initiated on 07/29/21 with revisions on 08/04/21 by the Dietician. The CP diagnosis included "unspecified fracture of the lower end of right radius, subsequent encounter for closed fracture with routine healing." The CP did not include any reference of the right wrist splint and did not include any instructions to routinely assess the extremity for circulation, motor and sensory (CMS) or if the splint could be removed for bathing and skin examination. In addition, the CP did not include specifics for the splint application, i.e. padding. The only reference to skin integrity was "weekly skin check per facility policy."	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		

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the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to review and revise the Comprehensive Care Plan (CP) for 5 of 22 residents (Resident 59, 2, 24, 46, and 65) in the sample to effectively address their status, condition, and needs in a timely manner. As a result of this deficient practice, staff did not have the information necessary to adequately care for these residents so that they could safely meet their highest potential of physical, mental, and psychosocial well-being. This deficient practice has the potential to affect all the residents at the facility.

Findings include:

1) Cross Reference to F684. Resident (R)59 presented with bruising to bilateral lower extremities. R59's bruises reportedly are old, and there is no documentation of a skin assessment notating the bruising. There are care plans to address other areas of compromised skin and R59's care plan was not revised to develop person-centered interventions to prevent further

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injury to her skin.

2) Cross Reference to F690. Resident (R)2 was admitted with an indwelling Foley catheter. Based on an assessment to address R2's penile tear/laceration, the facility did not develop a person-centered care plan to deter further injury related to the use of the indwelling Foley catheter.

3) Cross Reference to F744. Resident (R)24 is diagnosed with dementia with behavioral disturbance. R24's observed behaviors included repetitively speaking in a loud voice, clapping his hands, and rhythmically slapping the overbed tray with his hands. The facility did not revise the care plan to assure that a person-centered care plan was developed to address R24's behaviors to prevent distressing other residents or putting him at harm for resident-to-resident altercations.
4) R46 is a 56-year-old male admitted on 03/05/19 for long-term care with diagnoses that include left hemiplegia (paralysis on one side of the body) and hemiparesis (muscle weakness on one side of the body) following a stroke, heart failure, diabetes, and kidney failure. R46 was admitted on hospice care, however, was discharged from hospice on 07/08/19. On 08/12/21, R46 spiked a fever of 102.3 degrees and was placed on transmission-based precautions (TBP), and the COVID-19 Plan for a Suspected COVID-19 Resident was activated.

On 08/13/21 at 10:15 AM, during a review of R46's CP, it was noted that the facility still listed " ...self-care performance deficit due to his medical condition: Hospice care" as an identified problem. It was also noted that the interventions as part of the COVID-19 Plan initiated on 08/12/21 due to R46's fever, had not been added to his CP.

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F 657	Continued From page 43 On 08/17/21 at 11:20 AM, an interview was done with the Assistant Director of Nursing (ADON) in the conference room. The ADON agreed that R46's CP should have been revised to remove the hospice terminology when he was discharged from hospice, and that adding the COVID-19 Plan interventions to his CP could have been helpful as part of the response to his fever. 5) R65 was admitted to the facility on 06/25/21 for long term care. Her pertinent medical history (Hx) included malignant neoplasm of the colon, weakness, major depressive disorder, paranoid schizophrenia, hypertension, anemia, and history of a stroke. A record review of R65's medical record was completed on 08/13/21, which revealed the following: On 06/25/21 admission orders written by the physician (MD)1 included aspirin 81 mg (milligrams) orally for "Dx (diagnosis) History of stroke." On 06/29/21 the Pharmacist completed the "Pharmacare LTC Consultant Pharmacist Communications" form which included " no ADR (adverse drug reaction) monitoring for Aspirin in place." The recommendation was "For aspirin therapy, consider monitoring potential adverse effects of bleeding, bruising." On 07/02/21 MD1 ordered "Monitor for bleeding/bruising due to Aspirin." The comprehensive care plan was not revised to include monitoring R65 for adverse reactions due to Aspirin.	F 657		

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F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to provide the necessary care and services to maintain the activities of daily living, including grooming, personal and oral hygiene, eating, and transfer and mobility for three residents (Residents 7, 18, and 65) in the sample. As a result of this deficient practice, these residents were hindered from attaining their highest practicable well-being and placed at risk for a decreased quality of life. This deficient practice has the potential to affect all the residents at the facility. Findings include: 1) Resident (R)7 is a 64-year-old female admitted on 01/11/20 for long-term care with diagnoses that include traumatic cervical spinal cord injury with central cord compression and intractable neuropathic (nerve) pain. As a result of these diagnoses, R7 requires extensive assistance with her activities of daily living such as dressing, oral hygiene, and showering, and total assistance with transfers. On 08/11/21 at 08:15 AM, an observation and concurrent interview was done with R7 in her room on the second floor. R7 was observed lying flat in her bed wearing a wrinkled gown, with her hair uncombed, contractures noted to all the fingers of her right hand and the middle finger of	F 677		

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her left. R7 stated she was last showered three days ago but "usually" receives a bed bath daily. R7 continued saying she would like to shower every day, but staff often tell her they have no one to transfer her, sometimes stating they have pain that day, or have an injury. When questioned about how she used her hands, R7 stated that she cannot brush her teeth or her hair with either hand, but she can feed herself with her left hand using a special utensil. R7 stated that she is never assisted with washing her hands before meals "because they [staff] are too busy." R7 also stated that when she showers, that is the only time someone assists her with brushing her hair. When asked about oral care, R7 stated she could not remember the last time staff assisted her with brushing her teeth, and that "sometimes" she was offered mouthwash, but not regularly. R7's dental status appeared to be in an advanced state of decay, with several teeth missing, and what teeth remained were brown in color.

On 08/13/21 at 08:50 AM, an observation and concurrent interview was done with R7 in her room on the second floor. R7 was observed lying flat in her bed wearing a clean gown, with her hair unwashed and uncombed. R7 stated she did not receive, nor was she offered, a bed bath or shower yesterday, but did receive a bed bath this morning. When she asked the certified nurse aide (CNA)3 if she could have a shower instead, CNA3 told her she was by herself today so she couldn't get resident up to the shower. When asked, R7 reported that she was not offered any assistance to brush her teeth or hair.

On 08/13/21 at 08:57 AM, an interview was done with CNA3 in the hallway outside room 216. When asked about staffing, CNA3 stated CNA7

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was her partner today but had come in late this morning, so when she cared for R7 she was by herself and could not transfer her to the shower chair alone. When asked whether she knew how often R7 liked to be showered, CNA3 stated she did not know.

2) Cross reference to F725 Sufficient Nursing Staff.
R18 was observed on 08/10/21 and 08/11/21 at lunch. R18 was set up and left to feed herself independently with no assistance. On 08/10/21 R18 was observed to take a bite of entrée but had difficulty getting the food and moving the fork to her mouth. No one monitored R18's ability to feed herself independently, or assist her. On 08/12/21 at 11:20 AM observed a CNA sit next to R18 to assist with her meal. After making one attempt to give R18 a bite of food, the CNA was requested to assist elsewhere and no one replaced the CNA or assisted R18 for that meal.

R65 was observed on 08/10/21 and 08/11/21 during the lunch mealtime. Each day a CNA assisted R65 to sit on the side of the bed, set up the meal tray, and left. R65 laid back down in bed shortly after the set up. She did not eat lunch on 08/10/21 and documented less than 25% intake on 08/11/21. The staff did not monitor, encourage or assist R65 with these meals.

Reviewed R65's records on 8/16/21 revealed the following nursing progress note entered on 08/13/21 at 5:42 PM; "Nursing management decided that resident has a significant change AEB (as evidence by) decline in physical functioning, requiring increased assistance in eating (from set up to staff having to assist, although, reportedly she may refuse). She has

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F 677	Continued From page 47 been having poor PO intake."	F 677		
F 679 SS=E	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 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 observation, record review, and interview with resident representative based on a comprehensive assessment and care plan, the facility did not assure an ongoing program to support residents' activities was provided and designed to support the mental and psychosocial well-being of each resident. The activities developed for 3 of 5 residents were not person centered to create opportunities for each resident to have a meaningful life by supporting his/her wellness (joy and meaning). Residents 24, 42 and 35 are diagnosed with dementia and the facility did not assure they received activities to meet their specific needs. The care plans were not individualized to ensure the residents' interests were addressed. Findings include: 1) Cross Reference to F744, Treatment/Services for Residents diagnoses with Dementia.	F 679		

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Resident (R)24 was admitted to the facility on 05/17/19 and has diagnoses of dementia with Lewy bodies and dementia in other diseases classified elsewhere with behavioral disturbance.

Morning observations on 08/10/21, 08/11/21, and 08/12/21 saw R24 in his room, repetitively speaking in a loud voice, hand clapping and rhythmically slapping the top of his overbed tray. Interventions were not observed. Staff members reported it is difficult to engage R24 in activities due to his behavior.

Interview with resident's representative on 08/11/21 at 02:03 PM, it was reported the facility encourages R24 to participate in activities, but he does not want to. The resident's representative further reported, R24 would watch television all day at home and would complain to have the station changed as he already saw the program on television. The resident's representative reported that's why R24 does not have a television.

On 08/17/21 at 12:15 PM, the Activities Director (AD) provided a copy of R24's activity assessment, plan of care, and participation log. Review of the annual activity assessment dated 04/21/21 notes R24's activity pursuit patterns and preferences as bowling, coloring, drawing, sports, and talk story. AD also notes R24 is able to communicate with staff through writing on a white erase board. Staff member will have to write down the statements. In regard to behavior, AD notes resident refuses to get out of bed and has behavior episodes of yelling, sometimes uncooperative with care or environmental issues that may hinder or reduce activity participation.

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Review of the plan of care, identifies a goal for R24 is to continue to engage in 1:1 room visits and at least 1-2x per week for social interaction and sensory stimulating activities. Approaches include conduct 1:1 visits at least one to two times a week (conversation, watch videos, reminisce, ukulele, boss toss), respect decision if he refuses; approach in calm manner and greet by resident's name; encourage and assist facetime video call with family as scheduled; offer newspaper/magazines if he is interested; and use a white board to communicate, he is able to read and respond.

Review of R24's participation record from 07/01/21 through 08/14/21 documents resident is asleep when approached for 1:1 activities or brief greeting while resident is engaged in sitting up in bed and hand clapping and/or singing. There is one documentation of R24 of each of the following activities, resident reading the newspaper, resident watching television in his room (no television?), and offering of newspaper.

2) R42 was admitted to the facility on 07/12/19 with diagnosis of vascular dementia with behavioral disturbance.

Observation on 08/12/21 at 01:34 PM, R42 was asleep in bed. On 08/11/21 at 09:19 AM, R42 was observed in activities in the downstairs dining room until lunch. She was seated in a wheelchair with her head hanging down and eyes closed. The movie, "Cheaper by the Dozen" was being shown to the residents. Second observation at 03:36 PM found resident asleep in bed. After the movie, R42 remained in the dining room for lunch. There was no observation of staff

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members encouraging social interaction between residents or residents spontaneously engaging in social interaction.

The AD provided copies of activity assessment, care plan and activity participation record on 08/17/21 at 12:15 PM. The activity assessment dated 12/04/20 notes R42's interests include contact with others, enjoys helping others, room visit and is independent in activities. R42 also assessed to prefer 1:1, small and large group activities in the morning. The care plan goal is for R42 to continue to participate in activities she enjoys once a week. The approaches include: encourage resident to eat lunch in the dining room to promote social interaction, assist with facetime/zoom call with family, encourage to be out of bed to participate in morning/afternoon group activities daily (i.e. exercise, TV/movies, cognitive games, arts and crafts), and room visits at least 1x week for 1:1 interaction.

Review of the participation log found no entry of R42 attending movie on 08/11/21. There are entries of resident being asleep when approached for activities.

3) R35 was admitted to the facility on 03/18/14 with diagnosis of vascular dementia with behavioral disturbance.

On 08/10/21 during the initial tour, R35 was observed in her wheelchair parked in the hall with breakfast tray on her overbed tray. R35 was asleep, her head hanging down with eyes closed. At 10:41 AM and 01:46 PM, R35 was observed asleep in bed. On 08/11/21 at 07:49 AM, R35 was awake, seated in her wheelchair next to her bed eating breakfast. At 09:23 AM, resident was

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F 679	Continued From page 51 parked in the hall, asleep. Staff member put her back to bed and prepared to give R35 a bed bath. Observation at 03:39 PM, staff member was providing personal care. On 08/12/21 at 09:02 AM, R35 was observed parked in the hall, asleep, she would often place both hands around her head. The AD provided copies of R35's activity assessment, care plan and participation log on 08/17/21 at 12:15 PM. Review of the activity assessment dated 05/13/21 notes resident preferred activity setting is own room and day/activity room. The preferred time preference is morning and afternoon with 1:1 and small and large groups. R35's leisure interest include music, catholic mass, walking/wheeling outdoors, watching TV/movies and pet visits. The care plan goal is for R35 to attend activity program at least once a week if desired. Approaches include continually encourage resident's participation in group/1:1 activities and assist when needed (exercise, balloon toss, bingo, recreational games, and sensory stimulation); encourage to be out of bed to attend family visitations; provide opportunities for resident to engage in playing with tactile objects or offer magazines to browse, listening to music, or watching tv/or videos on ipad for her individual activity; and greet resident by her first name. Review of resident's participation in activities notes resident watching television in the hallway; however, observations found resident was not placed in front of the unit's television. R35's preferences for television programs or movies are not identified in the care plan.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		

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§ 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 observation, record review and interview with staff members the facility failed to comprehensively assess, identify the problem, and provide the necessary care and services in a timely manner, with goals for care using professional standards of nursing practice for 4 of 22 residents (Residents 59, 181, 78, and 65) in the sample. The facility failed to meet the residents' highest practicable level of functioning and well-being related to assessing and protecting skin integrity, providing rehabilitative services, developing baseline care plans, ensuring comprehensive care plans were person-centered, and identifying nutritional and hydration deficits. This deficient practice has the potential to affect all the residents at the facility.

Findings include:

1) Cross Reference to F657 Care Plan Revision.

Resident (R)59 was admitted to the facility on 03/25/15. Diagnoses include unspecified dementia without behavioral disturbance, history of falling, and abnormal weight loss.

On 08/11/21 at 03:36 PM observed R59 asleep in

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bed. R59's pant legs were raised exposing the resident's lower extremities (legs). R59's shins were mottled with dark purple and red areas with a scab possibly from a skin tear. Observed Certified Nurse Aide (CNA)14 transfer R59 from the wheelchair to bed after assisting the resident with breakfast on 08/12/21. CNA14 swung the footrests to the side, placed her arms under the resident's arms and while pivoting R59, CNA14 accidentally hit the resident's leg against the wheelchair, R59 was heard to say "ouch". Subsequent observation at 09:15 AM found R59 independently wheeling herself around the unit.

Review of R59's electronic health record (EHR) notes entries for "RMC Injury/Integumentary Alteration." There were three entries: 06/24/21 noting right forearm bruise; 07/22/21 noting right dorsal hand linear cut; and 08/06/21 noting abrasion to back of right upper arm. There was no documentation of altered skin to R59's lower extremities. (Note: the facility switched EHR vendors/systems in May 2021).

R59's previous quarterly Minimum Data Set (MDS) with assessment reference date (ARD) of 06/27/21 and 03/29/21 notes the resident is not coded for the use of an anticoagulant. The annual MDS with an ARD of 10/03/20 also notes the resident is not coded for the use of an anticoagulant. The physician orders do not document the use of an anticoagulant.

R59's care plan provided by the facility documents two problem areas for skin integrity (resident has linear cut on the right dorsal hand and resident is at risk for alteration in skin impairment related to purple discoloration on right forearm). Interventions include assess resident

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for presence of risk factors, treat, reduce, eliminate risk factors to extent possible; conduct a systematic skin inspection weekly, pay particular attention to the bony prominences; keep clean and dry as possible to minimize skin exposure to moisture; do treatment as ordered; encourage physical activity, mobility, and range of motion to maximal potential; good handling during care; and monitor signs of bleeding and report. The care plan did not include interventions to prevent injury to resident's legs.

On 08/13/21 at 08:15 AM interviewed Registered Nurse (RN)1 regarding R59's skin integrity. RN1 reported R59 has bruises and cuts because of her advanced age and has bruising from moving around independently and may bang into something. RN1 reported thick socks and tube cloth are used to protect R59's shin.

On 08/13/21 at 08:25 AM interviewed CNA1. CNA1 reported the resident's skin is fragile, and she may hit her leg on the footrest. Inquired what measures are taken to prevent skin breakdown. CNA1 replied R59 is dressed in long pants with tube socks to protect her legs. Concurrent observation of the resident's socks found the socks were loose and went slightly past the resident's ankle. CNA1 was asked whether these socks would protect the resident's legs as it doesn't extend farther up. CNA1 did not respond.

On 08/13/21 at 12:00 PM interview and concurrent record review was done with the Minimum Data Set Coordinator (MDSC). MDSC reviewed R59's record and noted an entry for weekly skin assessment which documents skin intact and dry and abrasion to back of right arm dry. MDSC reported ecchymosis of skin should

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be documented here. MDSC found another entry dated 08/13/21 at 08:45 AM, while resident was sitting on her wheelchair on the hallway this writer noted ecchymosis on bilateral shin of the resident. Good handling during nursing implemented. Resident Representative (RP) and Physician (MD) were updated. MDSC stated the facility had identified R59's ecchymotic skin. Informed MDSC, entry was made following surveyor's interview with nurse. There is no documentation prior to this interview related to the resident's legs.

MDSC reported R59 will wheel herself on the unit and in the past the facility has applied Styrofoam padding around the footrest to prevent bruising. MDSC reported this did not prevent bruising. Further queried whether geri-sleeves were tried, MDSC was not sure whether this was tried. MDSC was not aware of whether the interdisciplinary team conducted a root cause analysis to prevent further bruising.

Subsequently an interview was conducted with the Director of Nursing (DON). The DON reported some of the resident's bruises are old and the facility has ordered sleeves to apply to R59's bilateral lower extremities.
2) R181 was admitted to the facility for rehabilitation after a fall that resulted in a hip fracture. R181 had orders for physical therapy (PT) and the goal was to be discharged home.

On 08/16 /21 at 02:00 PM, during an interview with R181 in her room, she said PT came to work with her yesterday and she walked with gait belt and walker. When asked where she went and how far, R181 stated "I had to stay in the room, we walked back and forth in the room. It was

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hard to walk in the room." R181 said she wanted to go out in the hall, but the therapist (PT)1 wouldn't take her out of the room. R181 shared a room with another resident. The room was observed to have two chairs, one located next to each bed, two over bed tables, a fold up stool, and two walkers. The room had limited open space at the foot of the beds to walk with a clear pathway.

On 08/17/21 during an interview with PT1, reviewed the documentation of the PT session with R181 the previous day, which said "walked 56' (feet)." When asked PT1 about R181's therapy session, PT1 said "She (R181) is fresh (new admission) and COVID time, so give therapy in the room. I can do the same thing in the room." When asked how they walked 56' in the room, PT1 said; "We walked around the room in circles, able to test how well she maneuvered." PT1 said she considered R181 to be on quarantine because she was a new admission. PT1 said she was aware the facility did not have a yellow zone or quarantine for new admissions but said "Because I work so many places, gotta keep everything straight, so I practice same at every facility."

3) Cross Reference to F655.
The facility failed to develop a baseline care plan (CP) for R78 that ensured continuity of care. R78 had a right wrist splint on for a wrist fracture when she was admitted. The baseline care plan and initial orders did not include instructions or orders for the wrist splint.

4) Cross Reference to F656.
R78's comprehensive person-centered care plans (CP) failed to address all of her medical needs

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and did not include interventions, monitoring or application of the wrist splint.

On 08/10/21 at approximately 11:30 AM observed R78 in the dining area. The right wrist splint was a supportive short arm splint that stabilized her wrist. The splint was straight with the palm of her hand in contact with the splint and immobilized her wrist and knuckles.

On 08/13/21 at approximately 11:30 AM observed R78 in her room sitting in her wheelchair. The right wrist splint was observed to be in a different position than the day before. The splint was on the lateral side of R78's forearm and not positioned correctly. At that time interviewed RN5 who said he had not seen the splint himself so unsure what specific type it was. RN5 said the splint is taken off for bathing and then reapplied by the RNs. RN5 said R78 came with the splint and it was not one that their facility uses. RN said if the staff are not familiar with a splint, the PT department would educate them on it. RN and the DON accompanied surveyor to the room, observed R78's splint and agreed it was not positioned on her arm correctly.

On 08/17/21 at 11:45 AM during an interview with the DON, inquired how the staff check for skin integrity under the splint. The DON said the staff are suppose to do routine weekly skin checks. Concurrent record review (RR) revealed the staff did not routinely document assessment of skin integrity when the splint was removed. The DON also said the extremity should be checked and documented for circulation, skin color, and pulse every shift. The RR revealed CMS (circulation, motor, sensory) assessments were not documented every shift.

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F 684	Continued From page 58 RR of R78's nursing progress notes revealed the following : "07/30/21 at 22:59 ...C/o of right wrist pain with a rate of 3/10." There is no documentation about the splint or completion of a CMS assessment. "07/31/21 at 14:50 ... Right arm covered with ace wrap, swelling noted to hands, elevated this shift.." There was no documentation of CMS assessment and no documentation the extremity was monitored again until 08/01/21 at 21:38. "08/01/21 at 21:38 ... Right had [sic] splint in use to right hand with ace wrap, fingers with mild swelling, non-reddened, capillary refill within normal." There is no intervention documented to address the swelling. The next documentation of the right hand is 08/02/21 at 21:55 that noted ongoing mild swelling. There is no documentation of any intervention (i.e. elevation of extremity or check of the splint wrap). 5) Cross reference to F692. The facility failed to have a process in place to monitor and address R65's poor food and fluid intake. R65 had been assessed to be at risk of nutritional and hydration deficit and had goals established in the patient centered care plan. When intake goals were not being met the staff failed to address it in a timely manner and the physician was not notified to consider interventions to prevent complications	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 686		

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(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and
(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview with resident and staff member, the facility failed to provide care and services for one resident (Resident 380) to promote the prevention of pressure ulcer/injury. This deficient practice has the potential for Resident (R)380's pressure ulcer/injury to reoccur or development of new pressure ulcers/injuries.

Findings include:

R380 was admitted to the facility on 07/19/21. Diagnoses include gangrene, not elsewhere classified; acquired absence of left leg below knee; encounter for other orthopedic aftercare; end stage renal disease (on hemodialysis); peripheral vascular disease, unspecified, and Type 2 diabetic neuropathy, unspecified.

Interview with R380 on 08/10/21 at 01:24 PM, he reported that he has a "bed sore" on his butt which has healed. He states powder is applied; however, he has pain after sitting up for dialysis treatment. He receives hemodialysis treatment for 3-3/4 hours. Resident reported although he has pain, he is provided with medication. R380 observed with below knee amputation of the left

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leg.

Review of the physician orders notes prn (as needed) medications for pain and routine medication for neuropathic pain. There are no treatment orders for pressure injury.

A review of the progress notes on 08/12/21 at 12:57 PM documents R380 was admitted to the facility with a Stage 2 pressure injury to the coccyx. The subsequent progress notes for 08/09/21 documents the pressure injury as healed.

Review of R380's admission/comprehensive Minimum Data Set (MDS) with an assessment reference date of 07/23/21 notes he is independent in cognitive skills for daily decision making. Review of Section G. Functional Status documents R380 is coded to require extensive assist with one person physical assist for bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture), and transfer (how resident moves between surfaced including to or from: bed, chair, wheelchair standing position). In Section M. Skin Conditions, R380 noted with a Stage 2 pressure injury present on admission. He is coded to have pressure reducing device for chair, pressure reducing device for bed, and pressure ulcer/injury care.

Interview with the Assistant Director of Nursing (ADON) was done on 08/16/21 at 08:38 AM. Inquired whether R380's physician participates in the care plan meeting. ADON confirmed the physician does not participate in care plan meetings. The ADON reported the

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F 686	Continued From page 61 interdisciplinary team (IDT) reviews the wound consultant notes. The ADON acknowledges R380 had a pressure ulcer on admission and is at high risk for skin impairment. Further queried whether the IDT developed a plan of care to prevent pressure injury from reoccurring or to prevent new development of pressure injuries. The ADON reviewed R380's care plan and was unable to find a care plan for the prevention of pressure injuries.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure one resident (R)7 in the sample received the appropriate treatment, equipment, and services to increase or prevent further decrease in range of motion	F 688		

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(ROM) in her right hand. As a result of this deficient practice, R7 has experienced a decrease in function and mobility, and an increase in pain and numbness in the fingers of her right hand, resulting in an inability for R7 to reach her highest practicable well-being. This deficient practice has the potential to affect all the residents at the facility with ROM deficits.

Findings include:

R7 is a 64-year-old female admitted on 01/11/20 for long-term care with diagnoses that include traumatic cervical spinal cord injury with central cord compression and intractable neuropathic (nerve) pain. As a result of these diagnoses, R7 requires extensive assistance with her activities of daily living such as dressing, oral hygiene, and showering, and total assistance with transfers.

On 08/11/21 at 08:10 AM, an observation and concurrent interview was done with R7 in her room on the second floor. R7 was lying flat in bed with her hair uncombed, contractures noted to all the fingers of her right hand and the middle finger of her left. R7 stated she experiences pain in her hands and right shoulder every day and reported that she has not seen rehabilitation (rehab) staff or had anyone work with her hands or shoulder "for a long time." R7 stated she does have a splint for her right hand, but no one ever assists her to put it on, so she keeps it in the drawer of the nightstand by her bed. R7 further stated that she did not know why she was not receiving rehab services anymore but felt she really needed it. When questioned about how she used her hands, R7 stated that she cannot brush her teeth or her hair with either hand, but she can feed herself with her left hand using a

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special utensil. R7 explained that when she eats, her left hand "gets numb and sore", so she must take frequent breaks to rest her hand. R7 stated she feels her fingers and hands have become less functional and more painful and numb since she was admitted. She experiences more difficulty with eating and gripping the special utensils now.

On 08/16/21 at 10:30 AM, during a review of R7's hard chart, a Therapy Communication to Nursing form signed by three certified nurse aides (CNAs) on 07/16/21 was found. The form instructed nursing staff to "Please don R [right] resting splint during the day for 4-6 hours daily. Perform PROM [passive range of motion] to R hand prior to donning ..." An OT [occupational therapy] Initial Evaluation, dated and signed by OT1 on 06/30/21 was also reviewed, and revealed the following, "Patient referred to skilled OT due to new onset of deficits in R [right] hand ROM [range of motion] as well as L [left] hand numbness ..."

On 08/17/21 at 09:00 AM, during a review of R7's electronic health records (EHR), a progress note written by registered nurse (RN)7 on 07/16/21 at 05:05 PM revealed the following, "OT clarification order: D/C [discharge] from OT services on 7/16/21. Continue with RNA [restorative nurse aide] program and R. splint wear schedule daily for 4-6 hours as tolerated." A review of R7's comprehensive care plan noted that her contractures, right hand splint, and RNA program were not addressed or added. A review of R7's Point of Care History from 06/01/21 to 08/17/21 revealed the splint was applied once, and PROM was done twice, since the 07/16/21 order.

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F 688	Continued From page 64 On 08/17/21 at 11:24 AM, during an interview with the Assistant Director of Nursing (ADON) in the conference room, the ADON reported that there was no splint or RNA program refusal signed by R7 found in her chart, and acknowledged that the contractures, splint, and related interventions should have been added to R7's comprehensive care plan. The ADON also stated that she did not know why the recommended therapy plan was not being followed.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one resident (R)74 in the sample was free from accident hazards by not thoroughly investigating a fall the resident experienced to identify all contributing factors. As a result of this deficient practice, the resident was placed 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: R74 is an alert and oriented, cognitively intact, 78-year-old female, admitted on 07/23/21 for	F 689		

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short-term rehabilitation and strengthening following a cerebral infarction (stroke). R74's admitting diagnoses include disorientation, and adjustment disorder with mixed anxiety and depressed mood. On the morning of 08/10/21, R74 had an unwitnessed fall and sustained a hematoma to the back of her head. At the request of her family representative (FR), R74 was sent to the emergency room (ER) for evaluation.

On 08/10/21 at 01:59 PM, an interview and concurrent observation was done with R74 in her room on the second floor. R74 was anxious, restlessly fidgeting on her bed. R74 stated she "fell last night" when she went to the toilet, explaining that it was dark when she walked into the bathroom, as she tried to sit on the toilet, she could not because "something blocking it." When asked what was blocking it, R74 stated she did not know what it was called, then proceeded to describe the bedpan sprayer bar (a metal bar toilet attachment that can be folded down and has a spray nozzle at the end; when the toilet is flushed, the flush water is routed through the metal bar and used to wash bedpans and urinals). R74 stated she could not move the metal bar out of the way, so she walked out to the hall to find someone to help her. When she did not see anyone, she tried to sit on a chair because her legs were tired. R74 stated she could feel the chair behind her legs as she began sitting but the chair was not placed as well as she thought, so she fell back and hit her head. An inspection was done of the toilet to confirm what R74 had described. The bedpan sprayer bar was folded in the up position, out of the way. When the bedpan sprayer bar was placed in the down position, it completely blocked access to sit on

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the toilet. Surveyor noted that the bedpan sprayer bar was very difficult to fold up and down, requiring a moderate amount of strength and effort to do so. R74 stated she told the Social Services Designee (SSD) about the metal bar when she came back from the hospital, and he told her he did not know what she was talking about.

On 08/13/21 at 10:44 AM, an interview was done with R74 in her room on the second floor. R74 was very frustrated and anxious, near tears. Stated she tried to go to the bathroom again yesterday, and the metal bar [bedpan sprayer bar] was down and in the way again, preventing her from being able to sit on the toilet. R74 explained how frustrated she was with staff and expressed how she felt no one was listening to her, stating that sometimes she feels "like staff are messing with me."

On 08/17/21 at 07:25 PM, a review of the Resident Fall Incident Charting, dated 08/10/21 02:30 AM, was done. The Registered Nurse (RN) on duty at the time, RN8, documented that R74 stated "she was just tired staying in bed and got out from the room. Walked outside the room and sat on the computer chair with wheels ...the computer chair wheeled and she fell down ..." As a result, all interventions related to the fall focused on removing wheeled chairs from the hall. A review of the Fall Interview Record, dated 08/10/21, noted that it was completed by the same RN that filled out the fall incident report, however the Fall Interview Record form directs the user that it is "To be conducted by QA [quality assurance] nurse or DON [Director of Nursing] after the incident with involved/assigned staff." RN8 is neither the QA nurse nor the DON. During

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F 689	Continued From page 67 a review of R74's electronic health record (EHR), no other documentation was found of R74 walking out into the hall in the middle of the night because she was tired of staying in bed, and no documentation was found of the QA nurse or DON following up with R74 regarding the fall.	F 689		
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 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	F 690		

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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 observation, record review, and interview with resident and staff members, the facility did not assure a resident with a foley catheter received the care and services to prevent and address tear/laceration to the resident's penis. In addition, the facility failed to implement specific interventions as ordered and as directed in the plan of care to treat one resident's (R)18's constipation. Resident (R)2 was admitted with an indwelling foley catheter and has recurring penile tear/laceration. The facility failed to ensure acquisition of urologist consult to assess and recommend treatment for the continued use of the indwelling foley catheter and injury. Based on an assessment identifying factors contributing to the injury, the facility did not revise R2's care plan to prevent further injury. R18 did not have a bowel movement for five days. When interventions were initiated, the order was not followed as written. As a result of this deficiency, there is the potential R18 may have experienced prolonged constipation which had the potential for discomfort and pain. This deficient practice could affect other residents who have urinary catheters for extended periods of time, or who have orders to treat constipation, and could affect their quality of life.

Findings include:

1) Cross Reference to F657: Care Plan Revision.

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On 08/10/21 at 09:42 AM, Resident (R)2 was interviewed, R2 reported that he has an indwelling foley catheter and has some tearing. Inquired whether he has pain associated with the tear, R2 responded he is a paraplegic and does not have pain. R2 expressed he believes he was admitted with penile tear.

Record review notes R2 was admitted to the facility on 03/22/21. Admission diagnoses includes but not limited to unspecified injury at C7 level of cervical spinal cord, paraplegia, neuromuscular dysfunction of bladder, and pressure ulcer of sacral region (Stage 4).

A review of the physician's admission medication and treatment order does not have documentation that R2 had penile tear upon admission. A review of the Interdisciplinary Care Conference Summary and Resident Status Update dated 03/31/21 does not document penile tear.

The current physician order for R2 includes catheter care every shift, change foley cath once a day on the 2nd of the month, and cleanse penile tear with normal saline, pat dry, and cover with dry dressing twice daily until wound doctor sees resident - twice a day (start date 8/7/21).

A review of the progress notes, documents on 08/07/21 a Certified Nurse Aide (CNA) reported to the nurse a penile tear.

Further review found progress reports from the wound care consultant. Examination notes of 05/31/21 notes laceration to inferior aspect of penis from foley with green discharge. Subsequent note of 05/31/21 documents R2 on

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doxycycline for penis tear infection. The laceration is documented as healed on 06/07/21 with continued antibiotic for penis tear infection. The consultant's note for 07/05/21 documents, R2 was last seen by the urologist on 04/12/21 with a follow up for 05/17/21 which was canceled by the physician.

On 08/09/21, the wound consultant requested a urology referral for evaluation and treatment of chronic indwelling foley cath and urethral tearing.

Review of the urologist report dated 04/12/21 for consult related to wound care post op muscle flap (unclear of location of muscle flap procedure), the urologist notes possible mechanical pressure ulcer to penis at entrance of foley with recommendation to apply silver alginate every other day. The urologist reinforced offloading. No documentation R2 was seen by a urologist after the cancellation to his follow up scheduled on 05/17/21.

R2's care plans in the old and new electronic health record were reviewed. The care plan with onset of 03/23/21 has the goal for the resident to be free from signs and symptoms of catheter associated urinary tract infections. Approaches include assist with foley care at least once/shift and monitor for signs and symptoms of urinary tract infection. The care plan from the new electronic with a start date of 06/15/21 does not have a plan of care related to indwelling foley catheter. There are no episodic interventions or care plan update to prevent further tearing or injury.

Interview was done with registered nurse (RN)20 on 08/17/21 at 10:10 AM. Inquired what

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happened to cause the penile tear. RN20 stated R2 had a penile tear on 06/11/21 with infection but recalls R2 already had the tear on admission. RN20 found documentation R2 was awaiting appointment with urologist on 06/14/21; however, could not find documentation of the consultation. RN20 could not ascertain what happened to the resident's appointment. RN20 reported on 08/12/21, the facility has made a referral to the urologist.

On 08/17/21 at 10:37 AM, the nurse surveyor made observation of catheter care with RN2. The surveyor observed the anchor for the catheter was not clipped resulting in tugging during care. R2 reported he was admitted with a penile tear which never healed up. The nurse surveyor described the injury as possibly having been pressure related with the location of the wound and urethral opening as underneath the penile head, and the shape of the wound mimicing the shape of the catheter the penis rested on.

2) R18 was admitted to the facility on 01/14/19 and had a medical history of transient ischemic attack and cerebral infarction without residual deficits. She has dementia with behavioral disturbance and abnormalities of gait and mobility. She requires extensive assistance with her ADL's (activities of daily living). R18's bowel and bladder activity were monitored and recorded daily.

On 08/17/21 a record review (RR) was conducted which revealed R18 did not have a bowel movement (BM) documented for four days, August 7 through August 10, 2021.

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F 690	Continued From page 72 On 08/17/21 at 01:30 PM during an interview with the Assistant Director of Nursing (ADON), she said the "bowel protocol" should have been implemented when R18 did not have a BM on day three (08/09/21). The ADON provided a document titled "Suggested Standing Order: Ancillary treatments" which included "Bowel Protocol." The bowel protocol read: "-Colace 100 mg (milligram), 1 cap (capsule) daily @ 3-11 shift" "-Polyethylene glycol (Miralax} 3350 powder mix 17 gm (grams) in 8 oz (ounces) water and take by mouth once daily on 3-11 shift if no bowel movement on the 3rd & 4th day." "-If Miralax ineffective, give Dulcolax supp (suppository); PRN (as needed) rectally @ 7-3 shift" "-If Dulcolax supp ineffective, give fleet enema PRN @ 7-3 shift." Concurrent RR was conducted and the ADON said "The bowel protocol was not followed correctly." The ADON went on to say R18 "continued to receive the daily dose of Colace but did not receive the Miralax on day three (08/09/21) or day four (08/10/21). The Miralax was skipped in the protocol and she (R18) was just given the Dulcolax suppository on day five (08/11/21)." On 08/17/2021 RR reviewed the physician orders for constipation which matched the bowel protocol. When R18 had constipation, the staff did not correctly follow the physician orders.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration.	F 692		

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(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 (RR), the facility failed to provide care and services to prevent significant weight loss and/or dehydration for 2 of 22 residents (Residents 65 and 230) in the sample, despite identifying them as at risk for compromised nutrition and hydration. In addition, the facility lacked a systematic approach to monitor and address one residents (R)65 poor food and fluid intake. When intake goals were not met and persisted for several meals/days, the facility failed to address it in a timely manner. As a result of these deficient practices, the facility placed these residents at risk for avoidable declines and injuries. These deficient practices have the potential to affect all residents at the facility.

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Findings include:

1) Resident (R)230 is a 59-year-old female admitted on 08/05/21 for Hospice care due to liver disease, with additional diagnoses that include chronic kidney disease, and severe protein-calorie malnutrition (PCM), with a history of weight loss. Admitting weight documented on 08/05/21 was 49.1 lbs. [pounds], with an admitting diet of regular, moist minced solids, with thin liquids.

On 08/10/21 at 08:48 AM, an observation was done of R230 in her room on the second floor. R230 was alert and friendly, waved hello, communicated through hand signals, very thin in appearance, wearing a standard adult facility-issued gown that hung on her, revealing her clavicle, sternum, and arm bones prominently sticking out.

On 08/11/21 at 03:32 PM, during a review of R230's electronic health records (EHR), it was noted that R230 had a second measured weight on 08/08/21 of 47 lbs., reflecting a weight loss of 2.1 lbs. or 4.3% in 3 days. Further review noted no notification to the doctor or dietary of weight loss, no dietary supplements or dietary consult had been ordered, no weights taken since 08/08/21, and there was no dietary evaluation documented.

On 08/13/21 at 12:46 PM, during additional review of R230's EHR, it was noted that a dietary evaluation had been documented on 08/12/21 by the registered dietician (RD). The RD's Nutrition Admission Assessment of 08/12/21 at 12:23 PM stated, "Resident ...Wt. [weight] 47# [lbs.] is below IBW [ideal body weight of] (82-112#), BMI

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[body mass index] 10.9 is reflective of severe PCM ...will proceed with care plan." A review of R230's care plan for nutrition, updated by the RD on 08/12/21, revealed that although the RD recognized R230 with a "Problem [of] ...anticipated for fluid and nutritional deficit/decline ...underwt [sic] ...severe PCM ...", no additions/changes in diet, more frequent monitoring, or other interventions addressing the identified needs, had been recommended/ordered. The planned interventions included "Monitor wt [weight] monthly," and "Provide diet as ordered: Regular diet, moist minced solids, thin liquids."

On 08/16/21 at 11:06 AM, a phone interview was done with the RD regarding R230. The RD stated she did not physically see R230 on 08/12/21 as part of her Nutrition Admission Assessment but based her assessment and recommendations off a record review. The RD further stated that although she did not document on it, she did recognize that R230 had a 4.3% weight loss in 3 days but "did not treat it aggressively because she [R230] is on hospice," and she "wasn't sure if there was something wrong with the scale." When questioned if she had followed up on R230's weight to see if there was something wrong with the scale, the RD replied "no" and stated that she was "satisfied" to continue without additional intervention and to re-check R230's weight in a month.

2) R65 was admitted to the facility for long term care 06/25/21. Her pertinent medical history (Hx) included malignant neoplasm of the colon, weakness, major depressive disorder, paranoid

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schizophrenia, hypertension, anemia, and Hx of a stroke. R65 has ongoing episodes of nausea and vomiting. Early in her admission (06/30/21-07/06/21) R65 was given parental intravenous fluids (IV) for hydration.

Record review (RR) on 08/13/21 revealed R65's medical record did not include an advance directive. A POLST (physician orders for life support treatment) was in the chart with the date prepared of 07/28/21, but was not signed by the physician or resident representative. The POLST was checked to direct full treatment which included long-term artificial nutrition by tube (medical treatments that are provided through routes other than the usual oral route, typically by placing a tube directly into the stomach, the intestine or a vein).

The order written on 07/02/21 by the admitting physician (MD)1 was "Resident POLST status=FULL CODE (Full resuscitation)."

The interdisciplinary Care Conference Summary and Resident Status Update dated 07/02/21 read: "POLST was completed by daughter (primary) with assistance from Case Manager and; prefers to keep oxygen, feeding tube, ..."

On 08/11/21 observed R65 during lunch. Her food intake was very poor and less than 25% of the meal. Her fluid intake was also noted to be poor. When the Certified Nursing Assistant (CNA) came to pick up R65's tray, she asked if wanted any more and R65 shook her head no. There was no assistance offered throughout the meal or encouragement when the tray was picked up.

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On 08/12/21 observed R65 at lunch. She sat up a few minutes after being set up to eat by the CNA and then shortly after laid down. There were no observations through out meal time of staff entering the room to assist or encourage R65 to eat or drink. R65 did not eat her lunch meal.

On 8/13/20 at 11:45 AM R65 was observed to have dry cracked lips.

RR of R65's care plan (CP) was completed on 08/13/21. R65's CP identified her to be at risk for fluid and nutritional deficit d/t (due to) poor intake possibly d/t somnolence, DMII (Diabetes type 2), possible chewing deficit, increased calorie and protein need for healing, underwt (under weight)/severe PCM (Protein Caloric Malnutrition, a state of inadequate intake of food). The nutritional goals for R65 included to have gradual weight gain, achieve and maintain skin integrity and not to have symptoms of dehydration. The approaches included; "Encourage, cue assist or feed as needed to complete at least 50% of meals, at least 300 ml fluid per meal and at least 120 ml fluid between meals, Fluid goal ~1310 ml (milliliters)/day (day)..." and to monitor for signs/symptoms of dehydration."

RR of Vitals report documented the follow intake (CP goals were ~1310 ml)/d fluids and 50% intake of meals.
07/30/21 360 ml fluids, Breakfast (Bkf) 1-25%, Lunch none, Dinner refused
07/31/21 240 ml fluids, Bkf none, Lunch 1-25%, Dinner 1-25%, snack 26-50%
08/01/21 480 ml fluids, Bkf 1-25%, Lunch refused, Dinner refused
08/02/21 480 ml fluids, Bkf none, Lunch 1-25%, Dinner refused, snack 26-50%

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F 692	Continued From page 78 08/03/21 660 ml fluids, Bkf none, Lunch 1-25%, Dinner refused 08/04/21 380 ml fluids, Bkf none, Lunch refused, Dinner refused 08/05/21 520 ml fluids, Bkf refused, Lunch refused, Dinner documented twice, 1-25% and 51-75% 08/06/21 610 ml fluids, Bkf refused, Lunch refused, Dinner 51-75% 08/07/21 180 ml fluids, Bkf none, Lunch refused, Dinner 1-25% 08/08/21 270 ml fluids, Bkf none, Lunch none, Dinner 1-25% 08/09/21 360 ml fluids, Bkf 1-25%, Lunch none, Dinner refused 08/10/21 360 ml fluids, Bkf none, Lunch none, Dinner refused 08/11/21 360 ml fluids, Bkf none, Lunch 1-25%, Dinner refused 08/12/21 600 ml fluids, Bkf refused, Lunch refused, Dinner none 08/13/21 170 ml fluids, Bkf none, Lunch none, Dinner refused 08/14/21 120 ml fluids, Bkf refused, Lunch refused, Dinner none R65 was not meeting the established CP nutritional goals. On 08/13/21 at 10:55 AM during an interview with the Registered Dietician (RD), discussed R65's nutritional status. The RD said R65 had been stable a couple of weeks and then started with nausea and vomiting again. The RD went on to say when she did R65's admission, she completed the form (Malnutrition & Morbid Obesity Diagnosis Tool) for MD1 to sign and add PCM to R65's diagnosis. The diagnosis PCM was not added to R65's diagnosis and the form was not in the medical record. The RD said she	F 692		

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had "left R65's daughter messages twice before about artificial nutrition and again yesterday but she has not responded." The RD said she had not spoken to MD1 about R65's status. The RD explained she was a consultant to the facility and does not attend care conferences. She went on to say she reviews nutritional status of residents with the Food Services Manager (FSM) who discusses dietary status and resident needs at the care planning meetings.

On 08/16/21 reviewed the facility policy titled, "Hydration Management" revised date 10/10/17. The policy statement read; "The facility shall provide ongoing hydration regimen to assure that each resident achieves a minimum daily fluid intake of at least 1000 cc. (ml)." The policy included the following procedures:
"5. Residents who do not drink an average of 1000 cc/day will be placed on a weekly Hydration List and reviewed by the Nurse Manager or RN and/or dietitian."
"6. The Hydration List will be available at the nurse's station and residents on the Hydration List will be identified on the CNA communication book. All staff will make an effort to increase fluid intake of these residents."
"7. Resident's care plan will be updated to reflect the need for increased hydration with appropriate interventions identified and indicated."

On 08/16/21 at 10:15 AM during an interview with RN6 in the second floor nursing station, she said they do not have a hydration list of residents who need additional monitoring and encouragement to drink fluids.

On 08/16/21 reviewed the CNA communication book located in the second floor nursing station.

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The communication book did not include a list or any references to specific residents who were high nutritional risk or those that needed additional encouragement to eat or drink fluids.

On 08/16/21 at approximately 10:00 AM during an interview with the FSM, she said a hydration list was in her office, but it had not been kept up to date. When inquired if she monitored daily intake of residents identified at risk for nutritional deficits, the FSM said she does not do it daily, but checks the it prior to the care planning meetings.

RR of nursing progress notes included the following notes regarding R65's intake:
08/03/21 at 21:30; "...poor intake persists..."
08/05/21 at 22:16; "Resident with poor appetite, refused her Ensure clear and 2 Cal HN (supplement)at med pass..."
08/07/21 at 15:01; Resident has poor appetite, continue to refuse her ensure clear and 2 Cal HN at med pass despite of encouragement."
08/12/21 at 13:10 documented by RD; "Nutrition F/U: PO intake continues to be poor likely ongoing N (nausea)/V (vomiting) and receiving prn (as needed) meds. Wt 84.2# is below IBW (ideal body weight [100-137#). Resident is cachetic (physical wasting with loss of weight and muscle mass due to disease), poor intake, wt loss, underwt and severe PCM. Resident has been refusing nutritional supplements... POLST has not been signed or returned yet per staff..."
08/13/21 at 14:26; "Reviewed P.O intake and noted she consumed meals ranges from 1-25% and she also refused twocal [sic] supplement every med pass and ensure supplement at times. ...Attempted to update MD but unsuccessful, will call again."
08/13/21 at 14:56; "...Refused both meals and

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her supplements. Attempted to assist her but won't open her mouth despite encouragement. ..."
08/13/21 at 15:15; "Called MD and ordered : D5 1/2 NS (IV) via peripheral line at 40cc/hr x 3L.
There was no documentation or indication that anyone was reviewing or monitoring the daily PO intake prior to the entry in the progress note on 08/13/21, yet the pattern was documented in the vitals report much earlier and not addressed.
08/13/2 at 17:42; "Nursing management decided the resident has a significant change AEB (as evidenced by) decline in MDS physical functioning, requiring increased assistance in eating (from set up to staff having to assist, although, reportedly she may refuse). She has been having poor PO intake. ..."

RR of R65's physician (MD)1 notes and orders revealed and included the following:
06/30/21-07/06/21 D2.5%-.45% sodium chloride parental solution; intravenous three times a day for "Dx (diagnosis) Hydration."
07/02/21"Patient has been doing well. ... Supportive care..."
07/06/21"Required ivf (Intravenous fluids) recently... Assessment and Plan: Hypovolemia (Decrease in blood volume), Monitor..."
07/09/21"Patient has been doing well..."
07/13/21 "Poor po lately...Assessment and plan: Malnutrition. Followed by dietary services. On supplements."
07/20/21 "Patient has been doing well..."
07/23/21 "Patient has been doing well..."
08/03/21 "Patient has been doing well. ...Assessment and plan: colon cancer, Supportive care..."
08/06/21 "Has had decline in condition. ...Discussed with oncologist . Palliative care..."
There was no documentation what specifically

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F 692	Continued From page 82 changed in R65's condition and there were no new orders. 08/10/21"Patient has been doing well..." The assessment and plan included "palliative care." 08/13/21 MD1 called and ordered D5 1/2 NS via peripheral line at 40 cc/hr x 3L On 08/16/21 at 10:36 AM during an interview with the ADON, when inquired what the expectation would be if a resident was not meeting their goals for intake as identified in the CP, she said the physician should be notified after "two to three days." On 08/17/21 at 11:45 AM during an interview with MD1, he said he had not seen the form completed by the RD to add a diagnosis of PCM and had not been contacted about any specifics of R65's fluid and food intake. He also was unaware there was not a signed POLST in the medical record or that the daughter wanted full treatment and artificial nutrition.	F 692		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview with resident and staff members, the facility failed to ensure one resident received dialysis consistent with professional standards, as evidenced by inconsistent communication with the dialysis	F 698		

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facility. The facility failed to ensure pre-dialysis assessments were completed for 2 of 11 treatments to assure resident's physical status was assessed prior to sending him for hemodialysis.

Findings include:

Resident (R)380 was admitted to the facility on 07/19/21 with diagnoses of end stage renal disease, Type 2 diabetes with diabetic neuropathy, chronic diastolic (congestive) heart failure, and left below knee amputation.

R380 was interviewed on 08/10/21 at 01:14 PM. R380 reported he goes to a dialysis facility for hemodialysis three times a week for 3-3/4 hours. Inquired whether the facility nurse checks him upon his return to the facility. R380 reported the nurse does not check him upon return.

A record review found care plan documenting R380 goes out for hemodialysis treatments on Tuesdays, Thursdays, and Saturdays. The interventions include assess for fluid excess, monitor and record intake of food and fluids, monitor weight daily, and restrict intake of fluids to 1500 cc/day.

Further review found progress notes of post dialysis assessments by the facility's nurse. A review of the pre-dialysis assessments prepared by the facility nursing staff were reviewed. The pre-dialysis assessments were not completed for 08/03/21 and 08/05/21. The pre-dialysis vitals section was not completed. The pre-dialysis vitals include most recent weight and scale, most recent temperature and route, most recent pulse and pulse type, most recent respiration

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F 698	Continued From page 84 (breaths/min) and most recent blood pressure (mmHg) and position. On 08/16/21 at 08:31 AM, Registered Nurse (RN)6 was interviewed. RN6 confirmed there is missing documentation for pre-dialysis treatment for 08/03/21 and 08/05/21. RN6 stated nurses should be assessing the resident before leaving the facility for dialysis. And reported this information is important for communicating the resident's status prior to dialyzing.	F 698		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under	F 725		

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paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to ensure there was sufficient nursing staff to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, in addition to their physical, mental, and psychosocial well-being. As a result of this deficient practice, the residents experienced a decreased quality of life and were unable to attain their highest practicable well-being. Insufficient staff can affect all residents and their quality of life.

Findings include:

1) Cross-reference to findings from F677 ADL Care. The facility failed to provide sufficient staffing to meet the hygiene, grooming, and transfer requests of resident (R)7. With two certified nurse aides (CNAs) staffed on each unit, staff arriving late for shift, or staff with pain or injuries, prevented R7 from receiving the care and services she needed, and led to staff denying her requests for care.

On 08/10/21 at 08:28 AM, an interview was done with registered nurse (RN)6 at the second-floor nurses' station. The staffing board at the nurses' station indicated a census of 73, with 2 RNs, and 7 CNAs. RN6 explained that the staffing levels were split between the first and second floor, so 1 RN on each floor, and usually 2 CNAs on the first and 6 CNAs on the second (2 CNAs for each of the three units). RN6 stated they were short one

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CNA that day, and when asked about usual staffing, stated they were "short CNAs at times."
2) On 08/10/21 at 11:15 AM observed R18 sitting in a wheelchair (w/c) in the hall on the second floor with several other residents. Her lunch tray was placed in front of her, and she was set up with utensils to eat. R18 was then left to feed herself independently with no assistance offered during the next hour. R18 was observed to eat her ice cream and attempted a couple of times to take a bite of entrée but had difficulty moving the fork to her mouth. When the tray was removed, nothing else had been touched. R18's intake for this meal was very poor. All staff were observed to be busy, with no one monitoring R18's intake or ability to feed herself independently.

On 08/10/21 at 02:26 PM, an interview was done with RN6 at the second-floor nurses' station. When asked how many residents on the second floor required feeding assistance, RN6 answered that of the 62 residents on the second floor, there were 8 that needed feeding assistance (3 on the unit where meal service had just been observed). Surveyor questioned how 8 residents are assisted with eating at every meal when the second floor is staffed with 6 CNAs at the most. RN6 stated "usually supervisors help with feeding, or activities staff can help feed." When questioned if all staff had received training on how to assist with feeding, RN6 stated that activities staff feed residents under licensed staff supervision only. When questioned how licensed staff could be supervising when they are kept busy passing trays, fluids, and assisting other residents, RN6 stated "I misspoke, activities help by passing trays."

On 08/11/21 observed R18 at 12:00 PM sitting in

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a w/c in the hall on the second floor with several other residents. She again had her lunch meal tray set up for her and was not assisted, cued, or encouraged by the staff to eat. When her tray was removed, her total intake was only a few bites.

On 08/11/21 at approximately 01:00 PM during an interview with the second floor Change Nurse, she said they were short a Certified Nursing Assistant (CNA) today.

On 08/11/21 reviewed R18's care plan which revealed R18 was at risk for fluid and nutritional deficit. Staff were directed to "Encourage, cue, assist or feed as needed to complete at least 50% of meals, at least 300 ml (milliliters) fluid per meal and at leaset 120 mL between meals. ..." In addition, R18's CP revealed she has some visual impairment and to monitor for change in vision, or "seeing food when eating..."

On 08/12/21 at 11:20 AM observed a CNA sit next to R18 to assist with her meal. When the CNA attempted to give R18 some food, R18 pushed her hand away. An RN then approached the CNA and told her she was needed to assist somewhere else and the CNA left. No one replaced the CNA or assisted R18 for that meal.

On 08/13/21 observed CNA7 sitting next to R18 in the hall feeding her lunch. Observed R18 pinch CNA7 multiple times throughout the mealtime, but CNA7 managed her behavior and continued to feed her. CNA7 took approximately 40 minutes to assist R18. When R18 had finished, she had good intake and consumed over 75% of her meal.

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F 725	Continued From page 88 3) On 08/10/21 observed R65 during lunch. A CNA assisted R65 to sit on the side of the bed and set up the meal tray and left. R65 was observed to lift the glass and drink some liquid. Less than 10 minutes later observed R65 laying down in bed and she had not touched the her meal tray. Observed the CNA enter the room, ask R65 if she was done with her lunch or wanted anymore and she shook her head no. The CNA did not encourage or offer assistance to R65 at that time, and no one during the hour entered the room to monitor or assist her with eating. On 08/11/21 at 11:30 AM observed a CNA assist R65 to sit on the side of the bed, set up the meal tray and leave. At 11:50 AM R65 was observed to be laying down in bed. Her intake was poor with only a few bites. The tray was later removed without any assistance or encouragement for R65 to eat. On 08/11/21 reviewed R65's care plan which revealed R18 was at risk for fluid and nutritional deficit. Staff were directed to "Encourage, cue, assist or feed as needed to complete at least 50% of meals, at least 300 ml fluid per meal and at leaset 120 mL between meals. ..." Review of the facility policy titled "Nursing Services" revised date 01/05/18 revealed the policy statement was " ...shall have qualified competent and sufficient nursing staff to meet the acuity levels of the residents and in accordance with applicable federal and state regulations." The policy directs staff to "provide assistance as needed" for meal setup/feeding, and to "Report poor food and fluid intake."	F 725		
F 726 SS=D	Competent Nursing Staff	F 726		

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F 726	Continued From page 89 CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review (RR), one Certified Nurse Assistant (CNA) failed to demonstrate competency to accurately measure and record one residents (R)18 meal intake. Specifically, on 08/10/21 and 08/11/21	F 726		

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R18's intake was observed to be very poor (less than 25%). CNA2 inaccurately documented the intake to be much greater on both days. As a result of this deficiency, R18's trend of poor intake may not be identified and puts her at increased risk of weight loss and associated complications. This deficient practice has the potential to affect all residents identified for nutritional risk and prevent them from obtaining their highest practicable physical well-being.

Findings include:

1) On 08/16/21 RR of R18's Vitals Report revealed the following :
08/10/21 at 01:08 PM CNA2 documented R18 ate 26-50% of her lunch. Surveyor observed R18 to eat only a few bites of her meal and using the facility reference to measure intake should have been documented as intake less than 25%.

On 08/11/21 at 01:07 PM CNA2 documented R18 ate 51-75% at lunch. Surveyor observed R18 to eat very poorly and only a small amount. This entry should have been less than 25%.

On 08/16/21 Reviewed CNA2's competency evaluation which documented she had been evaluated to be competent on 06/29/21 in "Feeding residents who are unable to feed self...Feeding residents with swallowing problems."

On 08/17/21 the Assistant Director of Nursing (ADON) provided the education material used in the CNA orientation to determine meal intake. The document titled "Dietary Intake Guide" had five categories to record intake, "Refused-0% refused meal completely, or consumed only one

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F 726	Continued From page 91 or two bites of each item; Poor-25% Approximately 25% of entrée, or 50% of one item consumed; Fair-50% Approximately half of food consumed (i.e., 50% of entrée, 25% of vegetable and soup left); Good-75% Majority of the meal is consumed, but a significant amount of one or more items is left ....); All-100% Entire meal is consumed except for a minimal amount of food ..." The guide included some "Common Errors Made Estimating Dietary Intake." 2) Review of the facility policy titled "Nursing Services" revised date 01/05/18 revealed the policy statement was " ...shall have qualified competent and sufficient nursing staff to meet the acuity levels of the residents and in accordance with applicable federal and state regulations." The policy directs staff to "provide assistance as needed" for meal setup /feeding, and to "Report poor food and fluid intake." 3) Cross reference FTag 684 When R78 was admitted to the facility she had a right wrist splint on for a fracture. There was no physician order for the splint, the Care Plan did not include the wrist splint and the staff did not document skin assessments as ordered, or assessment of circulation, motor, and sensory which is the standard of nursing care. In addition, the splint was observed to be in the wrong position on 08/17/21 and there was lack of documentation of intervention and monitoring shift to shift when edema of the fingers was documented.	F 726		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is	F 744		

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F 744	Continued From page 92	F 744		

diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview with staff members, the facility did not assure a resident who is diagnosed with dementia with behavioral disturbance receives care to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Resident (R)24 was observed with behaviors of yelling, clapping, and pounding the table, the facility failed to assess possible underlying causes to develop a person-centered plan of care to address these behaviors.

R24's behavior has the potential to impact other resident's psychosocial well-being and may result in resident-to-resident altercation (R24's roommate is independently ambulatory). R24's behavior may also be potentially distressing for the residents residing on the unit.

Findings include:

Cross Reference to F657: Comprehensive Care Plan Revision.

Resident (R)24 was admitted to the facility on 05/17/19. Diagnoses include dementia with Lewy bodies and dementia in other diseases classified elsewhere with behavioral disturbance.

On 08/10/21 during the initial tour of the facility, observed Resident (R)24 sitting up in bed, dressed in T-shirt and personal brief yelling and clapping his hands. At 09:59 AM, R24 sat quietly

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in bed. Second observation on 08/11/21 at 09:22 AM, R24 was sitting up in bed speaking in a loud voice with military cadence (speech unintelligible) and rhythmically slapping his hands on his overbed tray. R24's roommate (R48) was sitting up in bed. R48 was asked whether the yelling, clapping, and banging bothers him, he stated no. On 08/12/21 at 09:08 AM, R24 was sitting up in bed, speaking loudly, saying "get me out of here". Registered Nurse (RN)2 was observed outside of the resident's room at the medication cart. RN2 did not address the resident's behavior and continued to prepare and administer medications for the other residents on the unit. R24's room is at the end of the unit and could be heard at the nurses' station yelling and clapping his hands. At 09:28 AM (20 minutes later), R24 continued to repetitively yell, "left...left..." and "get me out of here". Clapping of hands was also heard at the nurses' station.

On 08/12/21 at 09:14 AM, Certified Nurse Aide (CNA)8 was asked what staff does when R24 exhibits yelling, clapping, and pounding overbed tray. CNA8 responded, they will tell the nurse. On 08/12/21 at 09:36 AM, RN2 was asked what staff does when R24 exhibits behavior. RN2 responded that she tries to talk to him, he becomes quiet but will start again. She also reported staff try to distract him, inquired how, she replied R24 does not like to attend activities. They will close his privacy curtain; however, he will open it again. RN2 reported R24 receives Seroquel (antipsychotic to treat schizophrenia, bipolar disorder, and depression), prazosin and an antidepressant (could not recall which antidepressant). RN2 further reported R24 has favorite staff members and they will go to try to calm him. RN2 noted R24 was not yelling

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yesterday and there are days when he does not yell.

Review of the physician's orders notes R24 is prescribed citalopram (antidepressant), 20 mg for dementia with behavior disturbance and Seroquel, 25 mg, 1/2 tablet twice a day for diagnosis of dementia with psychosis. Further review found a psychiatric consult dated 08/09/21. The psychiatrist notes R24 has prior history of traumatic brain injury with episodic agitation and confusion. The recommendation was to continue with citalopram, increase in prazosin to 2 mg every morning and 2 mg every evening, and continue with Seroquel 12.5 mg twice a day.

R24's comprehensive Minimum Data Set (MDS) with assessment reference date of 01/27/21 notes resident has trouble falling or staying asleep or sleeping too much during the assessment period (seven to eleven days). R24 was also coded with physical behavioral symptoms directed to others which occurred one to three days during the assessment period. These behaviors were noted to put the resident at risk for physical illness or injury, significantly interferes with care, and significantly interferes with participation in activities. Also, behaviors were noted to put others at risk, intrude on the privacy or activity of others, and significantly disrupt care or living environment.

Concurrent review and interview were done with the Minimum Data Set Coordinator (MDSC) on 08/17/21 at 08:55 AM. The facility developed a care plan for behavioral symptoms, psychotropic drug use and psycho-social well-being. R24 was noted to have episodes of behavior or mood

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outbursts. The identified behaviors include refusal of care, combative with staff (kicking and yelling), agitation, anger, restlessness, and slapping.

Interventions included greeting him by name, explain care that will be given (use written communication if needed), encourage resident to verbalize needs and concerns and find solution to meet his needs and concerns, staff to be sensitive to needs and respond promptly, monitor for possible mood and behavior outbursts (keeping distance and two or more staff when R24 becomes violent), inform physician and psychiatrist of any outbursts, continue psychotropic drugs, and monitor for signs and symptoms of adverse reaction.

MDSC reported staff will try activities with R24, inquired what activities should be presented. MDSC responded before R24 would scream because he was hungry so they would provide food. She also noted R24's yelling is random and there are times that the more you try to interact with him, the more agitated he becomes which may lead to hitting. Inquired what interventions have been identified to respond to R24 when he becomes "more agitated". MDSC acknowledged person-centered interventions to address R24's "outbursts" have not been identified. Further queried whether a root cause analysis of R24's behavioral outbursts was done. MDSC replied no.

On 08/17/21 at 09:15 AM, interviewed RN2 to inquire whether the facility provided in-service training related to providing care for residents with dementia. RN2 responded that she was not provided with training. Interview with RN6

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F 744	Continued From page 96 regarding training. RN6 reported they received in-service on how to deal with behaviors. For example, orienting the resident, talking to the resident, and asking what's happening. In response to R24's behaviors, RN6 shared R24 likes her so that she will go to him and ask if he's okay. RN6 also reported oftentimes they will use staff members (prefers male nurses) that R24 likes to provide care. RN6 stated there is no pattern to R24's behavior so they check if he is "wet and hungry" and although they change him or provide snacks, he may still have outbursts.	F 744		
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		

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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 observation, record review and interview with staff members, the facility failed to ensure each resident's drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being for 3 of 5 residents (Residents 59, 35 and 4) receiving antidepressant for unnecessary medication review. The facility reports there are 30 residents in the facility receiving antidepressant medications. This deficient practice has the potential to result in the unnecessary use of an antidepressant as evidenced by lack of gradual dose reduction,

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indications for use and not accurately monitored for residents' behavioral expression of depression.

Findings include:

1) Cross Reference to F656: Comprehensive Care Plan.

Resident (R)59 was admitted to the facility on 03/25/15. Diagnoses include unspecified dementia without behavioral disturbance, history of falling, and abnormal weight loss.

Review of the current physician order noted R59 is prescribed trazodone (antidepressant), 50 mg, one tablet at bedtime for diagnosis of dementia with behavior, start date of 03/10/21. The physician also ordered to monitor for adverse reaction (sedation, dizziness, headache, nausea, dry mouth, and fatigue), episodes of combativeness, refusal of care, medication and nourishment, and negative life statements.

Review of the Medication Administration Record (MAR) notes documentation of administration of trazodone and monitoring for adverse reactions. There was no documentation of monitoring for the behaviors identified in the physician's order.

R59's quarterly Minimum Data Set (MDS) with assessment reference date (ARD) of 06/27/21 indicates in Section N. Medications, R59 received antidepressant in the last seven days. A review of Section D. Mood, notes resident exhibited poor appetite or overeating in the last 7 to 11 days. In Section E. Behavior, R59 was not coded for any behavior. A review of the resident's care plan provided by the facility found no plan for the use

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of an antidepressant (trazodone) which includes non-pharmacological interventions to address R59's behavior.

Interview with the Assistant Director of Nursing (ADON) on 08/16/21 at 12:54 PM, inquired what behaviors are being monitored for R59 related to the use of an antidepressant. Concurrent review of R59's electronic health record (EHR), ADON confirmed the MAR does not include monitoring of R59's behavior.

Second interview was conducted with the ADON on 08/17/21 at 09:52 AM. The ADON reviewed the physician's order for the monitoring of behavior and reported this order should be transferred to the MAR; however, ADON confirmed the current MAR does not include the monitoring of behavior. Further queried regarding the diagnosis of dementia with behavior as an indication for use of an antidepressant. The ADON responded the psychiatrist would provide the rationale for using an antidepressant to treat dementia with behavior. The ADON could not find the psychiatrist's report. The ADON also questioned the use of an antidepressant with diagnosis of dementia with behavior. Further queried whether the facility conducted gradual dose reduction (GDR). The ADON confirmed a GDR was not attempted or brought to the attention of R59's physician.

2) Cross Reference to F656: Comprehensive Care Plan.

R35 was admitted on 03/18/14 with diagnoses that include vascular dementia with behavioral disturbance and major depressive disorder, single episode, unspecified.

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On the morning of 08/10/21 during initial tour of the unit, R35 was observed in the hallway sitting in her wheelchair with her partially consumed breakfast tray on her overbed tray. R35 was asleep in her chair. Second observation at 10:01 AM, R35 was falling asleep in her chair. On 08/11/21 at 07:49 AM, R59 was awake and seated at bedside eating her breakfast. She was placed in the hallway at 09:23 AM, she was asleep.

Record review on 08/13/21 at 10:14 AM noted current physician order included mirtazapine (antidepressant), 7.5 mg, by mouth at bedtime for diagnosis of depression. Start date of was mirtazapine is 08/31/20. The order includes to monitor for adverse reaction: dizziness, sedation, dry mouth, constipation, weight gain and negative life statements related to the use of anti-depressant drug use. The order also includes to monitor behavior, day and eve shifts for episodes of poor PO intake or refusal to eat.

A review of the care plan provided by the facility does not address the use of an antidepressant for signs and symptoms of depression. The care plan in the previous electronic health record (EHR) notes R35 has potential for behavior or mood outbursts related to diagnosis of dementia with behavior disturbances. The identified problem dated 03/04/20 indicates R35 refuses meds and haircut, can become combative and resistive to care, and can also be agitated. It is noted mirtazapine 7.5 mg. was started on 06/15/18. Interventions include monitor for possible mood and behavior outbursts (she can become physically abusive), continue psychotropic drugs as ordered to help regulate

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mood and behavior, monitor for adverse effects, and administer mirtazapine as ordered. The targeted end date is 11/17/21.

Interview was done with ADON on 08/17/21 at 12:57 PM. Inquired whether mirtazapine is being used for diagnosis of depression or appetite stimulant. The ADON replied for both. Further queried what specific behaviors are being monitored to determine the efficacy for the use of the antidepressant. ADON replied negative statements, refusal of care and pinching. Concurrent review of the MAR found the facility is monitoring R35 for making negative life statements and poor PO intake and refusal to eat.

Further reviewed the MAR and care plan with the ADON. The ADON acknowledged the behaviors identified in the physician's order, MAR and care plan does not match up. Further queried whether an attempt at GDR was done or whether R35's physician has indicated a reduction is contraindicated for R35. ADON reported, the psychiatrist will address GDR. Concurrent review of the psychiatric consult report was done with the ADON. The last consult dated 03/08/21 notes R35 is a 94-year-old with dementia, stable. The recommendation was to continue mirtazapine to help with behavior and appetite.

3) R4 is a 55-year-old male with relevant history of insomnia and anxiety. On 08/16/21 a review was completed of his medical records which included:

Current pertinent medication orders include Cymbalta (antidepressant) 60 mg. (milligrams) orally once daily for depression dated 06/15/20

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F 758	Continued From page 102 and traxodone 50 mg dated 03/10/21. The previous order was Cymbalta 30 mg. which was started on 02/11/20. Psychiatric consult dated 10/19/20 included; "mirtazapine (antidepressant) then Lexapro (antidepressant) which has been discontinued. Frequent falls are noted, medical director suggested possible changes of Lexapro to Cymbalta (antidepressant) to help with depression/pain and simplify medications. No further falls. Persistent sleep problems, on trazodone, now increased to 50 mg. Current medication listed as reviewed at that time included "cymbalta 30 mg and trazodone." The Plan/Recommendation was "reasonable to continue with trazodone. Could either increase trazodone to 75 mg hs (at bedtime) to help with sleep and/or increase hs dose of gabapentin." On 08/16/21 at approximately 01:49 PM during an interview with the ADON she said the psychiatrist does the review of medications for GDR. Concurrent RR at that time revealed there was no documented review of the clinical rationale for the ongoing use of Cymbalta. The ADON said "There was a referral done for the GDR on October 19, 2020. He (psychiatric consult) did the trazodone, but did not address the duloxetine (Cymbalta)."	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 761		

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instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure all medications used in the facility were labeled, administered, and stored in accordance with professional standards. Proper labeling, safe administration practices, and timely reconciliation of stored medications is necessary to decrease the risk for medication errors. This deficient practice has the potential to affect all residents in the facility.

Findings include:

1) On 08/12/21 at 08:41 AM, a medication pass observation was done with Registered Nurse (RN)2 in the hallway outside room 224. As she was preparing the Amlodipine for resident (R)22, RN2 was observed popping a tablet out of the

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Amlodipine 10mg blister pack, cutting the unscored tablet in half with a tablet splitter, placing one half of the tablet in the medication cup for R22, and placing the second half of the tablet back into the blister pack. Upon closer examination of the blister pack, it was noted that the pharmacy label read, "Amlodipine 10mg take 1 tab [tablet] by mouth once daily"; handwritten in small print to the left of the pharmacy label was: "Give 5mg 1/2-tab PO [by mouth] BID twice a day] 7/20/21." When questioned, RN2 confirmed that the order had been changed on 07/20/21, and that the facility had received a new blister pack from the pharmacy which was being stored in the medication cart.

A review of the facility's Long Term Care Pharmacy Policies & Procedures on 08/17/21 at 07:43 AM noted under Preparation and General Guidelines, " ...splitting of tablets should be avoided and every attempt should be made to obtain an alternative dosage form ...to avoid splitting. If breaking tablets is ultimately necessary to administer the proper dose ...if using only one-half of the tablet from a unit-dose package, the remainder is disposed of ..."

2) On 08/17/21 at 12:57 PM, while inspecting the medication cart on the first floor with RN1, an Insulin Aspart Flexpen was found labeled "opened 07/16/21, date to discard 08/21/21." Per RN1, facility policy is to discard insulin pens 28 days after opening. Further inspection found eight blister packs of medications that had been discontinued, and one blister pack of medication for a resident that had been discharged. RN1 stated that the facility policy is to pull medications immediately out of the cart and take them to the medication room for discard if they had been

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F 761	Continued From page 105 either discontinued, or leftover after a resident was discharged. RN1 then reiterated that they should not have been left in the cart.	F 761		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of	F 791		

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dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and

§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to promptly provide or obtain from their dental consultant, routine dental services to meet the resident's needs. In addition, the facility failed to assist one resident (R)7 in making an appointment to see the dental consultant upon her request. This deficient practice has the potential to affect all residents currently residing in the facility.

Findings include:

R7 is a 64-year-old female admitted on 01/11/20 for long-term care with diagnoses that include traumatic cervical spinal cord injury with central cord compression and intractable neuropathic (nerve) pain. As a result of these diagnoses, R7 requires extensive assistance with her activities of daily living such as dressing, oral hygiene, and showering, and total assistance with transfers.

On 08/11/21 at 08:10 AM, an observation and concurrent interview was done with R7 in her room on the second floor. R7 was lying flat in bed with her hair uncombed, contractures noted to all the fingers of her right hand and the middle finger of her left. When questioned about how she used her hands, R7 stated that she cannot

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brush her teeth or her hair with either hand, but she can feed herself with her left hand using a special utensil. With regards to oral care, R7 stated she could not remember the last time staff assisted her in brushing her teeth, and that "sometimes" she was offered mouthwash, but not regularly. R7's dental status appeared to be in an advanced state of decay, with several teeth missing, and what teeth remained were brown in color. R7 stated that her teeth bother her a lot, and that recently she felt something sharp in her mouth cutting her tongue. When she told the doctor about it, the doctor said he would tell the nurse. A short while later, a nurse came to give her pain medication and a mouthwash. R7 stated neither the doctor nor the nurse looked in her mouth to assess the source of the pain. R7 reported that she has asked to see the dentist a few times, but staff has told her that "the dentist is closed."

On 08/16/21 at 10:30 AM, during a record review of R7's hard chart on the second floor, an Oral Inspection document, dated 04/04/21, was found. The Licensed Practical Nurse (LPN)2 who conducted the inspection circled "yes" under "Gums/mucus membranes: lesions, inflammation, irritation, bleeding?", and documented "gums slightly swollen and reddened." The LPN also circled "yes" for "Does the resident wish to see the dentist?" The form instructs the user, "If any of the above questions are answered yes, please refer to the following checklist and complete areas as indicated ..." The checklist includes interventions such as notify the doctor, obtain an order to see the dentist, "refer to MD/NP for further evaluation ...", update the care plan, and "Schedule Dentist appointment." None of the areas were checked

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F 791	Continued From page 108 off or completed. No further documentation was found in either the hard chart or in R7's electronic health record (EHR) that indicated what action, if any, was taken. On 08/16/21 at 02:50 PM, during an interview with the Assistant Director of Nursing (ADON) and the Ward Clerk (WC) at the second-floor nurses' station, the WC stated that the facility-contracted dentist usually comes once a year for routine visits, and as needed for acute or emergency visits. Since the outbreak of the pandemic however, the dentist has been refusing to come in "because of COVID." The WC stated that the dentist did not come in at all for routine visits in 2020 but did come in once to pull a tooth from a resident. The ADON stated that when they have a resident that needs to be seen or requests to be seen, the registered nurse (RN) or the WC normally call the dentist to come in. The ADON then stated that because of the challenges they were having to provide dental services, the facility was trying to get another dentist to come in instead, but he had not visited yet. On 08/17/21 at 04:16 PM, after asking for the ADON's assistance in locating documentation of what action had been taken in response to the 04/04/21 oral inspection, the ADON produced a copy of the original 04/04/21 Oral Inspection form which had the following addendum hand-written in at the bottom and signed by LPN2: "8/17/2021 late entry for 4/5/21. Resident brushed her teeth and gums. Inspect the following day no more redness and swelling. No complaints of pain."	F 791		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

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F 812	Continued From page 109 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview with staff members, the facility failed to ensure food items were labeled with dates of preparation or disposal, did not dispose of outdate/expired food items, staff member unaware of disposal date of food items, and staff members unaware of the system for taking food temperatures for prepared sandwiches. Unsafe food handling practices represent a potential source of pathogen exposure for residents. Findings include: 1) Initial tour on 08/10/21 at 08:00 AM of the kitchen was done with the Food Service Manager (FSM). In the walk-in refrigerator observed two plastic bins containing a total of 12 individual cups of various beverages. The cups were labeled	F 812		

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with residents' names atop the plastic wrap covering. Inquired when were these beverages dispensed and how long has it been in the refrigerator. FSM stated the beverages require labeling with the date.

Also observed a manufacturer's plastic container for miso soup paste. There was a date of 06/08/21 atop the cover. The FSM reported olives were being stored in the plastic container. Inquired how long can olives be stored before discarding. FSM did not respond.

Observation of the reach-in refrigerator found another manufacturer's plastic container for miso paste. The container was labeled 06/16/21. The FSM confirmed miso soup paste was being stored in the container. Inquired how long can the paste be kept in the refrigerator before disposal. FSM was unable to answer.

Interview with the Registered Dietitian (RD) was done via telephone. RD was asked how long can miso soup paste be kept in the refrigerator. RD responded that she would follow-up and get back to surveyor. RD later telephoned to report she contacted the manufacturer and the miso soup paste can be kept for one year in the refrigerator.

2) Observed food preparation on 08/11/21 at 10:45 AM. The menu included turkey sandwich, vegetable soup, and beets. A staff member had a large metal pan containing stacks of sandwiches and placed the thermometer into the sandwiches. The staff member reported the temperature was 49 degrees and placed the pan into a drop-in freezer. Inquired why were the sandwiches being placed in the freezer, the staff member responded when the sandwiches were

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F 812	Continued From page 111 taken out of the refrigerator, it was 44 degrees and needs to be below 40 degrees. Staff member confirmed the kitchen is serving tuna sandwiches, not turkey sandwiches. Interviewed the Registered Dietitian (RD) via telephone on 08/11/21 at 12:19 PM. The RD reported the temperature should be taken when the filling is removed from the refrigerator and staff have a window of two to four hours to spread the filling and serve the sandwiches. The RD stated retraining of staff will be done. 3) On 08/11/21 at 11:45 AM observation of the nourishment refrigerator on the Diamond Head unit was done with Licensed Practical Nurse (LPN)1. The lower bin contained three food items labeled with Resident (R)59's name and dates. Food items included bags of mochi rice dated 08/06/21, croquettes dated 08/06/21, and sushi dated 08/04/21. Inquired how long are food items for residents kept in the refrigerator, LPN1 responded three days and proceeded to toss out the three bags of food.	F 812		
F 842 SS=F	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		

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F 842	Continued From page 112 §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or	F 842		

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F 842	Continued From page 113 (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review (RR) and interview, the facility failed to have a process in place to ensure all clinical resident information was immediately accessible to the clinical team. Specifically, the facility failed to ensure that vital signs monitoring for all residents, including those for persons under investigation (PUI) [for COVID-19] were documented or even transferred to their electronic health records (EHR) in a timely manner. The interdisciplinary team did not have access to all the temperatures and the staff did not know where to locate them. Failure to have vital signs monitoring readily accessible could potentially contribute to a delay in care, or medical errors associated with a lack of communication and transcription of vital health care information. This affected all residents in the facility. Findings include: 1) On 08/12/21 at 08:57 AM a Surveyor was	F 842		

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notified that Resident (R)46 had a fever the previous night, had tested negative for COVID, was placed on droplet precautions, and was due for a chest x-ray (CXR) that morning. A quick record review (RR) of R46's electronic health record (EHR) revealed documentation of a fever of 102.3 degrees at 03:38 PM on 08/11/21, but no other vital sign documentation since. There was also no documentation found of a COVID-19 test being done.

On 08/12/21 at 10:35 AM, an interview was done with the Director of Nursing (DON) at the second-floor nurses' station. After asking the DON to indicate where R46's vital signs monitoring would be located, it was noted that the DON was unaware there was only the one high temperature documented in the EHR. Unable to find documentation of any vital signs monitoring in the EHR, the DON stated, "oh, it might be one other place," and began pulling down multiple binders from a shelf at the back of the nurses' station. The DON produced a COVID Testing binder which contained the vital signs of every patient on the second floor, taken once each shift. When asked about how that information is transferred into the EHR, the DON stated that the Ward Clerk (WC) was responsible for "scanning it in." The DON could not provide a timeline of how long it would take before the information was available in the EHR, stating, "scanning in the stuff for the new residents is the priority, so I don't know." A review of the COVID Testing binder noted vital signs and COVID symptoms logs for each shift and each resident from 08/11/21 to 08/12/21. An interview with certified nurse aide (CNA)9 at the second-floor nurses' station at 10:45 AM confirmed that all vitals taken are written in the binder. CNA9 did not know how or

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when the vital signs were transferred into the EHR.
2) On 08/17/21 at 10:00 AM asked RN5, the designated charge nurse on the first floor for documentation the facility took daily temperatures on all residents as part of COVID-19 screening. RN5 provided surveyor a binder that had two days (08/11/21 and 08/12/21) of temperatures documented, one page per day. Queried RN5 where the documentation was for the other days and he said he wasn't sure but someone pulls them and enters them in the computer.

On 08/17/21 at 11:17 AM interviewed the Director of Nursing (DON) in the first floor nursing station. The DON said the other temperature sheets for the first floor unit "are being entered into the medical record." She went on to say that the facility is utilizing other individuals located in the office who are entering the temperatures in individual resident records and they (the facility) is continuing to catch up and load things in the new system." The DON confirmed the temperatures were not immediately accessible to staff or physicians and was unable to provide a turnaround time for the data entry.

3) Cross Reference to Ftag 726-Competent Nursing Staff
Certified Nurse Assistant (CNA)2 failed to demonstrate competency to accurately measure and record R18's meal intake. Specifically on 08/10/21 and 08/11/21 R18's intake was observed to be very poor (less than 25%). CNA2 inaccurately documented the intake to be much greater on both days.

4) On 08/17/21 reviewed the facility policy titled "Documentation in the Medical Record" revised

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F 842	Continued From page 116 11/2017. The policy statement was "Each resident' medical record shall contain an accurate representation of the actual experience of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation."	F 842		
F 880 SS=J	Infection Prevention & Control 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	F 880		

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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 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, interview, and record review, after identifying a person under

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investigation (PUI), with a fever of 102.3 degrees at 03:38 PM on 08/11/21, the facility failed to ensure appropriate protective and preventive measures for COVID-19 and other communicable diseases and infections were executed, as evidenced by the facility failing to revise, follow and implement their infection prevention and control policies and procedures, including the transmission-based precautions of their COVID-19 Plan to control and prevent the spread of infections. Due to the community increase of COVID-19 delta-variant infection in vaccinated individuals, failure to follow the facility policy related to COVID-19 had the potential to contribute to an outbreak in the facility's vulnerable population. As a result of this deficient practice, staff and patient safety was compromised and an immediate jeopardy (IJ) was identified. In addition, the facility failed to have a functional, sanitary shower/toilet area on the first floor, Diamond resident care area or ensure staff performed hand hygiene between residents and after doffing gloves and failed to physically distance residents lined up in the hallway. These deficient practices have the potential to affect all residents in the facility, as well as all healthcare personnel, and visitors at the facility.

The State Agency (SA) identified Immediate Jeopardy (IJ) on 08/12/21 at 02:50 PM. On 08/12/21 at 03:26 PM, the Administrator was notified of the IJ at 483.80 (F880) and provided with the IJ template. The Administrator signed the template to attest receipt of the notice. The facility did not implement standard transmission-based precautions (TBP) to contain possible spread of COVID-19 upon identification of a resident suspected of COVID-19. The

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F 880	Continued From page 119 State's positivity rate for COVID-19, the Delta variant, has been exponentially increasing (> than 5% positivity). The facility failed to ensure the room door was closed, the resident's roommate (possibly infected) was seated amongst the other residents on the unit, the TBP supplies were not readily available for staff to sanitize their face mask or access the disposable liners, the resident's room did not have a container to dispose of gowns prior to exiting the resident's room, staff members did not follow the facility's COVID-19 guidelines (donning gowns properly and using an N-95 respirator), contractors did not don appropriate personal protective equipment (PPE), and there was no dedicated equipment for the PUI resident or provision of appropriate sanitizing solution for shared equipment. These deficient practices have the potential to result in adverse outcomes (spread of COVID-19) to residents and staff members in the facility. Due to the vulnerability of residents, contracting COVID-19 could result in death. On 08/12/21 at 06:00 PM, the facility provided a removal plan. The removal plan consisted of updating the facility's COVID-19 Plan and TBP signage, then re-training all staff on the updates, focusing on the procedure for responding to a suspected COVID-19 resident, and the implementation of TBP. The SA approved the removal plan. On 08/13/21, the facility provided a copy of their updated plan, and sign-in sheets verifying the staff that completed the in-service training. The SA requested return demonstration of the in-service training that was provided to the staff members. Three staff members were randomly selected by the SA to represent the direct care staff. The conference room and hall were set up to simulate a PUI resident's room.	F 880		

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PPE cart and signage were posted in the hallway and the room was provided with a vessel to dispose of PPE before exiting the room. The facility used revised signage and ensured staff members had access to the solutions for sanitizing their face shields. The staff members successfully demonstrated competency for donning and doffing of PPE while providing care for resident suspected of COVID-19 infection. On 08/13/21 at 03:16 PM, the SA verified the IJ was removed, however a pattern of deficient practices at F880 remain.

Findings include:

1) On 08/12/21 at 08:57 AM a Surveyor was notified that Resident (R)46 had a fever the previous night, tested negative for COVID, placed on droplet precautions, and was due for a chest x-ray (CXR) that morning. A quick record review (RR) of R46's electronic health record (EHR) revealed documentation of a fever of 102.3 degrees at 03:38 PM on 08/11/21, but no subsequent vital signs (temperature, pulse, blood pressure, respirations) documentation was found. There was also no documentation found of a COVID-19 test being done, or resulting as negative, as per the verbal report to the surveyor.

On 08/12/21 at 09:00 AM, observations were done outside R46's room on the second floor. R46's room door was propped open, and his roommate was observed sitting in the hallway along with three other residents, with no mask on his face. A portable CXR was being done on R46, and from the doorway it was observed that the radiology technician was wearing a gown, goggles, a procedure mask, and gloves, as he positioned R46. There were contact and droplet

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signage placed outside the door, and directly left of the doorway was a small, semi-transparent, personal protective equipment (PPE) cart with a box of gloves, a box of procedure masks, and a box of N-95 respirators placed on top. The top drawer was secured with a closed combination lock and contained a roll of trash bags, and a spray bottle filled with clear liquid. The second and third drawers were not locked and contained cloth gowns. There were no EPA [environmental protection agency]-approved disinfectant wipes observed in or by the room/cart.

On 08/12/21 at 10:15 AM, a Surveyor observed certified nurse aide (CNA)7 assist R46's roommate, who was still not masked, from the hallway into his room. CNA7 was observed taking note of the signage and PPE cart outside the doorway, turning to ask another staff member about it, then walking away from the room, leaving the door propped open.

On 08/12/21 at 10:24 AM, CNA7 was observed returning to the area outside of R46's room. CNA7 performed hand hygiene with an alcohol-based hand rub (ABHR), donned a cloth gown, and a pair of gloves, then entered the room with the face shield and procedure mask that she was already wearing. At 10:27 AM, CNA7 was observed doffing her gown and gloves near the doorway, placing them inside of a regular trash bag, and leaving the bag on the floor by the doorway. She then used ABHR to complete hand hygiene and stepped out of the room. CNA7 did not stop to clean her face shield or change her procedure mask. At 10:30 AM, an interview was done with CNA7 as she stood outside of R46's room. CNA7 stated she had seen R46's roommate dozing in the chair and wanted to help

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him to his bed to lay down. CNA7 confirmed that she "saw the precautions [signage]" after she assisted R46's roommate into the room and stated that droplet precautions required those who entered the room to wear a face shield, a gown, gloves, and a "duckbill." She clarified that the duckbill was an N-95 respirator. CNA7 stated that the top drawer of the PPE cart was locked, and she did not know the combination. When asked about the linen she left by the doorway she replied, "I didn't see any bins to discard everything in." When asked if it was okay for R46's roommate to be out in the hallway without a mask, CNA7 stated she did not know. CNA7 then explained that she had not attended the morning huddle, so she did not know why the transmission-based precautions (TBP) were in place. CNA7 confirmed that she should have worn an N-95 respirator in the room and should have closed the door.

On 08/12/21 at 10:40 AM, an observation and concurrent interview was done with R46 in his room on the second floor. R46 stated that he felt fine, was able to confirm that he had a CXR done but did not know if a COVID-19 test was conducted. There was no dedicated equipment for vital signs, no EPA-approved disinfectant wipes, and no receptacle to dispose of the used PPE in the room or shared bathroom. Not knowing where to place the doffed gown, this surveyor requested assistance from CNA9, while still standing in the open doorway of the room. CNA9 grabbed a regular trash bag to place the doffed gown in, picked up another trash bag that had been left inside the doorway, and walked them to the dirty linen room.

On 08/12/21 at 10:55 AM, an observation was

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done of CNA10 donning PPE outside of R46's room. CNA10 wore a face shield and procedure mask, donned a pair of gloves, opened the box of N-95 respirators on the PPE cart, and then closed it without taking one. CNA10 then removed a cloth gown from the PPE cart and donned it, securing it with a tie at the neck, and leaving the waist tie unsecured. CNA10 entered the room and turned to receive a lunch tray from another staff member in the hallway. CNA10 placed the lunch tray in front of R46's roommate, walked to R46's bed and was observed touching items in the environment, returned to R46's roommate after hearing him ask for something, and handled items on his food tray. CNA10 then walked back to R46's side of the room where she was again observed touching items in the environment. CNA10 then walked to the doorway and closed the door at 10:57 AM. CNA10 did not perform hand hygiene or change her gloves while providing care for R46 and his roommate. At the same time, the Assistant Director of Nursing (ADON) was observed trying different combinations to open the lock on the top drawer of the PPE cart without success. The ADON stated the top drawer contained alcohol spray for staff to clean their face shields with, and water-soluble plastic bags for the dirty linen.

On 08/12/21 at 11:04 AM, an interview was done with the ADON outside of R46's room. CNA5 had just been observed entering the room wearing a gown, a face shield, a procedure mask, and gloves. The ADON confirmed that because R46 was still "suspected [of potentially having COVID-19]", anyone entering his room should be wearing an N-95 respirator and not a procedure mask. The ADON was also informed that the radiology technician had not been wearing an

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N-95 respirator when he was in the room, and she acknowledged that although he was outside staff, he should have known that the policy when entering a room with a PUI was to don an N-95 respirator.

On 08/12/21 at 01:17 PM, a phone interview was done with the Infection Preventionist (IP). The IP stated that she is on-site three days a week and is full-time, splitting her time between the duties of both the IP and the MDS Coordinator positions. The IP reported that the facility uses the CDC guidelines for infection prevention. When asked about TBP and the Infection Prevention and Control Plan (IPCP), the IP stated that a couple weeks ago the facility changed its policy and was only admitting residents who were fully vaccinated. The facility also decided to remove its yellow zone at the same time. The IP reported that the DON and ADON helped to communicate the policy changes to staff. Asked to explain their COVID-19 Plan, the IP stated that when staff identifies a resident with COVID-19 symptoms, the plan is to isolate the resident (as much as possible), place a PPE cart and TBP signage outside the room, fill out a person under investigation (PUI) Form, which is kept on the unit, pull the privacy curtains around both the resident and roommate, and confine them both to the room until the PCR (polymerase chain reaction test for COVID-19) test is confirmed as negative. Also, the Charge Nurse notifies the IP, DON, and primary physician as soon as possible, and obtains orders for a PCR test, a rapid flu test, and a CXR. An antigen (screening test for COVID-19) test is usually done, and its result should be documented in the progress notes of the EHR. When asked about PPE for droplet precautions, the IP confirmed that primary staff

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(licensed nurses and CNAs) need to use gowns, N-95 respirators, face shields and gloves when entering the room. The IP then stated that although she was informed and on-site when R46's fever was identified, she did not participate in implementing the COVID-19 Plan. When asked if she did any assessment of the resident for surveillance purposes, the IP stated, "I went up there [to R46's room], but I failed to go in."

On 08/13/21 at 09:00 AM, an interview was done with Registered Nurse (RN)1 outside of room 204. When asked about vital sign equipment and monitoring, RN1 stated that staff use the vital signs equipment on the medication cart of their unit to monitor all residents' vitals once every shift. The equipment (a portable blood pressure machine and a handheld digital thermometer) is wiped down between residents with the "turquoise wipe [Sani-cloth HB]," which are also kept in the medication carts on each unit. A review of List N: Disinfectants for Coronavirus (COVID-19) revealed that Sani-cloth HB has not been approved by the EPA as a disinfectant that kills COVID-19. When questioned which vital sign equipment was used to take R46's vitals that morning, RN1 answered "the one on the cart." RN1 then confirmed that there was no dedicated equipment for R46 despite his TBP status.

On 08/13/21 at 09:05 AM, an interview was done with RN3 in the hallway outside room 224. RN3 stated the equipment on her medication cart was used to measure R46's vitals that morning. RN3 also confirmed that there was no dedicated equipment for R46 and stated that there should be.

2) On 08/10/21 at 11:50 AM, an observation was

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done of certified nurse aide (CNA)9 assisting resident (R)47 with her meal in the hallway of the second floor. Through the course of feeding her, R47 spit up a large amount of food. CNA9 was observed cleaning R47's mouth and chin with a cloth napkin, placing the napkin on R47's bedside table, grabbing a pair of gloves from inside the doorway of room 206, and donning those gloves without performing any hand hygiene. CNA9 then ran to the bathroom at the beginning of the hall for wet paper towels, returned to R47, and used the wet paper towels to wipe her face. CNA9 then walked back to the bathroom at the beginning of the hall, threw her gloves and paper towels away in the bathroom trash, then performed hand hygiene. CNA9 was interviewed at this time regarding hand hygiene, and she apologized for not doing it before donning her gloves, acknowledging that hand hygiene should be done before and after glove use.

3) On 08/11/21 from 11:53 AM to 12:00 PM, observations were done of the Social Services Designee (SSD) as he made his rounds on the second floor. The SSD was observed entering room 205, speaking supportively to the resident in bed 2, holding her hand, and touching her bedside table. The SSD then walked over to room 204, then room 206, and finally room 203. In each room, the SSD was observed visiting with residents, touching both the residents and items in their immediate environment such as their privacy curtain or bedside table, and moving on to the next resident. At 12:00 PM, the SSD was observed entering the elevator and leaving the second floor. At no time was the SSD observed washing his hands or using the alcohol-based hand rub (ABHR) outside each room or the elevator, to perform hand hygiene.

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4) On 08/10/21 at 10:46 AM observed five residents seated in the dining room waiting for lunch. The cart containing the lunch trays were brought out from the kitchen at 10:55 AM. Staff members distributed the lunch trays to residents. Residents were not observed to perform hand hygiene prior to consuming their meals.

Second observation was done on 08/11/21. At 10:50 AM the food cart was delivered to the dining room. Seven residents were seated in the dining room following participation in activities. The tables which accommodated two residents were fitted with a plastic barrier between the residents. The lunch meal consisted of sandwich, soup, and beets. Residents were not observed to perform hand hygiene prior to consuming their meals.

Observation on 08/11/21 of the Downstairs unit found staff members passing trays to residents' rooms. At 11:00 AM, Resident R4 was seated in the hall and requested to hand sanitize. Certified Nurse Aide (CNA)3 brought the dispenser of ABHR to R4. CNA3 was observed to provide ABHR to R80 with his lunch tray. Observed CNA13 deliver tray to R180, the resident was not provided with ABHR for hand hygiene before lunch.

Interviewed CNA3 regarding provision of ABHR to residents, CNA3 reported she learned to do this while working at another facility. CNA3 was not aware other residents were not being provided with ABHR to perform hand hygiene before their meals.

5) Observation on 08/10/21 during the lunch

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meal found residents seated in the hall next to the nurses' station having lunch. R78 and R59 were seated in their wheelchairs with overbed trays in front of them, and placed next to one another, less than six feet apart. Three female residents were seated across the nurses' station, two on a built-in bench and one in her wheelchair. The residents were provided with overbed trays and were placed next to one another, less than six feet apart.

Observation on 08/11/21 during lunch found R380 (R380 seated in his wheelchair facing the exit door with R4 seated in his wheelchair with his back to the wall). R380 goes out of the facility for hemodialysis three times a week. The residents were seated perpendicular to one another (R380 facing forward to the side of R4) and were placed less than six feet apart. The residents were observed to converse with one another.

On 08/13/21 at 12:23 PM observed R380 sitting in the hall with no face mask, facing the exit door next to the wall. R78 was placed less than six feet away with her wheelchair placed against the wall, resulting in the residents being perpendicular to one another. On 08/13/21 at 12:25 PM concurrent observation was made with the Infection Preventionist (IP). The IP reported R380 is required to wear a mask at the dialysis facility and wears a mask as tolerated while in the facility. IP also reported residents should be placed six feet apart from one another, and moved R380 back away from R78. R380 was asked about his tolerance for wearing a mask, he responded he's allergic and it scratches his face.
6) On 08/12/21 at 12:22 PM during an interview with RN1, she said R46 was in isolation and considered a PUI for COVID-19. RN1 said she

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was notified R46 was in isolation by "verbal endorsement at shift change and the antigen test done last night was negative." RN1 was unable to locate any documentation the antigen test was collected or the negative result. Inquired when the PCR result sent to the lab was expected, she said the lab had just picked up the specimen about 11:00-11:30 AM this morning and "the test was not ordered STAT [rush] because the doctor didn't order it that way." When asked if the unit had any special cleaning by housekeeping, she said she did not know.

7) On 08/12/21, reviewed the facility "COVID-19 Plan" provided to surveyor. The plan had a revision date of 07/2021. The Administrator said the plan had not been revised to include the closure of the yellow zone on the first floor had been the designated COVID-19 unit. The written plan included the following directions for a highly suspicious COVID-19 resident:
"2. Isolate resident in place with the door closed..."
"3. Primary Staff, the licensed nurse and CNA assigned to the resident - PUT ON FULL PPE (gown, N95, face shield, gloves) when entering the room. ...Since primary staff have been "exposed" to the resident with symptoms, they will wear FULL PPE for droplet precautions (Gown, N95 mask, face shield, grooves), when providing care to residents in other rooms."
"6. Other staff to return residents to their rooms and close the doors, Clean and sanitize all common areas (hallways, railings, door handles, shared bathroom, etc, ...)."
"7. Testing resident...Call Lab for stat pick up..."
The plan went on to direct staff if a resident was positive for COVID-19 to transport the resident to the designated COVID-19 unit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125024	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NUUANU HALE	2900 PALI HIGHWAY HONOLULU, HI 96817

(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 880	Continued From page 130 On 08/12/21 at 01:17 PM during a phone interview with the IP, when asked the current practice should be if a PUI had a roommate, she said "We have to keep in the room because of all the changes we made recently." The IP was informed the CNA didn't know if the room mate could come out of the room. She said the staff had "inservice's about a year ago" and the changes to the plan were communicated to the staff by the ADON and DON. The IP went on to say, "the DON, ADON and Administrator help me a lot with updates. Mostly our Administrator is getting the CMS [Centers for Medicare & Medicaid Services] and DOH [Department of Health] updates and monitors the positivity rate." On 08/13/21 at 02:00 PM during an interview with the IP, Administrator, ADON and two facility consultants, they confirmed the designated COVID-19 unit referred to in the facility plan had been closed approximately two weeks ago because the facility now admitted only vaccinated resident's. The facility did not have any documentation of education to the staff regarding the changes. 8) On 08/13/21 at 03:00 PM toured the first floor shower room located across from the nurses' station. The room had three distinct areas; a shower, and two additional areas divided by walls. The area adjacent to the shower had a toilet, the next area was equipped with a wheelchair-accessible sink and was utilized as a store room. There were no dispensers with ABHR or other ABHR available in the areas. During the tour, observed a full urinal labeled with R4's name hanging on the handrail by the toilet.	F 880		

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F 880	Continued From page 131 R4 utilizes a wheelchair and independently mobilizes throughout the unit. Neither R4 or staff were observed in the hall or immediate area at the time. The sink in the next room was not accessible and blocked by an overbed table and a folded wheel chair which an ambulatory person would have had to move to get to the sink. The store room area at this time was not a functional, sanitary environment. The room contained a closed mobile cabinet with the clean linen for the unit that had a large trash receptacle with a lid sitting directly in front of it. There was a shower chair with a commode on top of it. There was another commode with plastic bags filled with unknown items on top of it. In addition, there were shower boots, a shower gown on a handrail hanging over a trash can and a tennis shoe under the sink. There were several other unlabeled clear plastic bags with unknown items in them piled on folded wheelchairs and other unidentifiable pieces of equipment.	F 880		
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 member, the facility did not ensure a safe physical environment was provided for residents on one unit, the bathroom cabinet containing potentially hazardous chemical if swallowed was not locked. An ambulatory resident resides on this unit and freely traverses the unit.	F 921		

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F 921	Continued From page 132 Findings include: On 08/10/21 at 11:35 AM observed bathroom cabinet in the shower room on the Diamond unit with a padlock that was not locked. The cabinet housed cleaning solution, calmoseptine (incontinence ointment), foam shaving cream, and shampoo/body wash. The cabinet door has signage that reads "Place chemicals in cabinet and lock when finished." Concurrent observation was done with Certified Nurse Aide (CNA)6 at 11:40 AM. CNA6 confirmed the cabinet was not locked and is supposed to be locked. CNA6 engaged the lock. An ambulatory resident resides on this unit and freely traverses the unit, which would provide access to the items in the cabinet.	F 921		

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E 000	Initial Comments A recertification survey was conducted by the Office of Health Care Assurance on 08/10/21 - 08/17/21. The facility was found 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		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.