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	125064	A. BUILDING _____ B. WING _____	12/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENCE TC CHING VILLAS AT ST FRANCIS	2230 LILIHA STREET HONOLULU, HI 96817

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA). The facility was found not to be in substantial compliance with 42 CFR 483 Subpart B. Two Facility Reported Incidents (FRI) from the Aspen Complaints/Incidents Tracking System (ACTS), #9052 and #9208, were found to be unsubstantiated. A complaint, ACTS #9222, was substantiated. Survey Dates: November 30, 2021 to December 03, 2021 Survey Census: 70 Sample Size: 19	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550		1/15/22

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

Electronically Signed | 01/14/2022

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F 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to maintain the resident's right to be treated with respect and dignity for two residents (R), R172 and R218, in the sample. Staff spoke Tagalog in front of R172 and he felt that it was rude and he felt disrespected. The facility also failed to ensure R218's request to address him by his preferred name was honored. These deficient practices robs the resident's right to a dignified existence and has the potential to affect all residents. Findings include: 1) On 12/02/21 at 1:58 PM, an interview was done with R172 in his room. He answered	F 550	This Plan of Correction constitutes this facility□s written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. Guest # 172 remains in the facility, and during interview with guest, guest has stated that this has no longer occurred. Guest # 218 was discharged from the facility on 10/17/21. Completed by 1/7/22 2. Facility guests have the potential to be	

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F 550	Continued From page 2 questions appropriately and was found to be alert and oriented four times (person, place, time and situation). He stated that the staff speak Tagalog in front of him and he doesn't like that. He further stated that it is rude and he feels disrespected because he doesn't know if they are talking about him. 2) R218 is a 74-year-old male admitted to the facility on 09/23/21 from an acute care hospital. R218's admitting diagnoses include mitral valve (heart) surgery, anemia (low blood count), renal (kidney) failure, hypertension (high blood pressure), and acute respiratory failure secondary to pneumonia. R218 was discharged home against medical advice on 10/17/21. On 12/02/21 at 10:56 AM, the state agency (SA) received a complaint from R218 regarding the care he received while he was a resident. On 12/03/21 at 09:28 AM, a phone interview was conducted with R218. One issue raised by R218 was that staff frequently called him "uncle" without ever checking with him if it was acceptable to do so. R218 stated "I really didn't like that, I don't think I look that old, you know, I didn't appreciate that at all." On 12/03/21 at 11:35 AM, during a review of R218's electronic health record (EHR), it was noted that there was a baseline needs assessment documented and care planned on 09/23/21 by MDS [minimum data set] Support (MDSS)1 which clearly identified that the "resident [R218] prefers to be called...[by his first name]."	F 550	affected by the alleged practice. An audit of the current guests to determine if they have had any staff speaking non-English language in their presence. An assessment was completed to ensure that the guest□s preferred name is present on the care plan and profiled. To be completed by 1/14/22 3. Education provided to staff regarding appropriately speaking English while at the workplace and addressing each guest by their preferred name and where to find that information. The CNA and RN daily/shift team sheet has been updated to include the guest□s preferred name, the guest face sheet notes will be updated by HIM and placed under face sheet notes. To be completed by 1/14/22. 4. The Social Services Director/designee to the Social Services Director will perform random audits to ensure that the care plan is updated with the guest□s preferred name and that staff are speaking English. These audits will be performed weekly x4, then monthly x3, then quarterly until requirements are met. The audit findings will be reported in QAPI meeting.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F 578		1/15/22

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F 578	Continued From page 3	F 578		

§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the

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F 578	Continued From page 4 appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review (RR), interview with a staff member, and a review of facility policy, the facility failed to ensure that R45 was provided with information to formulate an advance healthcare directive (AHCD). As a result of this deficient practice, R45 has a potential risk for harm by not being able to exercise his right to refuse medical treatment. Finding includes: On 12/01/21 at 2:09 PM a RR was done for R45. The review found no documentation of an AHCD on file nor documentation of a discussion regarding one. In an interview on 12/01/21 at 2:30 PM with Social Services Manager (SSM), SSM stated that the facility's social service assistants document in the EHR that newly admitted residents received an admission packet. SSM stated that the admission packet includes information about AHCD. SSM was given R45's name to assist surveyor with finding documentation of an AHCD. In an interview on 12/02/21 at 07:05 AM, SSM stated that there was no documentation of an AHCD for R45 and no documentation of a discussion regarding an AHCD for R45. SSM further stated, "We have to improve on our documentation of our advance directives." On 12/03/21 at 2:00 PM, a review of the facility's "Advance Directives" policy dated 09/01/17, stated, "The Social Services Director and/or community Designee will review Advanced	F 578	1. Guest #45 guest has been discharged. 2. Facility guests have the potential to be affected by the alleged practice. An audit completed of current guests to determine if an AHCD is present and if not, if there is documentation to reflect that a discussion was conducted about AHCD. Completed 1/10/22 3. Education was provided to social services department workers regarding policy and procedure review along with process review. Change in process that the Social Services Associate (SSA) during the review of Admission Agreement paperwork and review of AHCD will document that this was reviewed, and information provided to the guest/responsible party. If there is no AHCD, the Social Services Worker will review with the guest/responsible party during the initial intake assessment and document accordingly. Completed 1/13/22 4. The Social Services Director/designee to the Social Services Director will perform random audits to ensure that AHCD has been reviewed and documented in the guest medical record weekly x4, monthly x3, then quarterly until the requirements are met. The audit findings will be reported in QAPI meeting.	

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F 578	Continued From page 5 Directives with the resident/guest Representative when appropriate...Required documentation that the information related to the Patient Self-Determination Act has been presented to the family and then kept on file."	F 578		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting	F 584		1/15/22

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F 584	Continued From page 6 levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on interview and RR, the facility failed to exercise reasonable care for the protection of the residents' property from loss for one resident, R218, in the sample. As a result of this deficient practice, the facility failed to preserve R218's right to have a home-like environment. Finding includes: R218 is a 74-year-old male admitted to the facility on 09/23/21 from an acute care hospital. R218's admitting diagnoses include mitral valve (heart) surgery, anemia, renal failure, hypertension, and acute respiratory failure secondary to pneumonia. R218 was discharged home against medical advice on 10/17/21. On 12/02/21 at 10:56 AM, the SA received a complaint from R218 regarding the care he received while he was a resident. On 12/03/21 at 09:28 AM, a phone interview was conducted with R218. One issue raised by R218 was that he lost several clothing items, all labeled with his name, that he sent to laundry through the facility. Some he got back after a couple weeks, some he did not, "I have no idea what happened to them, I kept asking but it never came back, one thing was a pajama top, you know, I got a really nice pair of pajamas from Macy's, that don't	F 584	1. Guest #218 no longer resides in the facility as was discharged on 10/17/21. 2. Facility guests have the potential to be affected by the alleged practice. Social services director completed an audit of missing items reports to determine if items were found/completed. 3. Education provided to staff on the process of missing items, and appropriate paperwork to complete when items missing. Education provided with licensed nurses to include review of the Inventory sheet and reconciling the form at time of discharge. To be completed 1/14/22 4. The Social Services Director/designee to the Social Services Director will perform random audits to ensure that the inventory sheet is present on admission, any changes throughout stay is updated, and at discharge the inventory sheet is reconciled with the guest/responsible party; any missing items are logged and investigated weekly x4, monthly x3, then quarterly until the requirements are met. The audit findings will be reported in QAPI meeting.	

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F 584	Continued From page 7 come cheap, I only got the pants back." On 12/03/21 at 05:50 PM, during a review of R218's Inventory of Personal Possessions sheets, it was noted that not all property accepted for inventory were reconciled and documented as returned to R218 upon his discharge. On 09/25/21, the following items were documented as "Received ...1 (one) pair slipper, 1 (one) pair pajama, 1 (one) cell phone with charger." On the day of his discharge, R218 signed that he received all other items on his inventory list except for the 1 (one) pair slipper[s] and 1 (one) pair pajama added on 09/25/21.	F 584		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F 655		1/15/22

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F 655	Continued From page 8 §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interviews and RR, the facility failed to revise R266's baseline care plan to include interventions addressing his diagnosis of orthostatic hypotension (low blood pressure with position change) and history of syncopal episodes (passing out). The facility also failed to provide R267 a written summary of his baseline care plan. As a result of these deficient practices, R266 was put at a potential risk for adverse health consequences and R267 was not informed of his goals for his stay at the facility. This has the potential to affect all residents. Findings include: 1) In an interview on 11/30/21 at 1:30 PM with	F 655	1. Guest #266 care plan updated to include problem of orthostatic blood pressure and interventions to address this problem area completed on 12/1/21. Guest #267 no longer resides in the facility and has been discharged on 12/18/21. 2. Facility guests have the potential to be affected by the alleged practice. Baseline care plans audited of current guests to ensure that the baseline care plan is completed within 48 hours and addresses instructions needed to provide effective and person-centered care. An audit of guests that have had a comprehensive care plan completed has been provided	

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F 655	Continued From page 9 R266, R266 stated that he sometimes felt dizzy and nauseated after his HD treatments because "They were pulling out too much fluid." R266 stated that he "Blacked out," while using the bathroom on 11/28/21. R266 stated that he had no injuries from the fainting episode on 11/28/21 and that he always uses the call light to ask for assistance to get out of bed to use the bathroom. On 12/01/21 at 1:00 PM, a RR of R266's EHR, indicated that R266 was admitted to the facility on 11/19/21 with diagnoses of acute respiratory failure with hypoxia secondary to fluid overload (inadequate oxygen levels due to too much fluid in the body). R266 diagnoses included chronic kidney disease (kidneys unable to filter blood adequately), congestive heart failure (heart unable to pump blood effectively), and Diabetes Type 2 (the body is unable to properly regulate levels of glucose in the blood). R266 received hemodialysis (HD) services offsite every Monday, Wednesday, and Friday. "Physician Orders" dated 11/23/21, ordered the following treatments for a diagnosis of orthostatic hypotension (a form of low blood pressure that happens when you stand up from sitting or lying down): "Abdominal binder when out of bed three times a day, compression stockings applied to both legs in the morning and then removed at bedtime, and obtaining heart rate and blood pressure once a day while sitting, standing, and lying down." In "Nursing Progress Note" dated 11/28/21 indicated, "While making BM [bowel movement], guest complained of feeling dizzy. Guest strained and lost consciousness for a few seconds. Assigned CNA [certified nursing assistant] was with guest and called for RN [registered nurse]." In "Nursing Progress Note" dated 11/29/21, R267 had a syncopal episode at his HD session and	F 655	with a summary of the care plan with the goals of stay, resident medication and dietary instructions and any services/treatments to be provided. To be completed 1/14/22. 3. Education provided to facility staff responsible for care planning regarding baseline care plans to include policy and procedure, person-centered care, and CMS regulatory guidelines. Review of process and process change to include that the MDS RN support will be providing the guest with the review of the plan of care to include a summary of initial goals, medications, dietary instructions and any services and treatments to be administered by the facility and any updated information based on the details of the comprehensive care plan, as necessary. The MDS RN support will document in the guest medical record progress note regarding this along with that the care plan was provided. Completed 1/13/22. 4. Director of Nursing/designee to Director of Nursing will perform random audits of the baseline care plan is completed and addresses the guest□s problem/potential problem areas and that guest receive a summary of the plan of care. These audits will be performed weekly x4, then monthly x3, then quarterly until requirements are met. The audit findings will be reported in QAPI meeting.	

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F 655	Continued From page 10 was recommended by the nurse practitioner to be seen at the emergency room (ER). R267 refused to be seen at the ER. Nurse practitioner prescribed new orders for syncope to include, "obtain orthostatic blood pressure and heartrate for 3 (three) days." A RR of R266's Care Plan indicated no care plan or interventions for R41's orthostatic hypotension. In an interview on 12/01/21 at 3:40 PM, concurrently reviewed R266's care plan with Nurse Manager (NM)4. NM4 confirmed that there was no care plan for R266's diagnosis of orthostatic hypotension. NM4 stated that "It (orthostatic blood pressure) would be something we would want to add into the care plan and monitor R266 for." 2) In an interview on 11/30/21 at 2:04 PM, surveyor asked R267 if he was given a summary of his baseline care plan. R267 stated, "No paper was given to me." A RR of R267's EHR was done on 12/02/21 at 2:25 PM. In a "Progress Social Work" note dated 11/24/21, R247 had a Brief Interview for Mental Status (BIMS) score of 15, meaning R247 is cognitively intact. There was no documentation in R247's record about a written care plan being offered to R247 by staff. In an interview on 12/02/21 at 3:00 PM with NM5, NM5 concurrently reviewed R267's EHR. NM5 confirmed that there was no documentation indicating that R267 had been offered or received a written summary of his baseline care plan.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		1/15/22

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care

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F 656	Continued From page 12 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop and/or implement a person-centered comprehensive Care Plan (CP) for two residents, R54 and R46 in the sample. R54 did not have a falls care plan despite being assessed and identified as a high-risk for falls and R46 lacked a resident-centered care plan for pain and bruising to his arms. As a result of these deficient practices, the residents were placed at risk for a decline in their quality of life and were prevented from attaining their highest practicable well-being. These deficient practices also has the potential to affect all the residents at the facility. Findings include: 1) R54 is a 91-year-old male admitted to the facility on 10/22/21 with a primary diagnosis of acute respiratory failure. R54's admitting diagnoses also include acute kidney failure, anemia, end stage renal disease (requiring hemodialysis), chronic obstructive pulmonary disease, diabetes, and history of stroke. On 12/03/21 at 1:32 PM, during a record review of R54's EHR, it was noted that R54 had suffered a fall on 12/01/21. Review of nursing progress note by RN8, documented on 12/02/21 at 12:35 AM, revealed the following: "Guest [R54] had an assisted fall at 2145 [09:45 PM] while being transferred from wheelchair to bed. Per CNA [certified nurse aide], she was guiding Guest to transfer him to bed, when he was unable to move	F 656	1. Guest # 54□s care plan was reviewed and updated to address fall risk and fall that occurred along with individualized to the guest completed on 12/3/21. For guest #46 the care plan reviewed and updated to be individual to guest on 12/3/21; care plan updated to reflect guest□s pain and interventions individualized to guest; care plan updated to reflect current skin condition (bruising) with interventions; care plan updated to reflect guest with contracture to right arm and interventions 2. Facility guests have the potential to be affected by the alleged practice. An audit of current in-house guests was completed to ensure that the problem area, goals, and interventions are addressed and are individualized/thorough to provide the care to the guest. To be completed 1/14/22. 3. Education provided to facility staff responsible for care planning regarding policy and procedure and CMS regulatory requirement regarding care plan and the need for individualized plan of care for each guest. Completed 1/13/22. 4. Director of Nursing/designee to Director of Nursing will perform random audits of care plan for guests to ensure that the care plan problem areas are addressed, and interventions are individualized to that guest. Audits will be completed weekly x4, then monthly x3, then quarterly until requirements are met. Audit findings will	

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further to bed to sit down he used his hand to reach the bed, bed was not locked in place causing bed to move. Per CNA, Guest was then slowly assisted to floor...Guest confirmed...bed was moving."

Review of R54's Johns Hopkins Falls Risk Assessment revealed the following: "Total Fall Risk Score: 15 Points High Fall Risk".

Review of R54's comprehensive CP noted that prior to the fall on 12/01/21, R54 had no falls care plan, what had been documented were two Baseline Needs Care Plans for Safety, initiated on 10/22/21 and 11/03/21. The 10/22/21 safety care plan listed two interventions: "History of fall-related injury:" and "History of Falls:", with no other information or resident-specific interventions documented. The 11/03/21 safety care plan documented a sole intervention of "History of falls:", with no other information added.

On 12/03/21 at 2:10 PM, during an interview with NM6 in her office, R54's falls risk assessment was reviewed. NM6 stated that when a resident is identified as a high falls risk, as R54 had been, their CP should be revised to include a care plan for falls to specifically address the identified problem. During a review of R54's CP, NM6 confirmed that a falls care plan had not been added until after his fall.

2) R46 is a 70-year-old male admitted on 11/10/21 following a fall at home that resulted in skull and neck fractures. As a result of his injuries, R46 was required to wear an Aspen Collar (a rigid neck collar restricting the wearer from moving his/her head). R46's admitting diagnoses include history of kidney transplant,

be relayed in QAPI.

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diabetes, atherosclerotic (thickening and hardening of the arteries) heart disease, chronic kidney disease, anemia, and history of right-sided weakness and paralysis following a stroke. R46 had been ordered acetaminophen (over the counter pain medication), and oxycodone (narcotic pain medication) as needed for his pain.

During an observation and concurrent interview with R46 in his room on 11/30/21 at 12:20 PM, R46 was observed with heavy bruising of both arms, a large dark purple bruise surrounded his right elbow, in addition to smaller purple bruises on both forearms. When asked about the bruises, R46 denied taking any blood thinners and stated, "I'm old." R46 was observed wearing an Aspen Collar that prevented him from turning his head. When asked about the collar, R46 stated he was told that he would have to wear the Aspen Collar "all the time for at least 6 months." R46 stated that the Aspen Collar was so uncomfortable that he had difficulty sleeping because he just could not find a comfortable position while wearing the rigid collar. R46 also reported that he was almost always in pain, experiencing sharp pains in his neck and constant headaches, with the pain increasing whenever he had to move, such as when turning from side to side in bed, or getting out of bed for physical therapy.

On 12/03/21 at 12:46 PM, during a record review of R46's CP it was revealed that his care plan for pain, initiated on 11/11/21, consisted of the following two interventions: "Administer medications as ordered. Evaluate/record/report effectiveness and any adverse side effects" and "Monitor and record any complaints of pain: location, frequency, intensity, affect [sic] on

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F 656	Continued From page 15 function, alleviating factors, aggravating factors." It was noted that the pain care plan lacked any non-pharmacological approaches for pain management and did not include an assessment of R46's pain management goals. Regarding the bruising to his arms, there was neither a care plan nor physician orders to address it. On 12/03/21 at 1:54 PM, during an interview with NM6 in her office, NM6 agreed that R46's pain care plan was minimal and not specific to his needs. Regarding R46's bruising to his arms, multiple skin assessments were reviewed with NM6. It was noted that on 11/20/21, a skin assessment documented bruising to his left chest, and under the Aspen Collar. It also documented "right FA [forearm] continuously purple with blood-filled blister." On 11/28/21, a skin assessment documented bruises on R46's right elbow, right shoulder, and scattered bruises to his extremities. NM6 confirmed that the bruising should have been care planned, and R46 should have been offered protective arm sleeves to help preserve the integrity of his skin.	F 656		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.	F 679		1/15/22

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F 679	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interviews and RR, the facility failed to provide the activity preference for 1 (one) out of 10 residents in the sample for activities. R43 was not provided individual activities of choice of music and no facility-sponsored group activities that would meet the guest's interests. This deficient practice has a potential for negative psychosocial outcomes and can potentially affect all residents. Finding includes: On 11/30/21 at 10:33 AM a concurrent interview and observation was done with R43. On observation, R43 in his room, sitting in his bed with lights off, no TV or radio. R43 stated, "I am leaving on Thursday. I had back surgery. I've been here for one month. I can't move." Surveyor asked R43 if he is participating in activities and he stated, "There are no activities I like here that were offered. I like music. The only thing I watch on the weekends is sports on TV." On 12/01/21 at 08:30 AM observed R43 sitting in his room, TV off, lights off, awake. No music or radio in room. He stated that he may go home tomorrow. On 12/02/21 at 10:59 AM, an interview with the assistant administrator (AA) and activities coordinator (AC) was done. AA stated, "Covid shut everything down including activities program." AA stated that they have not started group activities yet and is in the process of starting. AC just started approximately one month ago. AC stated that "Guests who prefer to stay in the room, I have a cart full of items at	F 679	1. Guest #43 is no longer in the facility and was discharged on 12/2/21. 2. Facility guests have the potential to be affected by the alleged practice. An audit was completed on 1/14/22 of current in-house guests to ensure that their preferences are documented and that they have preferences available to them along with doing the activity of their preference. 3. Education provided to staff responsible for providing activities regarding ensuring that guest preferences are available for the guest and that the guest is participating in what he/she enjoys promoting their psychosocial well-being. A flow chart to track and document guest preferred activities has been developed and initiated to support individualized activity plan for guests. Completed 1/14/22. 4. Director of Activities/designee to the Activities Director will perform random audits of guest preference to ensure that the guest has activity supplies and participating weekly x4, then monthly x3, then quarterly until requirements are met. Audit findings will be relayed in QAPI.	

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F 679	Continued From page 17 initial interview such as cross books, puzzling, religious material. If they are interested in music, I have radios. I have enough radios to go around. I help them set up the station. I don't have detailed notes on the guests. I have a checklist. My initial visit with R43, he was not in the room. When I did see him, he told me he did not want anything. My job is to keep their brain occupied. I tell them what I have on my cart. I will encourage them to take something and offer something. I don't like to take no for an answer." On 12/03/21 at 08:11 AM RR of R43's care plan was done. R43's care plan showed a preference to plan his/her own daily activities of their choice. Stated under approach, of the care plan is "general activity preferences include listening to music, be around pets, doing things with groups of people, do favorite activities. Review of the activity checklist stated that the most common use of resident's time was music and walking, leisure interests was music. Review of the MDS, section F for preferences, rated listening to music as very important. R43 was admitted to the facility for 26 days. His preference was noted in the RR to be music. R43 also verbalized that he only listened to music. Although, there were "enough radios to go around," R43 was observed in the room, in the dark with no activity of preference during his admission.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		1/15/22

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facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on observations, RR, and interviews, the facility failed to provide needed care or services (managing bowel regimen) of R268 resulting in a failure to improve and/or attain her highest practicable physical, mental, and/or psychosocial well-being. As a result of this deficient practice, R268 was put at risk for physical, mental, and psychosocial harm.

Finding includes:

On 11/30/21 at 3:50 PM, R268 was observed lying in bed on her back. R268 was holding her left buttock with her left hand. She had facial grimacing. She stated, "I can't talk right now. I'm constipated. I'm waiting for the bed pan."

On 12/03/21 at 07:12 AM, a RR was done for R268. R268 was admitted on 11/21/21 for a diagnosis of cardiogenic shock (heart is unable to pump enough oxygen-rich blood to the body organs), hypotension (low blood pressure) due to cardiogenic shock, metabolic acidosis (excess acid in the blood), and postmenopausal bleeding (bleeding or spotting from the vagina after menopause). R268 has a history of atrial fibrillation (irregular heartbeat), osteoarthritis (inflammation of joints) of both knees, and chronic lower back pain. "Progress Note" dated 11/21/21 stated, "Guest alert and oriented x4 (person, place, time, and situation). Guest lbm

1. Guest #268 bowel movement documentation and medication regimen reviewed; abdominal assessment completed with bowel sounds normoactive. Nurse involved in incident was re-educated. Completed 12/3/21
2. Facility guests have the potential to be affected by the alleged practice. An audit of current in-house guest□s bowel movements completed to ensure that bowel movements are documented and have had a bowel movement at least every 2 days. If there was no bowel movement, a review of the MAR was completed to determine if PRN bowel medication was administered as per physician order. To be completed 1/14/22
3. Education provided and completed on 1/13/22 to licensed nurses regarding protocols on bowel movement process/orders and monitoring along with physician review if there is no bowel movement within 2 days and if any declination of bowel medication documentation. The Unit Coordinator will review the vitals log for bowel movements and generate a list of guests that did not have a bowel movement within 2 days and provide it to the licensed nurse daily. The Resident Care Manager (RCM) will receive this list from the licensed nurse

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[loose bowel movement] noted today at hospital x3 [three times] after taking senna plus and prior to that lbm noted 11/19. Guest extensive 1 (one) person with bed mobility and 2 (two) person transfer using Hoyer. Guest continent of bowel and incontinent of bladder."

On 12/03/21 at 09:35 AM, RR of R268's "Vitals Daily Bowel Movement" sheet indicated that R268 had two bowel movements on 11/25/21, one bowel movement on 11/26/21, one bowel movement on 11/27/21, and two bowel movements on 11/30/21. RR of R268's Electronic Medication Administration Record (EMAR) dated 11/21/21-12/02/21 was done. The EMAR indicated that on 11/21/21, sorbitol (a laxative medication), 30 ml was ordered and could be administered as needed if there was no bowel movement for two days. Sorbitol was documented as administered on 11/30/21. The EMAR indicated that on 11/21/21, a bisacodyl suppository (a laxative medication), 10 mg was ordered and could be administered as needed if there was no bowel movement for three days. No documentation was found on bisacodyl being administered to R268.

In an interview on 12/01/21 at 09:31 AM, R268 stated, "Every week I have been constipated. I've taken prune juice, stool softeners, and rubbed my stomach. My constipation is bad."

In an interview on 12/03/21 at 08:12 AM with NM5, NM5 concurrently reviewed R268's EHR. NM5 confirmed that R268 did not have a bowel movement since 11/21/21 until 11/25/21. NM5 confirmed that sorbitol should have been offered to R268 on 11/23/21 for no bowel movement for two days and if unsuccessful, bisacodyl should

and review it to determine if medications were needed/given.
4. Director of Nursing/designee to Director of Nursing will perform random audits on the vitals report/BM log to ensure adequate bowel movements/medication administered if required will be conducted weekly x4, then monthly x3, then quarterly until requirements are met. Audit findings will be relayed in QAPI.

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F 684	Continued From page 20 have been offered to R268 on 11/24/21 for no bowel movement for three days. NM5 confirmed that R268 did not have a bowel movement since 11/27/21 until 11/30/21. NM5 confirmed that sorbitol should have been offered earlier to R268 on 11/29/21 instead of one day late on 11/30/21. In an interview on 12/03/21 at 09:38 AM, NM5 stated that sorbitol was offered to R268 on 11/23/21 (two days after R268's last bowel movement on 11/21/21) but was declined because R268 was "afraid for loose bowel movements." NM5 confirmed that there was no documentation indicating whether sorbitol or bisacodyl was offered to R268 on 11/24/21. NM5 also confirmed that there was no documentation that R268 was offered sorbitol on 11/29/21 (two days after R268's last bowel movement on 11/27/21). NM5 stated, "Sorbitol should have been offered on the 29th."	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and RR, the facility failed to ensure one resident, R54, in the sample was free from accident hazards by not developing a falls care plan after identifying the resident as high-risk for falls, and not ensuring a	F 689	1. Guest #54 had the bed locked at time of being found unlocked on 12/1/21. 2. Facility guests have the potential to be affected by the alleged practice. An audit of current in-house guest□s beds was	1/15/22

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safe environment. As a result of this deficient practice, the resident suffered an avoidable accident and was placed at risk for injury. This deficient practice has the potential to affect all the residents at the facility.

Finding includes:

R54 is a 91-year-old male admitted to the facility on 10/22/21 with a primary diagnosis of acute respiratory failure. R54's admitting diagnoses also include acute kidney failure, anemia, end stage renal disease (requiring hemodialysis), chronic obstructive pulmonary disease, diabetes, and history of stroke.

On 12/03/21 at 01:32 PM, during a record review of R54's EHR, it was noted that R54 had suffered a fall on 12/01/21. Review of nursing progress note by registered nurse (RN)8, documented on 12/02/21 at 12:35 AM, revealed the following: "Guest [R54] had an assisted fall at 2145 [09:45 PM] while being transferred from wheelchair to bed. Per CNA [certified nurse aide], she was guiding Guest to transfer him to bed, when he was unable to move further to bed to sit down he used his hand to reach the bed, bed was not locked in place causing bed to move. Per CNA, Guest was then slowly assisted to floor...Guest confirmed...bed was moving."

Review of R54's Johns Hopkins Falls Risk Assessment revealed the following: "Total Fall Risk Score: 15 Points High Fall Risk".

Review of R54's comprehensive CP noted that prior to the fall on 12/01/21, R54 had no falls care plan, what had been documented were two Baseline Needs Care Plans for Safety, initiated

completed to ensure that beds were locked in place. Completed 12/6/22.
3. Education provided to facility staff regarding the importance of having the bed in locked position, ensuring that the bed is locked prior to transferring in/OOB, and reviewed how to lock the bed. Completed 1/13/22
4. Director of Nursing/designee to Director of Nursing will perform random audits to determine that beds are in locked position will be conducted weekly x4, then monthly x3, then quarterly until requirements are met. Audit findings will be relayed in QAPI.

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F 689	Continued From page 22 on 10/22/21 and 11/03/21. The 10/22/21 safety care plan listed two interventions: "History of fall-related injury:" and "History of Falls:", with no other information or resident-specific interventions documented. The 11/03/21 safety care plan documented a sole intervention of "History of falls:", with no other information added. On 12/03/21 at 2:10 PM, during an interview with NM6 in her office, NM6 confirmed that residents' beds should always remain in the locked position, especially when transferring the resident into or out of the bed. NM6 stated that the CNA should have verified the bed was locked before attempting a transfer. During a review of R54's falls risk assessment, NM6 stated that when a resident is identified as a high falls risk, as R54 had been, their CP should be revised to include a care plan for falls to specifically address the identified problem. During a review of R54's CP, NM6 confirmed that a falls care plan had not been added until after his fall.	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and RR, the facility failed to prevent and manage pain adequately for one resident, R46, in the sample. Specifically, the facility failed to recognize and document when R46 was experiencing pain so	F 697	1. Guest #46 record review completed to address guest□s pain levels along with plan of care to address specific and individualized goals of pain relief that include non-pharmacological pain	1/15/22

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F 697	Continued From page 23 that an effective care plan could be developed, and failed to evaluate what R46's pain management goals were. As a result of this deficient practice, R46 was prevented from attaining or maintaining his highest practicable level of well-being and this has the potential to affect all residents residing in the facility. Finding includes: R46 is a 70-year-old male admitted on 11/10/21 following a fall at home that resulted in skull and neck fractures. As a result of his injuries, R46 was required to wear an Aspen Collar (a rigid neck collar restricting the wearer from moving his/her head). R46's admitting diagnoses include history of kidney transplant, diabetes, atherosclerotic, heart disease, chronic kidney disease, anemia, and history of right-sided weakness and paralysis following a stroke. R46 had been ordered acetaminophen, and oxycodone as needed for his pain. During an observation and concurrent interview with R46 in his room on 11/30/21 at 12:20 PM, R46 was observed wearing an Aspen Collar that prevented him from turning his head. When asked about the collar, R46 stated he was told that he would have to wear the Aspen Collar "all the time for at least 6 months." R46 stated that the Aspen Collar was so uncomfortable that he had difficulty sleeping because he just could not find a comfortable position while wearing the rigid collar. R46 also reported that he was almost always in pain, experiencing sharp pains in his neck and constant headaches, with the pain increasing whenever he had to move, such as when turning from side to side in bed, or getting out of bed for physical therapy.	F 697	management. Completed 12/3/21 2. Facility guests have the potential to be affected by the alleged practice. An audit of current in-house guest diagnosis, medication list, and guest□s pain levels was completed to determine if plan of care is meeting guest□s pain relief goal. To be completed by 1/14/22 3. Education provided and completed 1/13/22 to clinical and therapy staff regarding identification of pain (verbal/non-verbal), means of pain relief including non-pharmacological and pharmacological means, and the goals of the guest for pain relief/management. The RCM will review vital signs report for pain to determine guest□s pain levels, assessment of cause of pain, and to review the current plan of care/goals for re-evaluation. 4. Director of Nursing/designee to Director of Nursing will perform random audits on pain levels of guests/pain relief weekly x4, monthly x 3 then quarterly until requirements are met. Audit findings will be relayed in QAPI.	

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F 697	Continued From page 24 On 12/03/21 at 12:46 PM, during a record review of R46's CP it was revealed that his care plan for pain, initiated on 11/11/21, consisted of the following two interventions: "Administer medications as ordered. Evaluate/record/report effectiveness and any adverse side effects" and "Monitor and record any complaints of pain: location, frequency, intensity, affect [sic] on function, alleviating factors, aggravating factors." It was noted that the pain care plan lacked any non-pharmacological approaches for pain management, did not identify non-verbal signs of pain, and did not include an assessment of R46's pain management goals. On 12/03/21 at 1:54 PM, during an interview with NM6 in her office, NM6 agreed that R46's pain care plan was minimal and not specific to his needs. During a review of his pain monitoring, NM6 confirmed that the documentation contained only R46's stated numerical ratings of pain and did not document any other factors such as activity level at the time and non-verbal signs of pain. When questioned about a pain management program, NM6 stated that the facility did not have a formal pain management program. NM6 agreed that as a facility of primarily short-term rehabilitation residents, it would be reasonable to anticipate that the majority of the residents would require some level of pain management, and that a formal pain management program could be helpful.	F 697		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with	F 725		1/15/22

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F 725	Continued From page 25 the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and RR, the facility failed to provide sufficient nursing staff which includes registered nurses and nurse aides to assure resident safety and maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This deficient practice has the potential to affect their safety and outcomes in accordance with the resident's care plans. Findings include:	F 725	1. Guest #38 had been interviewed to determine call light response by staff and verbalized better on 1/10/22. Review of nursing schedule and assignment sheet for 11/30/21 night shift reveals that there was 3 Certified Nurse Aides present. Guest #268 interviewed on 1/10/22 and verbalized call light response is better. Review of staffing levels on 11/30/21 with day shift 2 CNAs and 1RN; evening shift 2 CNAs and orientee and one nurse; and on night shift with 1 CNA and 1 nurse with a	

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F 725	Continued From page 26 1) During an interview on 11/30/21 at 10:50 AM, R38 stated, I broke my hip and my knee. Everything is ok here, just sometimes staff take 30 minutes to get to my room when I call. It sometimes happens in the middle of the night and then during the middle of the day. The next day, during an interview on 12/01/21 at 07:52 AM, R38 stated, last night I pressed the button three times. I waited 35 minutes. Sometimes, the staff press their phone and don't answer. The floor had only one nursing aide last night. It mostly happens with the midnight shift. They are rushing and I needed my brace to be taken off. It was about 11:45 (PM). My brace can be on all night, but I take it off at about 11:00 (PM). During an interview on 12/01/21 at 2:08 PM with scheduler who explained how the floors are staffed. 3rd floor - Day and evening shifts - Two RNs and four CNAs. 3rd floor - Night shift - One RN and three CNAs. 4th floor - Days and evening shifts - Three CNAs and two RNs. 4th floor - Night shift - Two or three CNAs and one RN. 5TH floor - Days, evening, and night shifts- One RN and two CNAs for day and evening shifts and one CNA on the night shift. The scheduler stated, if someone calls in sick, we first try on-call staff, then part-time, then proceed with full time with people who are off that day. The last resort is mandating. Surveyor queried, "Are you short staffed here?" Scheduler	F 725	total unit census of 13. Guest #41 interviewed on 1/10/22 and stated call light response better; call light checked to ensure proper function, which was working appropriately. Guest #46 licensed nurse re-educated on 1/11/22 regarding offering alternate means of toileting (i.e., Bed pan) if the staff requires 2 assist to avoid guest having to wait. Guest #61 has been discharged and no longer in the facility. 2. Facility guests have the potential to be affected by the alleged practice. An audit is being completed to review time of response to call lights/guest needs on all three shifts and is on-going. To be completed 1/14/22. 3. Education provided to facility staff to include timeliness of call light response, anticipating guest needs. Education to licensed nurses on the importance of providing pain medication timely when a guest is experiencing pain and asking for medication. Process of any staff member to respond to the guest call light to ensure that the guest□s needs are being met timely. Completed 1/13/22. 4. Director of Nursing/designee to Director of Nursing will conduct random audits on call light response time to include timely toileting needs met, and timely administration of pain medication weekly x4, then monthly x3, then quarterly until requirements are met. Audit findings will be relayed in QAPI.	

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answered, "We are short staffed here at the facility." Queried "How long have you all been short for CNAs?" Scheduler stated, "In June, we went short CNAs and it's been hard to hire."

During an interview on 12/03/21 at 10:05 AM, the DON stated, we have a bonus for CNAs and nurses. We have a $1000 dollar recruitment bonus offered for both CNAs and nurses. The bonus applies to any of the departments after $500 and then after 90 days, they get $500 more. Human resources go to the colleges. Our staff are recruiting for nurse aids as well. Student nurses come here to do their clinical. We are hoping to recruit nurses this way. It's hard. We compete with the hospitals for nurses. If we are shorthanded, then the managers and me will work the floors. We try to get the nurses. I won't go above census. I look at the acuity - 16:1 ratio. I must get the nurses in the building. We have a recruiter that is helping us get nurses here. My cap for a nurse is 16:1. We take the acute people from the hospitals. We do a good orientation. We are open to new grads. We have 3 (three) CNAs and 2 (two) RNs starting Monday and hope they stay.

RR on 12/03/21 at 11:00 AM revealed the shift assignment for the 4th floor on evening shift with one CNA calling out from work, one CNA working until 6 pm, leaving one CNA on the floor.
2) On 11/30/21 at 3:50 PM, R268 was observed lying in bed on her back. R268 lifted her left buttock with her left hand. She had facial grimacing. She stated, "I can't talk right now. I'm constipated. I'm waiting for the bed pan."

In an interview on 12/01/21 at 09:42 AM, R268 stated, "I waited on the bed pan for forty-five

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minutes to an hour yesterday waiting for help. It's not good to be on my back on the bed pan for so long since I have back pain".

On 12/03/21 at 07:12 AM, a RR was done for R268. R268 was admitted on 11/21/21 for a diagnosis of cardiogenic shock (heart is unable to pump enough oxygen-rich blood to the body organs), hypotension (low blood pressure) due to cardiogenic shock, metabolic acidosis (excess acid in the blood), and postmenopausal bleeding (bleeding or spotting from the vagina after menopause). R268 has a history of atrial fibrillation (irregular heartbeat), osteoarthritis (inflammation of joints) of both knees, and chronic lower back pain. Review of the "Progress Note" dated 11/21/21, indicated at 10:21 PM the nurse documented, "Guest alert and oriented x4 (times four - person, place, time, and situation). Guest extensive 1 (one) person with bed mobility and 2 (two) person transfer using Hoyer. Guest continent of bowel and incontinent of bladder."

3) In an interview on 11/30/21 at 10:43 AM, R41 stated, "One time the CNA put me on the commode and said she would come back at 10:30 PM, but I think she went home. I was on the commode for an hour and five minutes. I made a formal complaint and haven't seen the CNA since. A second time I was on the commode for twenty-five minutes calling out for help because my call light was broken."

In a RR on 12/02/21 at 10:20 AM, R41 was admitted to the facility on 11/01/21 for a fracture of the upper and lower end of the right fibula (lower leg). R41's diagnoses include morbid (severe) obesity due to excess calories and congestive heart failure. Admission MDS report

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with Assessment Reference Date ARD of 11/07/21 showed a BIMS score of 14 meaning R41 is cognitively intact. Admission MDS report with ARD of 11/07/21, Section G0110 documented that R41 needs one-person physical assist to move in bed and two-person physical assist for transfers.
4) R46 is a 70-year-old male admitted on 11/10/21 following a fall at home that resulted in skull and neck fractures. As a result of his injuries, R46 was required to wear an Aspen Collar (a rigid neck collar restricting the wearer from moving his/her head). R46's admitting diagnoses include history of kidney transplant, diabetes, atherosclerotic heart disease, chronic kidney disease, anemia, and history of right-sided weakness and paralysis following a stroke, and he has an indwelling catheter for urine.

On 11/30/21 at 09:23 AM, observed R46 ask RN9 for help to the bathroom. RN9 said she would get someone to help him and left the room.

On 11/30/21 at 09:41 AM, after observing that no one had gone in to assist R46 to the bathroom yet, an interview was done with RN9 outside of a resident's room as she conducted her medication pass. When asked about how long R46 had been waiting for assistance, RN9 stated she was waiting for the CNA to go back, but she was busy. RN9 explained that R46 is a two-person transfer, so she needed the CNA to go in with her. RN9 stated that she had told CNA7 of R46's request as soon as she left the room.

On 11/30/21 at 09:47 AM, an interview was done with R46 in his room on the third floor. R46 had not been assisted to the bathroom yet, had poor eye contact with this surveyor, and spoke in a

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soft, quiet voice. When asked, R46 stated that sometimes he waits a long time for help. R46 further explained that he likes CNA6, "usually [CNA6] ...covers me up [places an adult disposable brief on him] so I don't make a mess, but she hasn't done it yet, she must be busy, I think I made a mess already." R46 stated he feels embarrassed when the CNA has to clean him because he could not hold his bowel movement.

At 09:50 AM, CNA7 was observed entering R46's room to assist him to bathroom. R46 stated to her that he couldn't wait and had "made a mess." From outside the room, CNA7 could be heard asking R46 if he had called for help, to which R46 explained that he did, and had verbalized his request for assistance to RN9. CNA7 then stated, "why didn't she do anything?"

5) R61 is a 65-year-old male admitted on 11/05/21 after fracturing his left femur. R61's admitting diagnoses include diabetes, renal failure with hemodialysis, high blood pressure, coronary heart disease, and blindness as a result of diabetic retinopathy (blood vessels of the retina in the eye are damaged due to diabetes).

On 11/30/21 at 10:38 AM, an interview was done with R61 in his room. R61 stated as a result of his injury and surgery, he has pain to his left knee, left hip and his back, and he takes acetaminophen and oxycodone for his pain. R61 stated that he already took acetaminophen this morning for pain he rated 7 (seven) on a scale of 1-10 (one to ten), and it has not provided much relief. R61 further stated that he knows he can take more pain medication, but he tries not to because the oxycodone "makes me constipated."

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On 11/30/21 at 12:41 PM, as a CNA was delivering his lunch tray, R61 could be overheard from outside of his room yelling, "Where's that nurse? I been waiting a long time! My leg is killing me!" As the CNA explained that he would look for her, R61 yelled, "Tell her hurry up her butt!"

On 11/30/21 at 12:47 PM, an interview was done with CNA8 as he exited R61's room. CNA8 stated that sometimes residents can wait a long time for their pain meds if the nurse is busy. When asked about staffing, CNA8 stated "there is usually only 2 (two) nurses, so if they are busy or have an admission, the wait can be a little long."

On 11/30/21 at 12:49 PM, an interview was done with R61. R61 stated he had been waiting "over half an hour" for pain meds, "I called about 5 (five) times." R61 rated pain to his left knee and hip a 10 (ten) out of 10 (ten), stating, "I'm in a lot of pain."

On 11/30/21 at 12:51 PM, an interview was done with R61's nurse, RN10, outside of a resident's room. RN10 explained that she had been busy helping another one of her assigned residents with an enema for the past half an hour and could not leave. RN10 acknowledged that she had been told twice about R61's pain but had not had "a chance to get there yet." It was observed that in relation to R61's room, the room where she was currently located was almost on the opposite end of a very large floor. Of the 32 residents on the floor that day, RN10 stated she had half, "we [her and one other RN] split the floor." RN10 stated that is a normal resident assignment, and that it keeps her busy from the start of her shift

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F 725	Continued From page 32 until the end. RN10 explained that "sometimes we have three nurses, but this week it has only been two." Although RN10 was carrying a communication device, she stated that she can only receive communications on it, she cannot send any outgoing communications on it, such as calling for help.	F 725		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order	F 758		1/15/22

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F 758	Continued From page 33 unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on RR, interview, and review of policy and procedures, the facility failed to provide a diagnosis for a prescribed psychotropic medication (affecting the mental state) and failed to accurately monitor R24's targeted or associated behaviors to determine the efficacy of R24's psychotropic medication. As a result of this deficient practice, the facility failed to promote or maintain R24's highest practicable, mental, physical, and psychosocial well-being resulting in the potential risk of inappropriate treatment and adverse consequences. This has the potential to affect all residents needing psychotropic medications in the facility. Finding includes: In a RR on 12/02/21 at 10:20 AM, R41 was admitted to the facility on 11/01/21 for a fracture	F 758	1. In review of the confidential patient list provided, there is no resident #24 present on this list. For guest #41 the appropriate diagnosis was obtained from physician along with adding behavior monitoring. Completed 12/2/21 2. Facility guests that receive psychotropic medication have the potential to be affected by the alleged practice. An audit of any guest on psychotropic medication was conducted to determine appropriate diagnosis is in place and Behavior log is in place. Completed 1/13/22. 3. Education completed 1/13/22 was provided to licensed nurses regarding completion of physician orders for psychotropic medication to ensure that there is an appropriate diagnosis and monitoring of behaviors/side effects. The	

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	125064	A. BUILDING _____ B. WING _____	12/03/2021

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CLARENCE TC CHING VILLAS AT ST FRANCIS	2230 LILIHA STREET HONOLULU, HI 96817

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F 758	Continued From page 34 of the upper and lower end on the right fibula (lower leg). R41 has a diagnosis of depression. Admission MDS report with ARD of 11/07/21, indicated a BIMS score of 14, meaning R41 is cognitively intact. R41's "Care Plan for Mild Depression" dated 11/30/21, documented the following interventions to "Monitor targeted behaviors: tearful/crying, verbalize feeling sad." R41's EMAR indicated that on 11/30/21, sertraline hydrochloride (an antidepressant medication), 150 mg was administered to R41 for a diagnosis of depression. R41's EMAR had no documentation monitoring adverse side effects or targeted behaviors for sertraline hydrochloride on 11/30/21. The order was discharged on 12/01/21. "Physician orders" indicated that on 12/01/21, sertraline hydrochloride 100 mg tablet at bedtime was ordered with no diagnosis documented. The first scheduled administration date for sertraline hydrochloride 100 mg was 12/01/21. There were no orders or behavioral log documented for this new order of sertraline hydrochloride in R41's EHR. In an interview on 12/02/21 at 2:31 PM with NM5, NM5 concurrently reviewed R41's EHR and EMAR. NM5 confirmed that sertraline hydrochloride was administered on 11/30/21 and 12/01/21. NM5 confirmed that there was no diagnosis documented for the current physician order of sertraline hydrochloride 100 mg tablet at bedtime. NM5 stated, "It is the nurse manager's responsibility to check every day to update medication orders. I didn't check R41's chart yesterday to add the depression diagnosis to the new order." NM5 also confirmed that there were no orders or behavioral log to monitor R41's targeted behaviors while R41 is on sertraline hydrochloride.	F 758	RCM will run psychotropic medication report to review any new orders for psychotropic medications and review that there is a diagnosis and target behavior monitoring. 4. Director of Nursing/designee to Director of Nursing to perform random audits on guests receiving psychotropic medication will be conducted weekly x4, then monthly x3, then quarterly until requirements are met. Audit findings will be relayed in QAPI.	

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F 758	Continued From page 35 In a review on 12/02/21 at 3:00 PM of the facility's policy on "Use of Psychotropic Drugs" dated 02/11/21, the policy stated, "Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record...The resident's response to the medication(s), including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record."	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761		1/15/22

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F 761	Continued From page 36 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on an observation and interview of a staff member, the facility failed to provide for the security of one resident's, R44's, medications. This deficient practice is a failure of the facility to practice the basic nursing standard of always keeping resident's medication(s) secure and has the potential to affect all residents in the facility. Finding includes: On 12/02/21 at 08:26 AM, a medication administration observation was made with RN11 to R44. RN11 situated her medication cart at the doorway of R44's room. R44's room was at the end of the hallway next to closed double doors. RN11 popped the medications out of the blister packs into a medication cup from the individual medication cards for R44. One staff member passed through the double doors during this time. After she prepared R44's medications, she left the individual medication cards on top of the medication cart and did not lock her cart. RN11 stated, "I need to check her heart rate." She entered R44's room and proceeded to administer the medications to R44. Another staff member passed through the closed double doors and passed by the unlocked medication cart with the medication blister packs on top of it. A follow up query was made with RN11 after she administered medications to R44 about her unlocked medication cart and medications left on top. RN11 stated that she needed to check R44's heart rate before she could give one of the medications, that's why she did not put the blister	F 761	1. Medications for guest #44 was stored back into the medication cart. The licensed nurse involved in this incident was re-educated on proper medication storage protocols. Completed 1/10/22. 2. Facility guests have the potential to be affected by the alleged practice. An audit being performed on medication pass of licensed nurses to ensure no medications were left on cart and that the medication cart locked when out of sight of the licensed nurse. To be completed 1/14/22. 3. Education provided to licensed nurses regarding proper medication storage policy along with CMS regulations on proper medication storage, when needing to go away from the medication cart that any medication is securely placed and locked into the medication cart. Completed 1/13/22. 4. Director of Nursing/designee to Director of Nursing will perform random audits on medication pass to ensure that medication cart is locked/no medication is not left on cart out of view of nurse weekly x4, then monthly x3, then quarterly until requirements are met. Audit findings will be relayed in QAPI.	

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F 761	Continued From page 37 packs of medications away. She did state that she should have put the medications away and lock the medication cart before leaving it.	F 761		
F 838 SS=C	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and	F 838		1/14/22

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F 838	Continued From page 38 food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview and RR, the facility failed to ensure the documented Facility Assessment included information on the ethnic, cultural, religious, staffing, training, and personnel resources necessary and available to care for its residents competently. This is a failure of the facility to identify the personal needs of each and every resident that resides there. Finding includes:	F 838	1. The Facility Assessment was reviewed and updated on 1/14/22 as needed by Administration regarding the information under the Cultural Section for cultural/religious services to reflect current population and services available. The Staff trainings needs / competencies relating to the defined topics based on the facility evaluation had all taken place and are ongoing. However, they were not included in the Facility Assessment	

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F 838	Continued From page 39 On 12/02/21 at 2:05 PM, a concurrent interview with the facility's Executive Director (ED) and a review of the Facility Assessment were done. It was noted that for the ethnic, cultural, and religious factors, including activities, food, and nutrition services necessary to care for the resident population, there were lists of different items, but no data had been collected to reflect the residents' potential needs in these areas. For example, under "Spiritual/Religious Services" there was the following list: Catholic Mainline Protestant Other Christian Jewish Buddhist There was no information to indicate how many residents, if any at all, practiced each faith listed. None of the categories were defined or clarified, such as "Other Christian". There was no indication if the residents actually practiced their faiths, or what their spiritual/religious needs might be as a person actively practicing their faith. The lists of categories lacking collected data reflecting the resident population continued throughout the ethnic, cultural, and religious sections. Under the Staffing, Training, Services and Personnel section it was noted that there were lists of resident needs (functional, mobility, disease-specific, etc.) with three columns titled: Overall Staffing, Staff Competencies, Services. Below each of the three columns, instead of data indicating what the staff resources, education, training, and competencies were, the word "Evaluated" was repeated for every category in	F 838	supporting documentation. These were reviewed and included with the Facility Assessment by the Staff Development Coordinator / Infection Control Preventionist. 2. Facility guests have the potential to be affected by the alleged practice. 3. The Administrator and Staff Development Coordinator (SDC) were inserviced on 1/14/22, on the Facility Assessment by the Compliance Officer. Inservices will be ongoing as needed. Religious services were updated to reflect current population. Services available include laypersons non-denominational religious services / visits available, Catholic services available, Christian Chapel onsite with services (when allowed related to COVID and gatherings), inter-faith Chaplains visits, Buddhist priest available, end of life counseling services, community religious leader visits, transport for community worship services available. Guests personal religious/spiritual advisor visits are encouraged. Religious reading / study materials are available for all religions onsite and also available for download for individual use. Dietary reviews guests dietary preferences/practices. Religious observant and ethnic food choices are available. Both religious and non-religious holidays are observed per guest choice. The Administrator and SDC were inserviced on 1/14/22, on the Facility Assessment by the Compliance Officer. Inservices will be ongoing as needed.	

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F 838	Continued From page 40 the list. When questioned about the lacking data, the ED indicated he thought it was in there. As he turned through the pages of the Facility Assessment to show the surveyor where the data could be found, the ED stated, "oh, it says evaluated."	F 838	Along with mandatory education, staff training subjects were determined related to the Facility assessment. These included but not limited to ADL training, daily care, ambulation, transfer, toileting, mobility □ range of motion. The supporting documentation was added to the overall Facility Assessment. 4. The Administrator will monitor compliance with the overall Facility Assessment through review monthly and updates as needed for a minimum of 3 months or until compliance is achieved. The Activity Coordinator will monitor compliance with religious / cultural preferences through medical record audits weekly and updates as needed for 12 weeks or until compliance is achieved. The SDC will monitor staff trainings with identified needs from the Facility Assessment monthly and update as need for a minimum of 3 months or until compliance is achieved. The SDC will provide copies of staff trainings in identified subjects to the Administrator as they occur. Reviews and audits will be brought to the Quality Assurance and Performance Improvement (QAPI) meeting monthly for review and recommendations for a minimum of 3 months or until compliance is achieved.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		1/15/22

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F 880	Continued From page 41	F 880		

comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

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F 880	Continued From page 42 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and RR, the facility failed to maintain an effective infection prevention and control program designed to provide the appropriate decontamination of equipment and an appropriate process when sterile supplies are used. These deficient practices has the potential to transmit infections and communicable diseases to residents, staff, volunteers, and visitors. Findings include: 1) Observation on 12/01/21 at 06:34 AM revealed a blood pressure (BP) taken of a resident in the hallway. The BP equipment was then taken into a resident's room. No decontamination was done	F 880	1. Guest #172 IV tubing reviewed and labeled with date; re-education provided to licensed nurse involved in this incident. Completed 12/1/21 2. Facility guests that receive IV therapy and use of multi-use equipment have the potential to be affected by the alleged practice. An audit completed 1/13/22 for any guest receiving IV (intermittent and continuous) to ensure that there was appropriate labeling of date/time hung and that tubing changed per policy; audit performed on staff regarding proper disinfecting practices with multi-use equipment. 3. Education provided to Licensed nursing	

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F 880	Continued From page 43 by the staff of the BP cuff before entering the resident's room. On the same day at 06:41 AM, same floor, observed CNA1 washing hands on exit of a resident's room. Cavi-wipe (disinfecting wipe) container was noted in the cart of the BP machine. No decontamination of the BP equipment was noted at 06:43 AM Staff went into another resident room with the same equipment. No decontamination with Cavi-wipe by staff was observed of BP equipment upon exit of room. Observation on 12/01/21 at 06:45 AM on another nursing unit revealed CNA2 going into a resident's room. CNA2 did hand hygiene. Cavi-wipe container was in the basket with no decontamination done on BP cuff or equipment upon entry. At 06:48 AM, student nurse (SN) brought the BP machine out and did not decontaminate the equipment. At 12/01/21 at 06:51 AM, the SN reminded CNA2 to decontaminate the equipment. CNA2 then decontaminated the BP machine. An interview was done with CNA2 on 12/01/21 at 07:00 AM, who stated "It is our protocol to wipe down the machines before and after use." CNA2 was able to state the kill time of the Cavi-wipe. During an interview on 12/01/21 at 07:15 AM, the surveyor asked what the Cavi-wipes in the basket of the BP equipment were used for. CNA1 stated "Oh yea, we are supposed to wipe (the BP equipment) after you're all done in the rooms." During an interview on 12/03/2021at 11:08 AM, the Education Specialist (ES) stated that staff should be decontaminating the equipment with Cavi-Wipes before and after going into the	F 880	staff regarding policy regarding IV tubing protocol with labeling tubing and when tubing would be changed; education provided to staff that use multi-use equipment and proper disinfecting in between each guest. All staff received education on the CDC Sparkling Surfaces and Clean Hands videos along with completion of the CDC training module 6A Principles of Standard Precautions and 11B Environmental Cleaning and Disinfection. Completed 1/13/22. 4. Infection Prevention RN/designee to the Infection Prevention RN will perform random audits on proper disinfecting between multi-use equipment, labeling of IV tubing, proper hand washing, and proper sanitizing weekly x4, then monthly x3, then quarterly until requirements are met. Audit findings will be relayed in QAPI.	

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F 880	Continued From page 44 guest's (resident's) rooms. 2) On 12/02/21 at 3:30 PM, RN12 came into R172's room and asked R172 if he was ready for his IV (intravenous) antibiotic infusion. R172 stated that he was not ready yet. Hanging on the IV pole was an IV antibiotic bag full of fluid attached to IV tubing that was not dated. In a follow up query with RN12 at 3:40 PM at the nursing station, he stated that the IV tubing for R172's IV antibiotic should be dated to ensure that it was new equipment and not re-used. On 12/03/21 at 07:04 AM, the infection control policy was received by the DON. In a query about the use of sterile IV tubing, she stated that the IV tubing should always be labeled with a date. The " Section 3.2, General Clinical Policies for Infusion Therapy, Infection Control Standards, 04/08" policy was reviewed at 07:15 AM. It stated, "Primary intermittent tubing is changed every 24 hours..."	F 880		
F 917 SS=D	Resident Room Bed/Furniture/Closet CFR(s): 483.10(i)(4), 483.90(e)(2)(3) §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv) §483.90(e)(2) -The facility must provide each resident with-- (i) A separate bed of proper size and height for the safety and convenience of the resident; (ii) A clean, comfortable mattress; (iii) Bedding, appropriate to the weather and climate; and (iv) Functional furniture appropriate to the	F 917		1/15/22

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	125064	A. BUILDING _____ B. WING _____	12/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENCE TC CHING VILLAS AT ST FRANCIS	2230 LILIHA STREET HONOLULU, HI 96817

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 917	Continued From page 45 resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident. §483.90(e)(3) CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (e)(1) (i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations (i) Are in accordance with the special needs of the residents; and (ii) Will not adversely affect residents' health and safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and RR, the facility failed to provide a comfortable mattress for R41. As a result of this deficient practice, the resident was prevented from attaining or maintaining her highest level of independence and well-being. Finding includes: In an observation on 11/30/21 at 08:55 AM, R41 was observed sleeping in bed on her back. The head of the bed was raised at a 45-degree angle. A bed rail was located on each side of the head of the bed. R41 appeared well nourished and had a cast on her lower right leg. There were approximately 3 (three) inches of mattress space from each of R41's arms to the edge of the bed mattress. In an interview on 11/30/21 at 10:35 AM, R41 stated, "My bed is too small and uncomfortable. I have a wheelchair cushion on my bed for my bottom to make it more comfortable but it's still	F 917	1. Guest #41 had the bed changed out for an appropriately sized bed and an air loss mattress 12/2/21. 2. Facility guests have the potential to be affected by the alleged practice. An audit was completed on guest□s beds/mattresses to ensure that appropriate devices/preventative mattresses are present on the bed that meets the guest□s specific needs. To be completed 1/14/22. 3. Education provided to staff regarding notifying the EVS manager via phone or through maintenance book when a bed needs to be changed out. Completed 1/13/22. 4. Director of Nursing/designee to Director of Nursing will perform random audits on appropriate bed devices/preventative measures and right sized bed for guest weekly x4, then monthly x3, then quarterly until requirements are met. Audit findings will be relayed in QAPI.	

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F 917	Continued From page 46	F 917		

hard to sleep. I've been sleeping on this cushion for the last two nights. My bed was supposed to be changed but it can't fit through the doors because of the bed rails. I even asked maintenance to take off the door so the bed can fit through, but they said they can't do that."

On 11/30/21 at 10:35 AM, 12/01/21 at 08:29 AM, and 12/02/21 at 12:01 PM, R41 was observed sitting in her wheelchair in her room. A flat cushion was observed on top of the middle of R41's mattress. A thin bedsheet covered the cushion and the mattress.

In a record review on 12/02/21 at 10:20 AM, R41 was admitted to the facility on 11/01/21 for a fracture of the upper and lower end on the right fibula. R41 diagnoses included morbid (severe) obesity due to excess calories and congestive heart failure. Admission MDS report with ARD of 11/07/21 showed a BIMS score of 14 meaning R41 is cognitively intact. Admission MDS report with an ARD of 11/07/21, "Section G0110" documented that R41 needs one-person physical assist to move in bed and two persons physical assist for transfers.

In an interview on 12/02/21 at 11:44 AM, the DON stated, " I wasn't sure what the situation was about R41's bed." DON stated that she will follow-up with R41 about changing her bed and that the bedrails can be removed so that a new bed can be brought in.

In an interview on 12/02/21 at 11:53 AM, DON stated that R41's bed was changed to a larger bed.

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E 000	Initial Comments The facility was found in compliance with Section 483.73, Requirement for Long Term Care (LTC) Facility Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types, State Operations Manual.	E 000		

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

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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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	125064	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/16/2021**

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K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: K-345 Fire Alarm System-Testing and Maintenance This STANDARD is not met as evidenced by: Based on record review and observation of the fire alarm panel with facility manager, the facility failed to maintain the facility's fire alarm system in a fully operable condition in accordance with NFPA 70, National Electric Code, 2011 edition, NFPA 72 National Fire Alarm and Signaling Code, 2010 edition, NFPA 101, Life Safety Code, 2012 edition, section 9.6.1.2 through 9.6.1.5 This deficiency could affect all residents, staff, and visitors during a fire due to the lack of an operable fire alarm system. Findings include: During record review on 12/16/21 at approximately 12:15 pm revealed that the facility failed to address the issues causing a "trouble signal" on the fire alarm panel and inspection records. These findings were verified at the exit conference with the facility manager and Administrator on 12/16/21 at 2:00 pm.	K 345	This Plan of Correction constitutes this facility□s written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. To ensure that the facility□s fire alarm system is in a fully operable condition and to address the issues causing a trouble signal on the fire alarm panel and inspection records, the Maintenance Foreman, on 1/4/22, ordered the required replacement parts from and to be installed by a qualified contractor. The Maintenance Foreman is ensuring that fire watch procedures are occurring until the issue is resolved. 2. The facility has determined that all guests have the potential to be affected. 3. The Administrator provided, on 1/13/22, education as to the regulatory requirement for Fire Alarm System □ Testing and	1/13/22

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K 345	Continued From page 1	K 345	Maintenance, to the Maintenance Foreman. The facility□s work request system will be used to have a qualified contractor routinely inspect and test the fire alarm system to ensure that maintained is the facility□s fire alarm system in a fully operable condition. 4. The Maintenance Foreman or qualified designee will use the facility□s work request system to have a qualified contractor routinely conduct an inspection and testing of the fire alarm system. If inspection and testing find the fire alarm system not in a fully operable condition, appropriate repairs will be made without delay. The Administrator or qualified designee will review, monthly at the Quality Assurance and Performance Improvement Committee meeting, records after each fire alarm system inspection and testing, and verify that the records are maintained in a secure location and readily available for review. The findings will be submitted to the Quality Assurance and Performance Improvement Committee for review to ensure continued compliance; until at such time the committee recommends less frequent monitoring or that the issue has been resolved.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire	K 353		1/13/22

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K 353	Continued From page 2 Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: K-353 Sprinkler System-Inspection and Testing This standard is not met as evidenced by: Based on record review and staff interview with facility manager, the facility failed to produce documentation for a monthly and quarterly fire sprinkler system inspection and testing in accordance with NFPA 101, Life Safety Code, 2012 edition, section 9.7.5, and NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems 2011 edition, section 5.2. This deficiency could affect all residents, staff, and visitors during a fire due to the lack of monthly and quarterly inspections to ensure proper fire sprinkler operations during fire conditions within the facility. Findings include: During record review on 12/16/21 at approximately 11:15 am revealed that the facility failed to provide documentation for the monthly and quarterly fire sprinkler inspection and testing. These findings were verified at the exit conference with the facility manager and	K 353	1. The Maintenance Foreman will ensure that documentation for the monthly and quarterly fire sprinkler inspection and testing completed by a qualified contractor is readily available for review. 2. The facility has determined that all guests have the potential to be affected. 3. The Administrator provided, on 1/13/22, education as to the regulatory requirement for Sprinkler System □ Maintenance and Testing, to the Maintenance Foreman. The Administrator will verify that records of system design, maintenance, inspection, and testing are maintained in a secure location and readily available for review. Included in the record will be date sprinkler system last checked, who provided system test, water system supply source, and provided in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 4. The Maintenance Foreman or qualified	

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K 353	Continued From page 3 Administrator on 12/16/21 at 2:00 pm.	K 353	designee will use the facility□s work request system to have a qualified contractor monthly and quarterly fire sprinkler system inspection and testing. If inspection and testing find the fire sprinkler system not in a fully operable condition, appropriate repairs will be made without delay. The Administrator or qualified designee will review, monthly at the Quality Assurance and Performance Improvement Committee meeting, records after each fire sprinkler system inspection and testing, and verify that the records are maintained in a secure location and readily available for review. The findings will be submitted to the Quality Assurance and Performance Improvement Committee for review to ensure continued compliance; until at such time the committee recommends less frequent monitoring or that the issue has been resolved.	
K 531 SS=D	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with	K 531		1/13/22

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K 531	Continued From page 4 Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: K-531 Elevators This STANDARD is not met as evidenced by: Based on record review and staff interview with facility manager, the facility failed to produce documentation for an annual inspection for the facility's elevators in accordance with NFPA 101, Life Safety Code, 2012 edition, section 9.4.6.1. This deficiency could affect all residents, staff, and visitors during a fire due to the lack of an annual inspection to ensure proper fire fighter operations. Findings include: During record review on 12/16/21 at approximately 12:15 pm revealed that the facility failed to provide documentation for the annual elevator inspection. These findings were verified at the exit conference with the facility manager and Administrator on 12/16/21 at 2:00 pm.	K 531	1. The Maintenance Foreman, on 12/16/21, obtained the service report from the qualified contractor responsible for completing the annual inspection and testing of the facility□s elevators and will ensure that the report is readily available for review. 2. The facility has determined that all guests have the potential to be affected. 3. The Administrator provided, on 1/13/22, education as to the regulatory requirement for Elevators □ 2012 EXISTING, to the Maintenance Foreman. The Administrator reviewed the service report received on 12/16/21 and verified that it is maintained in a secure location and readily available for review. 4. The Maintenance Foreman or qualified designee will use the facility□s work request system to have a qualified contractor conduct an inspection and testing annually of the facility□s elevators. If inspection and testing find an elevator not meeting requirements, appropriate repairs will be made without delay. The Administrator or qualified designee will review, monthly at the Quality Assurance and Performance Improvement Committee meeting, the service report after completion of the annual inspection	

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K 531	Continued From page 5	K 531	and testing of the facility□s elevators and verify that the reports are maintained in a secure location and readily available for review. The findings will be submitted to the Quality Assurance and Performance Improvement Committee for review to ensure continued compliance; until at such time the committee recommends less frequent monitoring or that the issue has been resolved.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: K-761 Maintenance, Inspection and testing-Doors This STANDARD is not met as evidenced by: Based on record review and staff interview with facility manager, the facility failed to produce documentation for an annual inspection for the fire doors in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives,	K 761	1. The Environmental Services Manager ensured that all fire doors were inspected and tested on 1/11/22 and 1/12/22, by an individual who possess knowledge, training or experience that demonstrates ability to ensure compliance, and that written records of inspection and testing were received and readily available for	1/14/22

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K 761	Continued From page 6 2010 edition, sections 5.2, and 5.2.3. This deficiency could affect all residents, staff, and visitors during a fire due to the lack of an annual inspection to ensure proper protection from fire and smoke extension within the facility. Findings include: During record review on 12/16/21 at approximately 12:15 pm revealed that the facility failed to provide documentation for the annual fire door inspection. These findings were verified at the exit conference with the facility manager and Administrator on 12/16/21 at 2:00 pm.	K 761	review. 2. To identify other guests having the potential to be affected, all fire doors were inspected and tested on 1/11/22 and 1/12/22, by an individual who possess knowledge, training or experience that demonstrates ability to ensure compliance. Written records of the inspection and testing have been received and are being maintained in a secure location and are readily available for review. Appropriate repairs if needed were made without delay and reinspected on 1/13/22 and 1/14/22. 3. The Administrator provided, on 1/11/22, education as to the regulatory requirement for fire doors assemblies being inspected and tested annually, to the Environmental Services Manager. All fire doors will be inspected and tested annually, by an individual who possess knowledge, training or experience that demonstrates ability to ensure compliance. The Administrator will verify that written records of the inspection and testing are maintained in a secure location and readily available for review. If inspection and testing find a fire door not meeting requirements, appropriate repairs will be made without delay. 4. The Environmental Services Manager or qualified designee will use the facility□s work request system to conduct an inspection and testing annually of fire doors assemblies. If inspection and testing find a fire door not meeting requirements, appropriate repairs will be made without delay. The Administrator or qualified designee will review, monthly at	

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K 761	Continued From page 7	K 761	the Quality Assurance and Performance Improvement Committee meeting, records after completion of inspection and testing of the facility□s fire doors and verify that the written records are maintained in a secure location and readily available for review. The findings will be submitted to the Quality Assurance and Performance Improvement Committee for review to ensure continued compliance; until at such time the committee recommends less frequent monitoring or that the issue has been resolved.	
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder	K 918		1/13/22

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K 918	Continued From page 8 circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: K-918 Electrical Systems-Essential Electric System Maintenance and Testing This STANDARD is not met as evidenced by: Based on record review and staff interview with facility manager, the facility failed to produce documentation for an annual testing of diesel fuel in accordance with NFPA 99 Healthcare Facilities Code, 2012 edition, section 6.5.4, and NFPA 110 Standard for Emergency and Standby Power Systems, 2010 edition, section 8.3.8. This deficiency could affect all residents, staff, and visitors during an interruption of grid power due to the lack of an annual diesel fuel test to ensure proper operation of the standby power system. Findings include: An observation on 12/16/21 at approximately 12:15 pm revealed that the facility failed to provide documentation for the annual diesel fuel test. These findings were verified at the exit conference with the facility manager and Administrator on 12/16/21 at 2:00 pm.	K 918	1. The Maintenance Foreman, on 12/16/21, obtained the service report from the qualified contractor responsible for completing the annual testing of diesel fuel and will ensure that the report is readily available for review. 2. The facility has determined that all guests have the potential to be affected. 3. The Administrator provided, on 1/13/22, education as to the regulatory requirement for Electrical Systems Essential Electric System Maintenance and Testing, to the Maintenance Foreman. The Administrator reviewed the service report received on 12/16/21 and verified that it is maintained in a secure location and readily available for review. 4. The Maintenance Foreman or qualified designee will use the facility s work request system to have a qualified contractor conduct an inspection and testing annually of the facility s diesel fuel. If inspection and testing find the diesel fuel not meeting requirements,	

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	125064	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/16/2021**

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K 918	Continued From page 9	K 918	appropriate action will be taken without delay. The Administrator or qualified designee will review, monthly at the Quality Assurance and Performance Improvement Committee meeting, the service report after completion of the annual inspection and testing of the facility□s diesel fuel and verify that the reports are maintained in a secure location and readily available for review. The findings will be submitted to the Quality Assurance and Performance Improvement Committee for review to ensure continued compliance; until at such time the committee recommends less frequent monitoring or that the issue has been resolved.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient	K 923		1/13/22

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K 923	Continued From page 10 care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: K-923 Gas Equipment-Other This STANDARD is not met as evidenced by: Based on observation and staff interview with maintenance staff, the facility failed to provide adequate separation for full and empty "E" oxygen cylinders and to keep the total capacity of compressed gas under 300 cubic feet, in accordance with NFPA 99, Healthcare Facilities Code, 2012 edition, sections 11.3.3, 11.6.5.2, and 11.6.5.3. This deficiency could affect all residents requiring oxygen therapy by the possibility of administering an empty oxygen cylinder in lieu of a full cylinder during an emergency. Findings include: During facility survey on 12/16/21 at approximately 12:45 pm, revealed that the facility failed to provide adequate separation and exceeded the 300 cubic foot limit (12 "e" cylinders) in the oxygen storage room. These	K 923	1. The Environmental Services Manager, on 12/16/21, ensured adequate separation for full and empty E-size oxygen cylinders and not exceeded was the total capacity of compressed gas under 300 cubic feet limit (12 E-size cylinders) in the oxygen storage room. 2. To identify other guests having the potential to be affected, the Environmental Services Manager inspected on 12/16/21, all oxygen storage rooms to ensure compliance. All other oxygen storage rooms had adequate separation for full and empty E-size oxygen cylinders and contained the appropriate number of E-size oxygen cylinders. 3. The Environmental Services Manager, on 1/7/22, posted signage in the oxygen storage rooms to display the requirements	

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K 923	Continued From page 11 findings were verified at the exit conference with the facility manager and Administrator on 12/16/21 at 2:00 pm.	K 923	regarding adequate separation for full and empty E-size oxygen cylinders and the appropriate number of E-size oxygen cylinders. The Environmental Services Manager, on 1/12/22, setup a work task schedule using the facility□s work request system to conduct an inspection, once weekly for 12 weeks, of the oxygen storage rooms. If an oxygen storage room does not have adequate separation for full and empty E-size oxygen cylinders and or does not contain the appropriate number of E-size oxygen cylinders, appropriate corrective action will be taken. The Administrator provided general education, on 1/11/22, 1/12/22, and 1/13/22, on the topic of Oxygen Storage Compliance to facility staff. 4. The Environmental Services Manager or qualified designee will use the facility□s work request system to conduct an inspection, once weekly for 12 weeks, of the oxygen storage rooms. If an oxygen storage room does not have adequate separation for full and empty E-size oxygen cylinders and or does not contain the appropriate number of E-size oxygen cylinders, appropriate corrective action will be taken. The findings will be submitted to the Quality Assurance and Performance Improvement Committee for review to ensure continued compliance; until at such time the committee recommends less frequent monitoring or that the issue has been resolved.	

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E 000	Initial Comments THIS FACILITY MET THE LIFE SAFETY REQUIREMENTS OF APPENDIX "Z"; IN ACCORDANCE WITH CFR 483.73, REQUIREMENT FOR LONG-TERM CARE (LTC) FACILITIES	E 000		

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

Electronically Signed | 01/14/2022

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.