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	125002	A. BUILDING ______ B. WING ______	10/28/2021

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F 000	INITIAL COMMENTS A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the Hawaii Department of Health, Office of Health Care Assurance. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 10/25/21 to 10/28/21 Survey Census: 34 Sample Size: 14 Supplemental Residents: 0	F 000		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure timely treatment and services related to vision were provided for one (Resident (R) 20) of three reviewed for communication and sensory problems in a total	F 685	CORRECTIVE ACTION OF RESIDENT IDENTIFIED: Resident 20 vision consult completed pending receipt of new eye glasses.	11/30/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 11/11/2021

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

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F 685	Continued From page 1 sample of 14 residents. Findings include: Review of a document provided by the facility titled "Patient Registration Form," indicated R20 was admitted to the facility on 05/20/21. Review of R20's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 08/18/21, revealed the resident had a "Brief Interview for Mental Status (BIMS)," score of 15 out of 15 which indicated the resident was cognitively intact. Review of a document provided by the facility titled "Consultation Record," dated 06/28/21 indicated R20 informed the eye doctor that he was near sighted (cannot see long distances). Review of a document provided by the facility titled "Nurse Note," dated 06/28/21 indicated R20 had an eye exam scheduled and prescription glasses had been ordered. Review of a document provided by the facility titled "Nurse Note," dated 08/12/21 indicated the nurse faxed R20's eye prescription to a national vision center. Review of a document provided by the facility titled "Nurse Note," dated 08/12/21 indicated a nurse received a return call from the national vision center. The nurse was informed that they did not take R20's insurance. The entry revealed the nurse then faxed over the resident's eyeglass prescription to a local vision center on 08/12/21. Review of a document provided by the facility	F 685	IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected. Residents were interviewed and assessed to identify any vision needs. Director of Nursing and/or Designee will be responsible for on-going compliance. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE: A vision log was developed to track resident vision needs. Resident identified will receive timely treatment and services related to vision. Education to be completed with all license nursing staff on the new vision log by November 30, 2021. Director of Nursing and/or Designee will monitor vision log to confirm timely treatment and services related to vision. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS: Director of Nursing and/or Designee will audit vision log for 90 days to monitor the effectiveness of these changes and to	

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F 685	Continued From page 2 titled "Nurse Note," dated 08/25/21 indicated facility staff called the local vision center to find out the status of R20's prescription glasses. The note indicated the eye center was closed and staff would attempt the next day. Review of a document provided by the facility titled "Social Services Note," dated 10/19/21 indicated R20 wanted an update on the status of his prescription eyeglasses. It was documented the Social Worker followed up with nursing and was informed national vision center would not fill his eyeglass prescription due to not accepting R20's insurance. The entry revealed the Social Worker called the local vision center and was informed they did not receive a fax regarding R20's prescription for glasses on 08/12/21. During an interview on 10/25/21 at 11:11 AM, R20 stated he had an eye exam a few months ago and still had not received his prescription eyeglasses. The resident stated he was near sighted. During an interview on 10/26/21 at 3:13 PM, the Social Worker stated the problem began with the initial eye exam. The doctor who conducted the eye exam did not fill eyeglass prescriptions. The Social Worker stated R20 had to wait a long time before the doctor's office let the facility know the doctor did not fill eyeglasses. The Social Worker confirmed it was not until 08/12/21 that the eye prescription was sent to the national vision center. The Social Worker also confirmed the national vision center did not participate in R20's insurance plan and the eye prescription was then sent to a local vision center. The Social Worker stated there was a COVID outbreak on 09/04/21 and local vision center was closed. The Social	F 685	ensure correction is achieved and sustained. Results of this audit will be reported monthly to the QAPI Committee	

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F 685	Continued From page 3 Worker stated the facility did not have a specific policy for vision or for obtaining prescription eyeglasses. During an interview on 10/28/21 at 12:26 PM, the Regional Nursing Director stated her expectation was to follow up on the needs of the resident.	F 685		
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 observations, interviews, and record review, the facility failed to ensure one resident (Resident (R) 23) of one, who was reviewed for positioning and mobility was provided with restorative services per her plan of care, in a total sample of 14 residents. R23 did not receive assistance to apply her splints per her plan of care. This failure had the potential to affect any	F 688	CORRECTIVE ACTION OF RESIDENT IDENTIFIED: All staff educated immediately on Resident 23 care plan for use of splint. IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED,	11/30/21

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F 688	Continued From page 4 resident who needed assistance implementing restorative care interventions. Findings include: The facility's Restorative/Splinting Policy was requested by the survey team, however no policy related to restorative care/splinting was provided to the team prior to survey exit. During an interview conducted with the Administrator on 10/28/21 at approximately 9:56 AM, she stated the facility did not have a policy addressing restorative care/splinting. Review of R23's undated "Patient Registration Form," provided directly to the survey team, revealed R23 was admitted to the facility on 08/20/20, with diagnoses which included history of stroke and hemiplegia (paralysis of one side of the body). Review of R23's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 08/21/21, indicated a Brief Interview for Mental Status (BIMS) score of eight, indicating moderate cognitive impairment. The MDS indicated R23 had Range of Motion (ROM) impairment to her upper and lower extremities on both sides of her body, and that a splint or brace had not been applied to the resident on any of the seven days prior to the ARD. Review of R23's "General Care Plan," dated 09/13/21 and provided directly to the survey team, indicated staff was to apply a resting hand splint the resident's right upper extremity and conduct a skin assessment with the application of the splint every day. The splint was to remain in place from 10:00 AM until 2:00 PM daily.	F 688	AND WHAT CORRECTIVE ACTION WILL BE TAKEN: An audit was completed to identify residents requiring restorative care interventions. All residents identified will ensure care interventions are done as stated in plan of care. All residents care plans updated to include appropriate interventions. Director of Nursing and/or Designee will be responsible for on-going compliance. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE: Director of Nursing and/or Designee will review splint worklist daily x 30 days and weekly x 60 days to confirm splint use and/or documented refusals. Director of Nursing and/or Designee will conduct spot check audit of 20% or residents with care planned splint use and confirm placement weekly x 90 days. MONITORING CORRECTIVE ACITON FOR SUSTAINED CORRECTIONS: Director of Nursing and/or Designee will audit for 90 days to monitor for the effectiveness of these changes and to ensure correction is achieved and sustained.	

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F 688	Continued From page 5 Review of R23's facility provided "Orders: Item Detail Report," dated 09/09/20 through current, indicated an order for a resting hand splint to be placed on the resident's right upper extremity for up to four hours per day as tolerated. Review of R23's "Occupational Therapy (OT) Note", dated 09/22/20 and provided directly to the survey team, read, "Spoke with [Nurse] regarding adherence to the splinting schedule. Per discussion, resident tolerating 4 hours per day without problems with skin integrity. Nursing staff with no concerns at this time;" and "Nursing to continue with resting hand splint to RUE [right upper extremity], 4 hrs [hours] daily." Observation on 10/25/21 at 1:33 PM revealed R23 was lying in her bed. The resident's right arm and hand were contracted. R23 was not observed to be wearing a brace or splint of any kind. A splinting device was observed to be hanging on the device which mounted the television to the resident's bed. Observation on 10/26/21 at 11:22 AM revealed R23 was lying in her bed watching television. The resident was not wearing a splint or brace to her right upper extremity. A splint continued to hang on the resident's television mounting device next to her bed. Observation on 10/26/21 at 1:30 PM revealed R23 was lying in her bed. The resident was not wearing a splint or brace. A splint continued to hang on the television mounting device next to the resident's bed. During an observation and interview with the	F 688	Results of this audit will be reported to the QAPI committee.	

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F 688	Continued From page 6 Social Worker (SW) on 10/26/21 at 3:45 PM, the surveyor and the SW observed R23 together. R23 was lying in her bed watching television and was not wearing a splint on her upper right extremity. When R23 was asked, by the SW, where her splint was, the resident pointed to the splint hanging on the television mounting device next to her bed. When asked, by the surveyor, if she would wear the brace if it was applied to her right upper extremity, R23 nodded yes. When the resident was asked, by the surveyor, if staff applied the splint to her upper extremity every day, R23 said, "Not always." R23 confirmed the splint had not been applied on that day or the day before. During an interview with the Administrator on 10/28/21 at 9:56 AM, she stated, "If [a splint] was ordered and on the plan of care, staff should be putting it [the splint] on per the order and/or the plan of care." During an interview with Certified Nursing Assistant (CNA) 8 on 10/28/21 at 10:10 AM, she indicated the resident's splint was to be applied every day from 10:00 AM until 2:00 PM. She indicated she applied the resident's splint every time she worked with the resident; however, she was unsure if other staff were doing the same. During an interview with the Regional Nursing Director on 10/28/21 at 12:32 PM, she stated it was her expectation splints would be applied according to a resident's physician's orders and their plan of care. She indicated any refusals to wear a splint by a resident should be documented in the resident's clinical record.	F 688		
F 692 SS=G	Nutrition/Hydration Status Maintenance	F 692		11/30/21

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F 692	Continued From page 7 CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to ensure adequate interventions were provided to establish proper nutrition for one (Resident (R) 17) of three reviewed for nutrition in a total sample of 14 residents. The facility failed to re-weigh R17 per facility policy when a significant weight loss was first identified, failed to immediately assess R17's nutritional status after a significant weight loss, and failed to immediately notify R17's physician of the significant weight loss. Findings include:	F 692	CORRECTIVE ACITON OF RESIDENT IDENTIFIED: Resident 17 has been identified and continues to be reviewed in weekly Skin and Weight meeting until stability is demonstrated and maintained for 4 weeks. Medical Director has been updated and aware of Resident 17 current plan of care. IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED,	

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F 692	Continued From page 8 Review of an undated document provided by the facility titled "Patient Registration Form," indicated R17 was admitted to the facility 03/23/21, with diagnoses that included hypertension (elevated blood pressure), left-sided weakness due to a cerebral vascular accident (CVA; stroke), and dementia. Review of a care plan provided by the facility, dated 03/23/21 indicated R17 was nutritionally at risk. The care plan directed staff to encourage R17 to eat and drink, to monitor monthly and as needed weights, to discuss in the interdisciplinary team (IDT) meetings, and to notify the physician and Registered Dietician (RD) of significant weight loss or gain. Review of a document provided by the facility titled, "New Nutrition Assessment/MDS (Minimum Data Set) Note" dated 03/31/21 documented R17 weighed 157.7 pounds on 03/23/21. Review of a document provided by the facility titled "Weight History," dated 05/02/21 indicated R17 weighed 156.5 pounds. Review of R17 significant change "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 05/19/21, revealed the resident had a "Brief Interview for Mental Status (BIMS)," score of two out of 15, indicating severe cognitive impairment. The assessment revealed the resident was independent with eating with set up from staff. The assessment revealed the resident weighed 157 pounds and the resident's height was five feet, six inches. The assessment indicated the Care Area Assessment (CAA) triggered under nutrition and directed the staff to develop a care plan.	F 692	AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected by this deficiency. An audit to identify residents with significant weight change has been completed and properly addressed following Skin and Weight Policy and Protocols. Director of Nursing and/or Designee will be responsible for on-going compliance. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE: The following education will be completed by nursing staff and Registered Dietician by November 30, 2021: 1. LTC Skin and Weight Policy and Procedure; 2. Notification protocol; 3. Weight education. A significant weight notification tool was developed to monitor and track significant weight changes. Director of Nursing and/or Designee will monitor residents weekly weight report to identify any significant changes in weight and report in the weekly Skin and Weight meeting as appropriate. Administrator and/or Designee will attend weekly Skin and Weight meeting for 90 days to ensure compliance with Skin and Weight policy and protocol.	

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F 692	Continued From page 9 Review of a care plan provided by the facility, dated 05/26/21 indicated R17 was nutritionally at risk and the resident was on a mechanically altered diet. The care plan indicated staff were to notify the physician and RD of significant weight loss or gain for R17. Review of a document provided by the facility titled "IDT (Interdisciplinary Team) Meeting Notes," dated 06/02/21 indicated R17's weight remained stable over a 30-day period. The document indicated the resident was on a regular/chopped diet, received Ensure Plus three times a day, was eating approximately 50 percent of his meals, and was consuming 100 percent of his nutritional supplements. The document indicated R17 voiced he had a poor appetite since his stroke. Review of a document provided by the facility titled "Weight History," dated 06/02/21 showed R17 weighed 153.2 pounds, indicating a 2.85 percent loss since 03/23/21. Review of documents provided by the facility titled "Nurse Note," for the months of July 2021 and August 2021 failed to address changes in R17's weight. Review of a document provided by the facility titled "Weight History," dated 07/09/21 showed R17 weighed 150.6 pounds, indicating a 4.5 percent loss since 03/23/21. Review of a document provided by the facility titled "Weight Chart," dated 08/08/21 indicated R17 sustained significant weight loss of 13.8 pounds from the last recorded weight of 150.6	F 692	MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS: Director of Nursing and/or Designee will audit significant weight change report for 90 days to monitor the effectiveness of these changes and to ensure correction is achieved and sustained. Results of this audit will be reported to the QAPI committee meeting.	

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F 692	Continued From page 10	F 692		

pounds. The resident's current weight of 136.8 pounds indicated a 9.16 percent loss since 07/09/21. The document revealed a Registered Nurse (RN) was notified of the weight loss of over three percent. There was no indication of what steps were taken by the RN after the electronic notification alert was made in the medical record. There was no evidence to show R17 was re-weighed or that weekly weights were implemented by nursing.

Review of an updated care plan provided by the facility, dated 08/23/21 indicated R17 was nutritionally at risk. The care plan did not address that R17 sustained a significant weight loss. The care plan indicated the staff were to encourage the resident to eat during mealtimes, provide nutritional supplements and snacks as ordered, and to notify the physician and RD of a significant weight loss or gain.

Review of a document provided by the facility titled "IDT Quarterly Screen," dated 08/26/21 indicated a chart review was conducted and R17 continued to require setup assistance for self-feeding. The form failed to address R17's significant weight loss as identified on the 08/08/21 "Weight Chart."

Review of a document provided by the facility titled, "Nurse Note" dated 08/26/21 documented R17 was started on antibiotics for a Urinary Tract Infection.

A document provided by the facility titled "Nutrition Assessment," dated 09/16/21, was completed by RD9. The form documented R17's last weight was on 08/08/21 with a result of 136.8 pounds. The note continued and indicated if that

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F 692	Continued From page 11 weight was accurate, R17 sustained a significant weight loss of 12.6 percent. This would indicate a total loss of 20.9 pounds over the past six months, or a 13.3 percent overall change in the resident's weight. The note indicated the resident required 1550 to 1870 kilocalorie (kcal; 1 kilocalorie equals 1000 calories) per day. RD9 wrote R17 received Ensure Plus three times a day which provided the resident 350 kcal and 13 grams of protein each (Three Ensure Plus supplements would provide a total of 1050 kcal per day). RD9 documented the resident consumed 20 percent of his meals and approximately 75 percent of supplements. RD9 recommended the resident remained on a regular chopped diet with texture as tolerated, and to continue to offer him Ensure Plus three times a day. There was no evidence the resident's physician was notified of the significant weight loss at this time. Review of a document provided by the facility titled "Weight History," dated 09/19/21 showed R17 weighed 127.2 pounds, indicating a 19.34 percent loss since 03/23/21. The document provided by the facility titled "IDT Meeting Notes," was signed by the physician on 09/21/21, indicating he was made aware of R17's significant weight loss 44 days after it was identified. The form documented R17 weighed 136.8 pounds on 08/08/21 and his body mass index (BMI) was 22.1, which fell within acceptable range for his age. The IDT notes continued, and indicated if the 08/08/21 weight was accurate, the resident lost 13.8 pounds over one month which was a 9.2 percent weight loss and would be considered a significant weight loss. The form lacked evidence that new orders were received	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125002	A. BUILDING ____ B. WING ____	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILO MEDICAL CENTER	**1190 WAIANUENUE AVENUE HILO, HI 96720**

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F 692	Continued From page 12 from the physician at that time. Review of a document provided by the facility titled "Weight History," dated 09/27/21 showed R17 weighed 128.2 pounds, indicating an 18.71 percent loss since 03/23/21. Review of a document provided by the facility titled "Nurse Note," dated 09/29/21, revealed staff notified R17's physician was of the resident's decreased appetite and received new orders to increase the resident's Remeron (an appetite stimulant/mood stabilizer) to 15 milligrams (mg) to be administered daily at bedtime. Review of a document provided by the facility titled "Weekly Skin/Weight Condition Review," dated 10/01/21, indicated R17 sustained a significant weight change, received a regular chopped meal, was noted to be refuse more meals, and received Ensure Plus three times per week, as well as Magic Cup twice a day at 2:00 PM and 8:00 PM. Review of a document provided by the facility titled "Weight History," dated 10/03/21 showed R17 weighed 125.9 pounds, indicating a 20.16 percent loss since 03/23/21. Review of a document provided by the facility titled "Weekly Skin/Weight Condition Review," dated 10/08/21, showed R17's was 124.8 pounds, indicating a 20.86 percent loss since 03/23/21. RD9 documented food preferences were discussed with R17, and she updated his menu. The document revealed R17's received Ensure Plus with meals and snacks, totaling six times daily. The recommendations were to continue weekly weights.	F 692		

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	125002	A. BUILDING ______ B. WING ______	10/28/2021

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F 692	Continued From page 13	F 692		

Review of a document provided by the facility titled "Weight History," dated 10/17/21 showed R17 weighed 128.6 pounds, indicating an 18.45 percent loss since 03/23/21.

Review of a document provided by the facility titled "Nutrition Assessment," dated 10/19/21 indicated R17's last weight was 128.9 pounds as of 10/17/21, and he had a BMI of 20.8, which fell below the resident's optimal range for his age. The entry revealed R17 had a noted decline in intake noted over the past three months. The document revealed R17's Ensure Plus was increased from three times daily to six times a day on 10/06/21 due to continued weight loss with consistent supplement intake. The form documented R17 had a weight loss of one percent over the last 30 days, 16.4 percent over the last three months, and 20.1 percent over the past six months.

Review of an updated care plan provided by the facility, dated 10/21/21 indicated R17 was nutritionally at risk and had sustained a significant weight loss.

Review of a document provided by the facility titled "Weekly Skin/Weight Condition Review," dated 10/21/21 indicted R17's current weight was 128.6 pounds. The document indicated R17 consumed more supplements than actual food. The document revealed the resident's physician was notified and the current treatments for the resident were to provide Ensure Plus six times a day. RD9 indicated she met with R17 and addressed food preferences and updated the menu.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125002	A. BUILDING ______ B. WING ______	10/28/2021

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F 692	Continued From page 14	F 692		

During an observation on 10/26/21 at 12:07 PM, staff delivered R17's meal tray which included a bottle of Ensure Plus. The staff member set up R17's meal, opened the bottle of Ensure Plus and, handed it to the resident. R17 was observed to drink the Ensure Plus. R17 was served a regular chopped meal, he was able to feed himself, and consumed approximately 90 percent of the meal during this observation.

During an interview on 10/26/21 at 1:36 PM, RD9 stated R17's appetite was not good, and he had been eating less. RD9 stated R17 received supplements which were increased from three times a day to six. RD9 stated R17 had an increase in Remeron, and she had addressed the resident's food preferences following the noted weight loss. RD9 stated she kept track of residents' weights on a monthly basis and if a resident was identified with a significant weight loss, they were added to a weekly meeting for review. The meeting included the Director of Nursing (DON), RAI Coordinator, and the Assistant Administrator.

During an interview on 10/27/21 at 9:39 AM Certified Nursing Assistant (CNA) 8 stated the staff could see a resident's weight change in the medical record and if there was a weight loss staff were to notify the nurse.

During an interview on 10/27/21 at 9:36 AM, Registered Nurse (RN) 11 stated the CNAs were to inform the nurses if there was a weight loss for a resident. The nurse then needed to determine if there was a discrepancy. If there was a question about a discrepancy, the resident would be re-weighed. Nursing should notify the physician and the RD immediately if a weight loss was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125002	A. BUILDING ______ B. WING ______	10/28/2021

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HILO MEDICAL CENTER	1190 WAIANUENUE AVENUE HILO, HI 96720

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F 692	Continued From page 15	F 692		

identified so they could investigate causes and develop interventions.

During an interview on 10/27/21 at 10:05 AM, RD9 stated R17 should have been re-weighed by nursing after 08/08/21 since the resident sustained over a three percent weight loss.

During an interview on 10/27/21 at 11:59 AM, RD10 confirmed he was the supervisor of RD9. He stated he reviewed RD9's documentation and confirmed RD9 did not address R17's weigh loss until 09/24/21.

During an interview on 10/28/21 at 9:04 AM, RD9 and RD10 were both present. RD9 stated she would review residents' weights monthly to identify significant weight changes. RD9 stated if a resident sustained a significant weight loss, staff were to implement weekly weights so the resident could be monitored more closely. RD9 stated nursing was to re-weigh the resident if the resident had a three percent or more weight loss to ensure accuracy. RD9 stated R17 had consistent weights until 08/08/21 and staff did not re-weigh or implement weekly weights per the facility's protocol. RD9 stated she was on leave multiple times during August 2021. RD10 stated RD9 missed a QAPI meeting while on leave, which was normally the process used for notifying the physician of a weight change. RD10 further stated typically another RD from the hospital side would step in and address the basic needs of a resident when the assigned RD was not available. RD10 stated since they were in a rural area, RD positions were short. During this interview, both RD9 and RD10 reported they were unable to locate documentation to show the physician was notified of the significant weight change when

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	125002	A. BUILDING ______ B. WING ______	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILO MEDICAL CENTER	**1190 WAIANUENUE AVENUE HILO, HI 96720**

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F 692	Continued From page 16 identified. RD9 stated she increased R17's nutritional supplement on 10/06/21 to address the resident's significant weight loss. During an interview on 10/28/21 at 12:22 PM, the Regional Nursing Director stated she reviewed the clinical records for R17 and confirmed the resident sustained a significant weight loss. The Regional Nursing Director stated her expectation was for nursing to re-weigh the resident if a three percent or greater weight loss was noted. The Regional Nursing Director stated if the resident was recognized as having a weight loss or gain staff were to implement weekly weights. The Regional Nursing Director stated she was aware, the clinical record lacked evidence that interventions were implemented when R17's weight loss was identified. She reported her expectations would be for the RD to be involved and review the services being provided to the resident on a weekly basis. The Regional Nursing Director confirmed there was a lapse before anything was done for R17 after the significant weight loss. During an interview on 10/28/21 at 1:07 PM, the Medical Director stated he believed he became aware of R17's weight loss approximately two months ago (September 2021). The Medical Director stated a nurse manager informed him of the weight loss of R17. Once he was made aware, he ordered blood work and a CT (Computed Tomography) scan of the resident's brain. The Medical Director stated the dietary supplements were not really effective and the decline in R17's weight was possibly related to his dementia diagnosis. The Medical Director stated the facility attempted to find an etiology and measures to increase the resident's caloric intake	F 692		

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	125002	A. BUILDING ______ B. WING ______	10/28/2021

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HILO MEDICAL CENTER	1190 WAIANUENUE AVENUE HILO, HI 96720

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F 692	Continued From page 17 to possibly reverse the weight loss. Review of a document provided by the facility titled "LTC (Long-Term Care) Skin & Weight Meeting," dated October 2021, indicated the purpose was ". . .To evaluate residents with significant weight changes. . .and to ensure timely intervention by the facility Interdisciplinary Team. . .Skin & Weight meeting will be conducted by the facility on a weekly basis. . .Residents who demonstrate a significant change in condition, significant weight loss/gain or gradual, consistent weight loss will be placed on weekly weights until stability is demonstrated and maintained for at least four weeks. Review of such residents will be documented using the Skin/Weight Condition Review form and placed in the LTC Skin and Weight note in the EMR (electronic medical record). The nursing staff will ensure the attending physician and/or ANP (Advance Nurse Practitioner) is informed of the skin/weight change. . .The Skin/Weight Condition Review placed in the resident's records will serve as documentation of each resident reviewed. Physician's orders will be required for new interventions deemed necessary by the Skin and Weight Committee. . ."	F 692		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	F 700		11/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125002	A. BUILDING ______ B. WING ______	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 700	Continued From page 18 §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and review of the facility's policy, the facility failed to ensure an assessment for the appropriate use of side rails to assist with bed mobility was completed and accurately care planned for one resident (Resident(R) 7) of one reviewed for the use of side rails in a total sample of 14 residents. Findings include: Review of the facility's policy titled, "Bed Rails Policy," dated 05/2021 read, in pertinent part, "Purpose: To encourage the use of alternatives, and to use the least restrictive and most appropriate bed rail(s) if needed for therapeutic treatment;" and "Policy: The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the patient/resident for risk of entrapment from bed	F 700	CORRECTIVE ACTION OF RESIDENT IDENTIFIED: Resident 7 assessed immediately and removal of bed rails completed. Resident 7 assessment completed to ensure appropriate use of bed rails to assist with bed mobility. Resident 7 care plans updated. IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected. An audit and assessments were completed to identify residents who met the criteria for side rail use to assist with	

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	125002	A. BUILDING ______ B. WING ______	10/28/2021

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F 700	Continued From page 19 rails prior to use. (2) Review the risks and benefits of bed rails with the patient/resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the patient/resident's size and weight. (4) Follow the manufacturer's recommendations and specifications for installing and maintain bed rails." Review of R7's undated "Patient Registration Form," provided directly to the survey team, revealed R7 was admitted to the facility on 10/01/21 with diagnoses which included history of stroke and dementia. Review of R7's admission "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 07/23/21, indicated R7 was severely cognitively impaired. The assessment indicated the resident had both short and long-term memory deficits. The assessment indicated R7 required physical assistance from two or more staff members for bed mobility, required extensive physical assistance from two or more staff members for transfers, was not steady when moving from a sitting to a standing position, and had not experienced any falls in the previous six months. The assessment indicated bed rails were not in use for R7. Review of R7's "Falls Care Plan," dated 10/01/21 and provided directly to the survey team, indicated the resident was to be encouraged to use two side rails to aid with bed mobility and transfer. The care plan read, "All side rails up to accommodate the use of air mattress for safety." Review of R7's "Restraint Assessment," dated	F 700	bed mobility and appropriately care planned. Director of Nursing and/or Designee will be responsible for ongoing compliance. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE: Use of bed rails will be assessed and reviewed upon admission, quarterly, and as needed. Education will be completed by November 30, 2021 on Bed Rail Policy with all nursing staff. MONITORING CORRECTIVE ACTIONS FOR SUSTAINED CORRECTIONS: Director of Nursing and/or Designee will audit for 90 days to monitor for effectiveness of these changes and to ensure correction is achieved and sustained. Results of this audit will be reported to the QAPI committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125002	A. BUILDING ______ B. WING ______	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 700	Continued From page 20	F 700		

10/12/21 and provided directly to the survey team, indicated the resident had impaired vision and was disoriented, forgetful, and confused. The assessment documented, "Resident is using 2 upper bed rails to assist with bed mobility and positioning."

Review of R7's "Orders: Item Detail Report," dated 10/20/21 and provided directly to the survey team, indicated an order for "All side rails up to accommodate use of air mattress for safety."

Review of R7's "Bed Rail Use Consent Form," dated 10/20/21, provided directly to the survey team, indicated bed rails were to be used for R7 for aiding in turning and repositioning within the bed, providing a hand-hold for getting into or out of bed, for providing a feeling of comfort and security, and for providing easy access to bed controls. The form indicated verbal consent from the resident's responsible party.

Observation on 10/25/21 at 1:45 PM revealed R7 was lying in his bed Three of the side rails on the resident's bed were in the raised position (two upper approximately 1/3 rails and one lower approximately 1/4 rail). The resident was awake and observed attempting to put his left leg up and over the two raised rails on the on the right side of the bed. The resident was not able to get over the rails and out of the bed due to apparent weakness.

Observation on 10/26/21 at 1:27 PM revealed R7 was observed sleeping in bed. The two upper 1/3 size rails were in the raised position on the resident's bed.

Observation on 10/27/21 at 8:43 AM revealed R7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125002	A. BUILDING ______ B. WING ______	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 700	Continued From page 21	F 700		

was observed in bed asleep on. All four of the rails on the resident's bed were in the raised position.

Observation 10/27/21 at 10:44 AM revealed R7 was observed in bed asleep on. All four rails on the resident's bed remained in the raised position.

Observation on 10/28/21 at 10:00 AM revealed R7 was observed in his bed. The resident was awake, and all four rails were in the raised position.

During an interview with Licensed Practical Nurse (LPN) 6 on 10/27/21 at 10:47 AM, she stated, "[R7] should not have four raised rails. Only the top two [rails] should be raised."

During an interview with Certified Nursing Assistant (CNA) 7 on 10/27/21 at 10:49 AM, she stated, "We put all four rails [on R7's bed] up because there is an air mattress on the bed, and four rails need to be up to keep the mattress from slipping off the bed".

During an interview with CNA8 on 10/28/21 at 10:13 AM, she stated, "We are using four rails [on R7's bed] because the mattress moves side to side. It's for safety. He [R7] does use the upper rails to turn himself and move up in the bed."

During an interview with the Administrator on 10/28/21 at 9:54 AM, she stated, "Therapy comes in and assesses residents for the use of side rails on beds." The Administrator indicated she would look for therapy's assessment for the use of R7's side rails.

During a follow up interview with the Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125002	A. BUILDING ______ B. WING ______	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 700	Continued From page 22 on 10/28/21 at 10:50 AM, she stated she was unable to locate a therapy assessment for the use of R7's side rails. She stated orders for the screening of all residents using side rails had just been put in the system. During an interview with the Regional Nursing Director on 10/28/21 at 12:23 PM, she stated her expectation related to the use of side rails was that there should be an assessment for side rail use prior to application, and the resident should benefit from the use of the side rails. She stated R7's top two rails were being used for bed mobility and she stated, "They [staff] put the bottom rails up for the use of the [R7's] air mattress. That is not our policy. Our policy does not state they are to use the rails with an air mattress."	F 700		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to ensure a medication error rate of less than five percent. A total of two errors were made during medication administration for one resident (Resident (R) 12) of six residents who were observed for medication administration. The facility's medication error rate was 8.0%. Findings include:	F 759	CORRECTIVE ACTION OF RESIDENT IDENTIFIED: Registered Nurse 5 was immediately educated by the Regional Nursing Director regarding the PharMerica Subcutaneous Insulin Policy and Procedure. Regional Nursing Director immediately	11/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125002	A. BUILDING ______ B. WING ______	10/28/2021

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F 759	Continued From page 23 Review of the facility's "Subcutaneous Insulin Policy," dated 05/2016, read, in pertinent part, "Always perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by: ensuring that pen and needle work properly, and removing air bubbles;" and, "Tap the insulin reservoir so that any air bubbles rise up towards the needle. Press the injection button all the way in. Check if insulin comes out of the needle tip;" and "You may have to perform the safety test several times before the insulin is seen. If no insulin comes out, check for air bubbles and repeat the safety test two more times to remove them;" and "(After injecting the insulin) Keep the injection button pressed all the way in and slowly count to 10 before you withdraw the needle from the skin. This ensures the full dose will be delivered." Review of R12's undated "Patient Registration Form" provided directly to the survey team, revealed R12 was admitted to the facility on 05/14/21 with diagnoses which included type 2 diabetes mellitus. Review of R12's "Medication Detail Report," dated 10/10/21 and provided directly to the survey team, indicated an order for the resident to receive Basaglar Insulin (medication used to treat diabetes) 85 units via Kwikpen (type of insulin medication administration tool) every morning subcutaneously. Observation on 10/26/21 at 9:37 AM revealed Registered Nurse (RN) 5 administered R12's insulin. The insulin had to be administered via two separate injections using two separate insulin pens due to the large dose required. 80 units was	F 759	developed a reference binder for each medication cart with PharMerica Insulin guidance sheets. IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected. Director of Nursing and/or Designee will be responsible for ongoing compliance. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE: Education will be completed by November 30, 2021 to all license nursing staff regarding the PharMerica Subcutaneous Insulin Policy and Procedure. Education will be completed by November 30, 2021 to all license nursing staff regarding the PharMerica Insulin guidance sheets. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS: Director of Nursing and/or Designee will conduct spot check observations of 20% of license staff with insulation preparation and administration weekly for 90 days to monitor the effectiveness of these changes and to ensure correction is achieved and sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125002	A. BUILDING ______ B. WING ______	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 759	Continued From page 24 administered via one pen, and five units was administered via a second pen. RN5 did not prime (perform the safety test) when preparing either of the insulin pens prior to injection of the medication. Both doses of insulin were administered into R12's right upper abdomen. RN5 was observed to leave the insulin pen in place for both doses for approximately two seconds, rather than the required 10 seconds prior to removal of the needle. During an interview with RN5 on 10/26/21 at 9:54 AM, she stated, "I was told we don't have to prime the [insulin] pens. We prime needles but not pens. Normally I leave the needle [inserted in the resident] for five seconds [when administering insulin via pen]." During an interview with the Regional Nursing Director and RN5 together on 10/26/21 at 11:30 AM, RN5 stated, "I should have primed the insulin pen prior to admin of insulin to [R12]." The Regional Nursing Director confirmed the insulin pens should have been primed prior to administration of insulin to R12 and confirmed the insulin pens should have been left in for five to 10 seconds prior to removal for proper absorption of the insulin.	F 759	Results of this audit will be reported to the QAPI committee meeting.	

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E 000	Initial Comments A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Hawaii Department of Health, Office of Health Care Assurance on 10/25/21 to 10/28/21. The facility was found not to be in compliance with 42 CFR 483.73.	E 000		
E 007 SS=F	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations,	E 007		11/30/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/11/2021

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

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E 007	Continued From page 1 including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's documentation, the facility failed to show the specific resident population they serve, along with the unique care needs these residents have in their Emergency Preparedness Plan (PPP). This deficient practice had the potential to affect all 34 residents residing in the facility. Findings include: Review of the facility's EPP titled "Emergency Management Plan Chapter 1," undated, failed to identify the specific resident population who reside in the facility and the specific needs of each resident. At the time of the survey there were two residents who utilized an invasive mechanical ventilator, four residents who required to be fed artificially, and multiple residents who required staff assistance for transfers and mobility. The facility also had other long-term care needs such as assisting residents to and from the toilet, assisting residents with bathing, and assisting residents with eating. The EPP failed to describe the type of resident who resided in the facility. Review of a facility document titled "Facility Assessment," dated 05/27/20, with a revision date of 05/26/21, under a section titled "Resident Population," indicated the assessment addressed the percentage of residents who were admitted	E 007	CORRECTIVE ACTION OF RESIDENT IDENTIFIED: Resident population via Facility Assessment integrated in the Emergency Preparedness Plan IDENTIFYING OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL TAKEN: All residents have the potential to be affected. Administrator and/or Designee will be responsible for on-going compliance. Facility Assessments into the Emergency Preparedness Plan Annually and as needed. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE: Education will be completed by November 30, 2021 to all license nursing staff on: "Quality Care Respiratory Care/Tracheostomy Care and Suctioning Policy and Procedure".	

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E 007	Continued From page 2 and length of stays. The assessment included information on the percentage of residents who received skilled services such as physical therapy. The assessment included the percentage of residents who had low, medium, and high mobility and function limitations. The assessment included the percentage of residents who required assistance with activities of daily living with the help of one staff member. The assessment included the type of diagnoses the resident population typically had in the facility. The information contained in the facility assessment was not integrated into the facility's EPP. During an interview conducted on 10/28/21 at 10:46 AM, the Administrator stated the only document they had was the Facility Assessment. During an interview on 10/28/21 at 12:28 PM, the Regional Nursing Director stated she was not involved in the EPP process. She reported the current Director of Nursing (DON) was involved in the EPP process but was on leave at the time of survey. The Regional Nursing Director stated the EPP had been discussed and there was an emergency response team that incorporated the nursing home and the hospital staff.	E 007	Education will be completed by November 30, 2021 to Administration of EP Program Patient Population regulation. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS: The Emergency Preparedness Plan will be reviewed annually by Administration to ensure compliance with EP Program Patient Population regulation.	