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	125051	A. BUILDING: _____ B. WING _____	04/19/2021

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KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

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4 000	Initial Comments A relicensing survey was conducted by the Office of Healthcare Assurance (OHCA). The facility was found not to be in substantial compliance with Hawaii Administrative Rules, Title 11, Chapter 94.1 Nursing facilities. Survey dates: April 14 to 19, 2021 Survey Census: 82 Sample size: 18	4 000		
4 112	11-94.1-27(1) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (1) The free exercise of rights as a resident of the facility and as a citizen or resident of the United States; This Statute is not met as evidenced by: Based on interview and observation, the facility failed to assure residents were aware of the posting location of the State inspection results. One of the two RC representatives was aware of the State inspection report; however, did not know where the report was located. This deficient practice impedes the resident's right to be informed and could potentially affect all residents in the facility.	4 112	Corrective Action R79 and R15 were oriented on 5/07/2021 to the location of State inspection results. Identification of others All residents have the potential to be affected by this practice. Education to Resident Council was initiated on 5/7/2021 on the of State Inspection results. All	6/3/21

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4 112	Continued From page 1 Finding includes: An interview was conducted with RC representatives, R79 and R15, on 04/14/21 at 02:00 PM. Due to the COVID-19 pandemic, the RC had not been meeting regularly. The Activities Director (AD) reported during the pandemic, she had been meeting with the residents individually. The residents were asked whether they are aware of the right to review the results of the State inspection. R79 responded being aware of the State survey inspection report; however, was unable to recall where it was located. Observation on the afternoon of 04/14/21 found both units provided a binder containing the State survey results next to resident's bulletin board. Although the facility posts the results of the State inspection, resident representatives were not aware of where to find the report for their review.	4 112	residents will be educated by 06/03/2021 regarding location of State Inspection results. Systemic Changes Effective 5/07/2021 Resident Council meeting agenda will include information regarding location of State Inspection results. Monitoring for Changes The Executive Director or designee will interview 5 random residents per week x 4 weeks to ensure they are aware of location and information. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 30 days to ensure compliance is achieved and maintained.	
4 120	1-94.1-27(9) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (9) The right to names, addresses, and telephone numbers of pertinent resident advocacy groups; This Statute is not met as evidenced by:	4 120		6/3/21

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4 120	Continued From page 2 Based on interviews and observations, the facility did not assure residents had knowledge of where the posting for names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies (State Long-Term Care Ombudsman, Adult Protective Services, and State Survey Agency) were located. The residents were also not aware that they may file a complaint with the State Survey Agency. This deficient practice prevents the facility's residents of knowing about their advocates and how to contact them and could potentially affect all residents in the facility. Finding includes: Interview was done with Resident Council (RC) representatives, resident (R)79 and R15, on 04/14/21 at 02:00 PM. When asked where the Ombudsman's contact information was posted, the residents were not aware of the role of an Ombudsman. Further queried whether they were aware that they can call the State Survey Agency with any complaints or concerns about the care they are receiving. The residents were not aware. Observations on the facility's units found postings about the Ombudsman; however, the posting of the pertinent State regulatory and information agencies was printed on an 8-1/2 by 11-inch sheet of paper and placed at the top of the bulletin board. The format of the information does not accommodate residents that are in wheelchairs or have visual impairments as the posting was too high and the font too small. Also observed postings on a bulletin board at the entrance to the dining room; however, during the COVID-19 pandemic, residents were not being taken to the dining room for meals.	4 120	Corrective Action R79 and R15 were oriented on 5/07/2021 to the location of posting of names, addresses, and telephone numbers of all pertinent State regulator and information agencies and their roles (State Long-Term Care Ombudsman, Adult Protective Services, and State Survey Agency; formatted (changed font size) and posted the information in a way that residents in wheelchairs or those with visual impairments are able to see the print. Identification of others All residents have the potential to be affected by this practice. Education with Resident Council was initiated on 5/7/2021 on the location - posting of names, addresses, and telephone numbers of all pertinent State regulator and information agencies and their roles (State Long-Term Care Ombudsman, Adult Protective Services, and State Survey Agency). All residents will be educated by 06/03/2021 regarding location of posting of names, addresses, and telephone numbers of all pertinent State regulator and information agencies and their roles (State Long-Term Care Ombudsman, Adult Protective Services, and State Survey Agency). Systemic Changes Effective 5/07/2021 Resident Council meeting agenda will include information regarding location - posting of names, addresses, and telephone numbers of all pertinent State regulator and information agencies and their roles (State Long-Term	

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4 120	Continued From page 3 On 04/19/21 starting at 11:05 AM, a concurrent observation was done with the Social Worker (SW)1 of both resident units. SW1 confirmed the placement of the information was too high for residents in wheelchairs and the font size was small.	4 120	Care Ombudsman, Adult Protective Services, and State Survey Agency) in subsequent meetings. New admissions beginning 5/14/2021 will also receive a revised and updated copy of state agency information in the admission packet. Monitoring for Changes The Executive Director or designee will interview 5 random residents per week x 4 weeks to ensure they are aware of location and information. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 30 days to ensure compliance is achieved and maintained.	
4 145	11-94.1-38(a) Activities (a) The facility must provide for an ongoing program of age-appropriate activities designed to meet the interests, physical, mental, and psychosocial well-being of each resident. This Statute is not met as evidenced by: Based on observation, interview, and RR, the facility failed to ensure there was an ongoing resident-centered activities program that fully identified the residents' needs, for two residents in the sample, R74 and R182. Specifically, the facility failed to act on the residents' need for social engagement, failed to implement activities the residents found meaningful, and failed to develop an activities program that included the residents' stated interests. As a result of this deficient practice, R74 and R182 experienced a decline in their psychosocial well-being as	4 145	Corrective Action R74 participated with group dining on 4/23/21, 4/30/21. Per resident's request, Activities set up new IPad so that she was able to Facetime husband daily, resident also had in-person visits with husband 2-4 times a week. Resident was seen daily by activities to provide conversation per her preference. R74 was discharged on 5/10/21. R182 offered to participate in group dining on 4/19/21 and 4/23/21 but resident declined both times. Resident	6/3/21

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4 145	Continued From page 4 evidenced by their feelings of distress, loneliness, and isolation. This deficient practice has the potential to affect most residents at the facility. Findings include: 1) R74 was an 82-year-old female admitted on 03/24/21 for short-term rehabilitation (STR) following a stroke. On 04/14/21 at 11:00 AM, an interview was done with R74 in her room. R74 stated that since arriving at the facility, she often feels isolated, and does not like the amount of time she has to spend in her room. R74 went on to explain that the only time she leaves her room is for visits once or twice a week, and for therapy. She also expressed frustration that the visits are only twenty minutes long. R74 stated she would like to have activities to do or some type of social interaction, but it was never offered to her. On 04/14/21 at 11:20 AM, an interview was done with Activities Aide (AA)1 outside by the fountain in the front courtyard. AA1 stated that group activities were done with the residents on the long-term care (LTC) wing, while the residents on the STR wing did individual activities. STR resident activities included word search puzzles, playing cards, newspaper, and crochet. AA1 stated that an Activities Aide visited each resident on the STR wing daily. On 04/15/21 at 09:16 AM, in an interview with R74 she was asked if anyone ever came in to offer her newspapers, books, or puzzles. R74 answered, "(they) came in once and offered me a section of the newspaper." R74 said that she would love to just sit and talk to people and would jump at the chance to eat in the dining room, but her only exposure to other residents is sometimes on her way to and from therapy, in	4 145	was provided 1:1 visits daily and resident would refuse at times. R182 was moved to bed B closer to window per request so that resident was able to see out of window, specifically to watch the birds. R182 was discharged on 5/5/21. Identification of others All residents have the potential to be affected by this practice. Room-to-room audit for all residents not on transmission based precautions able to participate with group dining completed on 4/19/21, 4/23/21, 4/30/21 and ongoing. Systemic Changes Effective 4/23/21 Dining room was open for Short Term Rehab (STR) unit for group dining. In addition to dining, group activities initiated on 5/11/21. Activities Director will ensure MDS activities assessment matches participation record with resident's stated interest. Monitoring for Changes The Executive Director or designee will review 5 charts per week x 4 weeks to ensure MDS activities assessment matches participation record with resident's stated interest. 5 Random residents per week x 4 weeks will be interviewed if they are being offered activities that interest them. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 30 days to ensure compliance is achieved and maintained.	

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passing. She stated she feels very isolated and a bit lonely. R74 had a roommate, but social interaction was very limited due to her roommate's diagnoses.

On 04/16/21 at 11:24 AM, an interview was done with RN UCC1 at the nurses' station. The RN UCC1 acknowledged that residents from the LTC wing were able to take their meals in the dining room, on a rotating basis, but the STR residents had not been offered that opportunity. When asked why not, RN UCC1 stated that she did not know.

On 04/16/21 at 01:27 PM, an interview was done with the Activities Director (AD) in the conference room. The AD confirmed that although limited group activities had started in "January, February" on one side of the facility, it had not been opened to include the STR residents yet. The AD stated that there were no activities calendars posted either, "because there are no set activities." Group activities occur on a rotating basis, as time and staffing allowed, on the LTC resident wing only.

In R74's RR, her Minimum Date Set (MDS), Admission Assessment, dated 03/31/21, her activity preferences were marked "very important" to R74 that she do things with groups of people, and that she be allowed to spend time outside when the weather was good. A review of R74's Comprehensive Care Plan (CP), dated 03/31/21, revealed the following planned intervention: "Provide a program of activities that is of interest and empowers ...(R74) by encouraging/allowing choice, self-expression and responsibility."

2) R182 was a 92-year-old female admitted on 03/27/21 for STR following a wedge compression

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4 145	Continued From page 6 fracture (a fracture of her spinal vertebrae). During an interview with R182 on 04/14/21 at 01:24 PM in her room, R182 stated that she used to enjoy watching the birds outside the window in her old room. She was moved to her current room and she can no longer see any birds. No one has offered to take her walking outside, to participate in any group activities, or asked if she wanted to eat in the dining room. Stated since being moved to this room, she is very tired all the time, and does not want to get out of bed, not even to eat or shower. R182 then went on to say, "I just want to go already." When asked where she wanted to go, R182 pointed upwards, closing her eyes. When asked if she meant heaven, R182 responded "yes." In R182's RR, her MDS Admission Assessment, dated 04/03/21, her activity preferences indicated that it was "very important" to R182 that she do things with groups of people, and that she be allowed to spend time outside to get fresh air when the weather was good. A review of R182's CP, revealed the following planned intervention initiated on 04/07/21: "Provide a program of activities that is of interest and empowers the resident by encouraging/allowing choice, self-expression and responsibility."	4 145		
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the	4 149		6/3/21

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4 149	Continued From page 7 physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty- first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided. This Statute is not met as evidenced by: Based on observations, RR and interviews, the facility failed to assure that R283 was provided with care and services that are resident centered and meets each resident's highest practicable physical needs. R283 was observed with two episodes of nausea and emesis (vomiting) and there was no documentation in the progress notes regarding these episodes. Also, there was no documentation that the resident's physician was notified to evaluate and, if indicated, determine a treatment course. This deficient practice could result in potentially affecting all the facility's residents. Finding includes: Cross reference to F580. R283 was admitted to the facility on 04/04/21. Admission diagnoses include cellulitis (inflammation of underlying skin) of left and right	4 149	Corrective action R283 was discharged from the facility on 4/16/2021. RN received 1:1 education on 4/19/2021 related to documentation, to include notifying family and MD on changes in medical status. Identification of others All residents who have changes in medical status are considered to be affected by this practice. Systemic Changes Staff education was initiated on 4/19/21 related to documentation, to include notifying family and MD on changes in medical status. Changes of medical status are discussed in grand rounds, and nursing leadership will inquire if family and MD have been notified of change.	

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4 149	Continued From page 8 lower limb; contact with and (suspected) exposure to COVID-19; muscle weakness; gastro-esophageal reflux disease (GERD) without esophagitis (food pipe inflammation); mild-protein-calorie malnutrition; personal history of other malignant neoplasm (cancerous tumor) of stomach; and acute chronic diastolic (congestive) heart failure. Observed R283 lying on her bed in her room holding a clear plastic receptacle which contained yellow fluid during the initial screening of residents on 04/12/21 at 09:30 AM. R283 was observed holding the receptacle over the left side of the bed. R283 reported feeling nauseous. Second observation at 12:40 PM found R283 in bed with the receptacle containing brown fluid with solid particles in the fluid. The receptacle was on the overbed table next to resident's lunch tray. Inquired whether she felt nauseous, R283 replied she would attempt to eat some lunch. On 04/16/21 at 08:10 AM observed R283 sitting up in bed with breakfast tray, the clear receptacle was placed on the resident's overbed table. On 04/12/21 at 12:20 PM, Registered Nurse (RN)1 reported R283 had been complaining of nausea and had vomited. RN1 also reported waiting on the resident's physician for medication to address nausea. On 04/14/21 at 03:00 PM, phone interviews with R283's representatives were done. The representatives reported that the facility did not inform them of R283 vomiting. A RR of R283's chart was done on 04/16/21 at 07:40 AM. The physician orders which include Calcium Carbonate antacid, 750 (milligram, mg)	4 149	Monitoring Changes The Director of Nursing or designee will conduct 5 random resident audits per week x4 weeks to ensure proper notification and documentation to MD and family regarding medical status changes. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 30 days to ensure compliance is achieved and maintained.	

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tablet, every four hours for GERD, indigestion; Augmentin 500-125 mg, give one tablet by mouth two times a day for cellulitis for 7 (seven) days; and Pantoprazole sodium tablet delayed release, 40 mg, give one tablet by mouth one time a day for GERD.

A review of the Medication Administration Record (MAR) found antacid was administered on 04/14/21 at 02:37 PM and at 07:30 PM which were documented as effective. On 04/15/21 antacid was administered at 07:38 PM, which was documented as effective. R283 was observed with emesis on 04/14/21 at 09:30 AM and 12:40 PM, antacid was not administered until 02:37 PM.

The facility developed a care plan for GERD with the goal for the resident to remain free from discomfort, complication or signs/symptoms related to GERD. The interventions/tasks include: avoid activities that involve bending, lifting; avoid snacks that aggravate the condition; avoid lying down for at least one hour after eating, keep head of bed elevated, encourage to stand/sit upright after meals; avoid overeating, provide small frequent meals rather than 3 large ones, encourage the resident to take their time eating, alternate food with sips of fluids; dietary, avoid foods or beverages that tend to irritate esophageal lining; give medications as ordered; and lab/diagnostic work as ordered, report results to physician and follow up as indicated. There are no interventions to address GERD with vomiting.

Review of the progress notes found no entry related to R283's vomiting. There was no documentation of frequency, description and volume of vomitus and resident's status (nausea,

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food consumption, fluid intake). There was no documentation that R283's physician was notified to assess and determine treatment course if needed.

On 04/19/21 at 08:20 AM interview was conducted with RN UCC1. Inquired whether there are progress notes related to R283 vomiting on 04/14/21. RN UCC1 reported she does not see documentation of the vomiting in the progress notes; however, agreed to contact RN1. Further queried where R283's physician documents notes are located. RN UCC1 responded that the physician's notes are in the resident's paper chart. A RR of R283's paper chart at 08:35 AM found no documentation by the physician related to emesis episodes.

On 04/19/21 at 10:35 AM an interview was conducted with the DON. The DON reported that the RN UCC1 was asked to follow up with RN1. The DON confirmed GERD with reflux, something out of the ordinary requires notification to the doctor and family.

On 04/19/21 at 01:51 PM, RN UCC1 reported R283 was provided with Tums (antacid) which was effective, so the resident's physician was not notified.

During a RR on 04/19/21 at 08:35 AM, it was documented that on 04/16/21, R283 complained of chest pain and was provided with three doses of nitroglycerin (medication to help blood flow to the heart). Administration of the nitroglycerin was ineffective, R283 was sent to the hospital emergency department.

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4 174	Continued From page 11	4 174		
4 174	11-94.1-43(b) Interdisciplinary care process (b) An individualized, interdisciplinary overall plan of care shall be developed to address prioritized resident needs including nursing care, social work services, medical services, rehabilitative services, restorative care, preventative care, dietary or nutritional requirements, and resident/family education. This Statute is not met as evidenced by: Based on interviews and RR, the facility failed to document R20's toothache on his care plan. This deficient practice could have resulted in a worst outcome for R20 due to the facility's lack of follow up with his pain and could potentially affect all the residents in the facility. Finding includes: Cross reference to F791. An initial interview was done with R20 on 04/14/21 at 03:20 PM in his room. R20 stated, "Last week I had a toothache." He further stated that he saw a dentist a couple of weeks prior to the toothache, but his tooth was not hurting then. He used a "prescription mouthwash" to treat the toothache, but staff took it away because it was a prescription medication without a doctor's order. He also stated that he did alert staff about his need for a dentist, but there had been no follow up by staff for a dentist to assess his tooth pain. R20 stated that he did not have a dentist and he had been waiting for a dental appointment. A review of R20's electronic health record (EHR) on 04/16/21 at 08:00 AM, revealed that he was a 56-year-old male admitted for cellulitis	4 174	Corrective Action R20 was seen by facility dentist for follow up of tooth pain on 4/20/2021, and has had weekly follow ups since then. R20 care plan updated on 5/6/2021 to reflect dental status, including intermittent pain. 1:1 Education completed on 5/5/2021 with Unit Manager regarding follow up on toothache and ensuring to follow emergency dental services policy, to include updating care plan timely. Identification of others All residents with tooth pain have the potential to be affected by this practice. One other resident currently residing in facility with complaint of toothache. Dental appointment scheduled for 5/13/2021. Comprehensive care plan reflects toothache and follow up interventions. Systemic Changes Staff education initiated on 4/19/2021 regarding reporting during grand rounds and/or shift to shift report of any complaints of medical status change to include dental concerns and updating the care plan. Nursing leadership to review	6/3/21

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4 174	Continued From page 12 (inflammation of underlying skin) of his right leg and muscle weakness and receiving physical therapy. Review of his care plan revealed that there was no entry for his toothache. The progress notes of his EHR showed "Orders - Administration Note" for Acetaminophen Tablet (pain reliever medication) 325 mg (milligrams) for toothache. Nurses had administered this medication to him for this complaint and monitored for its effectiveness. The progress notes further revealed a "Health Status Note" documented on 04/12/21 at "15:49" (3:49 PM) stated, "Bottle of Orajel (contains numbing medication used for minor mouth and gum irritation) mouthwash found at resident's bedside. Resident stated he ordered Orajel for toothache relief. Reported during grand rounds and instructed by DON (Director of Nursing) to remove Orajel bottle from resident's possession while awaiting orders from MD (Medical Doctor)." The following progress note showed "Orders - Administration Note" documented on 04/13/21 at "14:29" (2:29 PM), "May use 10 (ten) CC (cubic centimeters, equivalent to milliliters) of own supply of Orajel Analgesic (pain reliever medication) mouth rinse every 12 hours as needed for Tooth pain located in med cart." Review of R20's EHR did not reveal that his toothache was resolved. An interview with the Registered Nurse Unit Care Coordinator (RN UCC)3 was done on 04/19/21 at 1:15 PM at the nursing station. When queried about why R20's toothache was not care planned,	4 174	documentation and ensure care plans are updated accordingly. Monitoring for Changes The Director of Nursing or designee will interview 5 random chart reviews per week x 4 weeks to ensure care plans are updated reflecting any dental concerns. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 30 days to ensure compliance is achieved and maintained.	

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4 174	Continued From page 13 she stated that after R20 used his Orajel mouthwash, he stated his toothache was better. An interview was conducted with SW1 on 04/19/21 at 01:46 PM in her office. She stated that the dentist did his annual rounds on the facility's residents on 03/27/21 and assessed R20 but found no problems. She stated that she was unsure if R20 had complained about a toothache and would "have to check" and get back to the surveyor. SW1 did not return to the surveyor with an answer. In a follow up query with SW1 on 04/19/21 at 04:00 PM while the surveyor was exiting the dining room, she stated that R20 had a dental appointment for the following day.	4 174		
4 182	11-94.1-45(a) Dental services (a) Emergency and restorative dental services shall be available to each resident. This Statute is not met as evidenced by: Based on interviews and RR, the facility failed to provide R20 with a follow up to his complaints of a toothache. This deficient practice could have resulted in a worst outcome for R20 due to the facility's lack of follow up with his pain and could potentially affect all the residents in the facility. Finding includes: An initial interview was done with R20 on 04/14/21 at 03:20 PM in his room. R20 stated, "Last week I had a toothache." He further stated that he saw a dentist a couple of weeks prior to the toothache, but his tooth was not hurting then.	4 182	Corrective Action R20 was seen by facility dentist for follow up of tooth pain on 4/20/2021, and has had weekly follow ups since then. 1:1 Education completed on 5/5/2021 with Unit Manager regarding follow up on toothache and ensuring to follow emergency dental services policy, to include updating care plan timely. Identification of others All residents with tooth pain have the potential to be affected by this practice. During grand rounds, 3 other residents	6/3/21

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4 182	Continued From page 14 He used a "prescription mouthwash" to treat the toothache, but staff took it away because it was a prescription medication without a doctor's order. He also stated that he did alert staff about his need for a dentist, but there had been no follow up by staff for a dentist to assess his tooth pain. R20 stated that he did not have a dentist and he had been waiting for a dental appointment. A review of R20's electronic health record (EHR) on 04/16/21 at 08:00 AM, revealed that he was a 56-year-old male admitted for cellulitis (inflammation of underlying skin) of his right leg and muscle weakness and receiving physical therapy. Review of his care plan revealed that there was no entry for his toothache. The progress notes of his EHR showed "Orders - Administration Note" for Acetaminophen Tablet (pain reliever medication) 325 mg (milligrams) for toothache. Nurses had administered this medication to him for this complaint and monitored for its effectiveness. The progress notes further revealed a "Health Status Note" documented on 04/12/21 at "15:49" (3:49 PM) stated, "Bottle of Orajel (contains numbing medication used for minor mouth and gum irritation) mouthwash found at resident's bedside. Resident stated he ordered Orajel for toothache relief. Reported during grand rounds and instructed by DON (Director of Nursing) to remove Orajel bottle from resident's possession while awaiting orders from MD (Medical Doctor)." The following progress note showed "Orders - Administration Note" documented on 04/13/21 at "14:29" (2:29 PM), "May use 10 (ten) CC (cubic	4 182	were identified on 5/6/2021 with dental concerns, appointments with dentist was scheduled for all 3 residents. Systemic Changes Staff education initiated on 4/19/2021 regarding reporting during grand rounds and/or shift to shift report of any complaints of medical status change to include dental concerns. Nursing leadership to review documentation and ensure residents are seen in a timely manner (within 72 hours) or documentation of PO intake and pain until follow up appointment. Monitoring for Changes The Executive Director or designee will interview five random residents per week x 4 weeks to determine if appropriate interventions and follow up completed in a timely manner. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 30 days to ensure compliance is achieved and maintained.	

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4 182	Continued From page 15 centimeters, equivalent to milliliters) of own supply of Orajel Analgesic (pain reliever medication) mouth rinse every 12 hours as needed for Tooth pain located in med cart." Review of R20's EHR did not reveal that his toothache was resolved. An interview with the RN UCC3 was done on 04/19/21 at 1:15 PM at the nursing station. When queried about why R20's toothache was not care planned, she stated that after R20 used his Orajel mouthwash, he stated his toothache was better. An interview was conducted with SW1 on 04/19/21 at 01:46 PM in her office. She stated that the dentist did his annual rounds on the facility's residents on 03/27/21 and assessed R20 but found no problems. She stated that she was unsure if R20 had complained about a toothache and would "have to check" and get back to the surveyor. SW1 did not return to the surveyor with an answer. In a follow up query with SW1 on 04/19/21 at 04:00 PM while the surveyor was exiting the dining room, she stated that R20 had a dental appointment for the following day.	4 182		
4 192	11-94.1-46(i) Pharmaceutical services (i) Appropriately licensed and trained staff shall be responsible for the entire act of medication administration, which entails removing an individual dose from a container properly labeled by a pharmacist or manufacturer (unit dose included), verifying the dosage with the physician's orders, giving the specified dose to the proper resident, and promptly recording the	4 192		6/3/21

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4 192	Continued From page 16 time, route, and dose given to the resident, and signing the record. Only a licensed nurse, physician, or other individual to whom the licensed professional has delegated the responsibility pursuant to chapter 16-89, subchapter 15, may administer medications. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to ensure medications used in the facility were labeled with easily identifiable expiration dates and identifiable medication names. Proper labeling of medications is necessary to promote safe administration practices and decrease the risk for medication errors. This deficient practice has the potential to affect all residents in the facility. Findings include: 1) On 04/16/21 at 08:30 AM, while observing a medication pass with RN2 outside of Room 506, it was noted that medication expiration dates were not visible on the blister packs RN2 was extracting medications from. The top front of each blister pack contained the pharmacy label with clearly identifiable information, but no identified expiration date. When RN2 was asked to point out the expiration dates, she was unable to identify any. RN2 asked RN UCC2 if he was able to identify the expiration date on the label, but he was also unable to. RN UCC2 then called over RN UCC1 who pointed to some indecipherable scribbles written in black ink on the lower half of the pharmacy label and said that that was the expiration date. 2) On 04/16/21 at approximately 08:35 AM,	4 192	Corrective Action On 4/16/2021 RN2 and RNUCC2 were educated on location of expiration date on medication labels. On 4/16/21 ED reached out to Lead Pharmacist at PharMerica regarding concern of legibility on expiration dates. Further follow up with ED, DON, and PharMerica's pharmacy nurse consultant on 5/6/2021 to discuss proper labeling placement and importance of expiration dates legibility. Identification of others All residents have the potential to be affected by this practice. Systemic Changes Pharmacy nurse consultant/designee will initiate education with pharmacist and pharmacy techs on 5/07/2021 regarding proper label placement and legible expiration dates; Facility education initiated on 5/6/2021 with licensed nurses regarding placement of medication label, expiration date location, and ensure legibility, upon receiving medication delivery. Monitoring for Changes	

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4 192	Continued From page 17 another observation was done at the medication cart outside Room 506. RN2 was preparing Humulin 70/30 insulin (medication for high blood sugar) pen for a resident. The pharmacy label covered the name of the insulin contained inside. When RN2 was asked how she confirmed that the insulin she was about to give was Humulin 70/30, she confirmed that she could not. RN2 then proceeded to carefully peel off the pharmacy label and moved it down enough so that she could match the name of the insulin to the pharmacy label and the physician order.	4 192	The Director of Nursing or designee will conduct 5 random medication label audits per week x 4 weeks to ensure legible expiration dates and correct label placement. The Director of Nursing or designee will also conduct 5 random nurse interviews to determine if they know location of expiration date on medication labels. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 30 days to ensure compliance is achieved and maintained.	
4 203	11-94.1-53(a) Infection control (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the correct hand hygiene procedure was followed, and that soiled laundry was stored properly. This deficient practice could potentially spread infections throughout the facility and affect residents, staff and visitors. Findings include: 1) On the morning of 04/14/21, RN UCC1 provided orientation to the COVID-19 unknown	4 203	Corrective Action 1. Staff education was initiated on 5/5/21 regarding proper donning and doffing procedure. Staff inservice scheduled on 5/12 and 5/14. 2. Triple linen sorter middle bin, cover was replaced on 4/14/21. Identification of Others All residents have the potential to be affected by this practice.	6/3/21

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4 203	Continued From page 18 status resident unit staff members. RN UCC1 instructed them to don gown and gloves when entering residents' rooms. The RN UCC1 also instructed to use the "purple gown" which is stored on the clean linen cart which also contains resident gowns. Observation on 04/14/21 at 10:00 AM on the COVID unknown status resident unit, Certified Nurse Aide (CNA)1 wheeled R80 back to the unit. CNA reported R80 was returning to the unit after being weighed. CNA went to the covered clean laundry cart, removed a cloth gown then performed hand hygiene with alcohol-based hand sanitizer. CNA donned the cloth gown, performed hand hygiene and donned gloves. Observed signage posted on the unit for donning personal protective equipment (PPE). The procedural instructions for the donning of PPE include: hand hygiene, gown, hand hygiene, gloves. On 04/19/21 at 09:33 AM, interview was done with Infection Preventionist (IP) in the conference room. Inquired whether staff are to perform hand hygiene prior to removing a gown from the linen cart. IP confirmed hand hygiene should be performed before taking a gown from the clean linen cart. 2) On 04/14/21 at 09:06 AM in the hallway between rooms 103 and 105, surveyor observed a triple linen sorter with the bin on the left covered and labeled "Soiled Linen", the middle bin without a cover or label, and the bin on the right covered and labeled "Resident Personal Linen." Inside the middle bin without a cover or label was a wet white towel.	4 203	A 100% audit was completed by Housekeeping supervisor on 4/14/2021 ensuring all soiled linen cart lids were covered and functioning properly. Systemic Changes 1. Infection Preventionist initiated education regarding donning and doffing procedures, hand hygiene and linen management. 2. Staff education was initiated on 5/5/21 of reporting broken equipment related to infection control. 3. RCA initiated regarding infection control findings. Monitoring Changes The Director of Nursing or designee will conduct 5 random staff audits per week x4 weeks to ensure staff are properly donning and doffing PPE. The Executive Director or designee will conduct 5 random cart audits per week x4 weeks to ensure all soiled linen cart lids are covered and functioning properly. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 30 days to ensure compliance is achieved and maintained.	

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4 203	Continued From page 19 In a concurrent observation and interview with CNA2 on 04/14/21 at 09:12 AM in the hallway, CNA2 stated the middle bin is for soiled linens and should be covered. CNA2 proceeded to look around the bin then walked away leaving the bin uncovered. A subsequent observation on 04/14/21 at 09:41 AM found the middle bin was still left uncovered. In an interview with the Infection Preventionist (IP) on 04/19/21 at 09:34 AM in the conference room, she stated that the linen separator bins should be covered to contain the bacteria from soiled laundry.	4 203		