STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125026	A. BUILDING _____ B. WING _____	12/14/2021

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KUAKINI GERIATRIC CARE, INC	347 NORTH KUAKINI 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 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) #9221 and #9203 were found to be un/substantiated. Two complaints, ACTS #8791 and #9235 (unsubstantiated) were found to be un/substantiated. Survey Dates: December 09, 2021, to December 14, 2021 Survey Census: 140 Sample Size: 28	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		1/28/22

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

Electronically Signed | 02/04/2022

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F 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the resident's right to be treated 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 for 5 of X (Resident (R)52, R234, R84, R20, R97, and R334) residents sampled. This deficiency has the potential to affect the resident's psychosocial health and affect their quality of life. Findings include: 1) R52 is a 93-year-old male who was admitted to	F 550	Corrective Action: " Catheter bag covers were provided for Residents (R) 52, (R) 234, and (R) 84 Completed 12/14/2021 " The therapeutic recreation staff TRS1 was educated on (1) the correct approach to addressing Resident (R) 20□s requests for assistance to ensure that residents' requests are communicated timely to the nursing staff Completed 01/28/2022	

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F 550	Continued From page 2 the facility on 09/24/21 with diagnosis that include high blood pressure, gastroesophageal Reflux Disease (GERD), benign prostatic hyperplasia (an enlarged prostate that makes it difficult for the resident to urinate), pneumonia due to aspiration (breathing in a foreign substance/particle into the lungs), malnutrition, failure to thrive, and a urinary tract infection. R52 was admitted with a Foley catheter. Review of R52's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/30/21 documented a Brief Interview for Mental Status (BIMS) score of 13, indicating he is cognitively intact. On 12/09/21 at 08:40 AM, observed R52 seated in a wheelchair, in the hallway, with his catheter tubing exposed. Dark yellow urine was observed in the catheter tubing and two (2) female residents were within approximately 6 feet of him. At 09:30 AM, inquired with R52 regarding being in the hallway with the catheter tubing exposed. R52 stated initially when he came out of the room, he had a blanket over his lap. Staff removed the blanket to put lotion on his legs and did not place the blanket back on him. R52 reported feeling badly that he needs a catheter to help empty his bladder. 2) R234 was admitted to the facility on 11/04/21 with diagnosis that included a stage 4 pressure ulcer with underlying cellulitis, multiple pressure wounds, vascular Dementia, contractures, and left sided weakness due to a stroke. He was admitted to the facility with a Foley catheter. On 12/09/21 at 3:20 PM, from the hallway, this surveyor observed the resident's uncovered catheter bag hanging from the side of his bed closest to the door. Inquired with Licensed Staff	F 550	" Resident (R) 97□s Assessment was completed, and Resident (R) 97's Comprehensive Care Plan was reviewed and updated to reflect the required individualized care including the language barrier and behavioral needs. Completed 12/22/2021 " Resident (R) 334□s Occupational Therapy screen was completed for all activities of daily living (ADL) and transfer care and there were no new recommendations for the services to provide to the Resident (R) 334. Resident (R) 334 continues to require total assist with use of the Hoyer lift for all transfers and is not recommended for transfer via Hoyer lift to toilet or bed side commode due to safety. Resident (R) 334 was given education to request and use a bed pan for toileting needs. Completed 12/14/2021 Systemic changes: " The KGC Director of Nursing (DON) or designee identified all residents who have orders for Foley catheters and ensured that these residents were provided with catheter bags covers. Completed 12/14/2021 " The Nursing Home Administrator educated the Therapeutic Recreational Activity Staff to notify the nursing staff of	

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F 550	Continued From page 3	F 550		

(LS)10 regarding the visibility of R234's uncovered catheter bag from the hallway. LS10 acknowledged if his catheter bag is visible from the hallway, then it should have been covered or placed on the other side of his bed to conceal it from other residents and visitors that pass by R234's room.

3) R84 was admitted to the facility on 11/8/21 with diagnosis that include sepsis (a life-threatening complication of an infection in the blood stream), urinary retention, Dementia, renal (kidney) failure, low blood pressure, and a stage 4 pressure ulcer on sacrum (the bottom portion of the spine). R84 was admitted with a Foley catheter.

On 12/09/21 at 10:15 AM, while standing in the hallway, this surveyor observed R84's uncovered catheter bag hanging from her bedside closest to the doorway. The uncovered catheter bag was filled (approximately a third full) of yellow colored urine.

4) On 12/10/21 at 07:10 AM, R20 was observed to be awake and lying-in bed with the front of his brief rolled down and tucked under his behind, exposing his genitals. R20 quickly tried to cover himself after surveyor knocked and entered his room. At 09:06 AM, R20 was observed to be lying in bed with a napkin and towel around his neck, there was no breakfast tray at his bedside. At 10:23 AM, R20 was sitting up in his wheelchair in the solarium participating in an activity. At 11:13 AM, R20 was observed to be sitting up in his wheelchair in the hallway fronting the nursing station. The therapeutic recreation staff (TRS)1 asked R20 if he wanted to go into the solarium for activities, unlocked his wheelchair and started to wheel him towards the solarium. R20 responded

any resident needs that are brought to their attention by the residents including requests to use the restroom.

Completed 01/28/2022

" The Patient Care Coordinators (PCC) or designee reviewed the mood and behavior of all the residents in order to identify unwanted behavior. All identified unwanted behaviors were properly addressed in the residents Comprehensive Care Plans with specific interventions. A behavior log was developed to monitor behavior the residents and interventions in order to improve the management of the unwanted behavior.

Completed 12/22/2021 and ongoing

" The PCC or designee reviewed all the residents with any communication and/or language barriers and concerns. All the identified communication needs and/or language barriers are properly addressed in the updated individualized residents Comprehensive Care Plans with specific communication techniques and available options to address the language barriers.

Completed 12/22/2021

" The PCC or designee conducted an audit of all residents with Hoyer lift transfers to verify that the resident's mode of transfer technique continues to be current and accurate based on the individualized resident's preference and

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F 550	Continued From page 4 by saying that he wanted to go to the restroom. TRS1 stated, "Oh!" parked him back into the hallway, locked the wheels of the wheelchair and left. At 11:24 AM, patient care coordinator (PCC)5 wheeled R20 into the television room. At 11:37 AM, R20 was observed in the solarium doing a coloring activity. R20 told TRS1 loudly that he needed to use the restroom. R20's request was again ignored by TRS1 as she told him that lunch was being served. On 12/14/21 at 07:51 AM, R20's health record was reviewed. The "Queens University Medical Group Nursing Home Progress Note," dated 11/15/21, revealed that R20 was a 78-year-old resident initially admitted to the facility on 08/09/21. He receives hemodialysis for kidney failure and suffers from bipolar disorder (mental illness characterized by extreme mood swings) and depression treated with medications. On 12/14/21 at 1:00 PM, query was done with certified nurses' aide (CNA)5 in the hallway in front of the nursing station about what should be done if a resident asks a TRS to use the restroom and she stated that the TRS should notify the nurse. 5) An initial record review for R97 was done on 12/09/21 at 12:42 PM. He is a 57-year-old resident receiving hemodialysis for kidney failure, admitted on 10/25/21. The facility's Minimum Data Set (MDS) report "updated: 10/19/2021" (a recent MDS report was requested of the facility but was never provided) revealed that he is receiving antianxiety and antidepressant medications. On 12/13/21 at 08:27 AM, R97 was observed to	F 550	transfer status and recommendations from the residents Occupational Therapy screening. Completed 01/28/2022 and ongoing " The KGC DON or designee provided education to all KGC employees on the Resident's Rights and Responsibilities. Completed 01/28/2022 Monitoring and corrective action: " The Patient Care Coordinators (PCCs) or designee will conduct monthly audits of residents with Foley catheters to ensure these residents are provided catheter bag covers. The audit result will be reported to the Interdisciplinary team (IDT) meetings and the Performance Improvement (PI) Committee meetings. Completed 01/28/2022 and ongoing " The PCC or designee will conduct three random monthly resident interviews to identify any communication and/or language barrier concerns for a three-month period. The audit results will be reported to the Interdisciplinary team (IDT) meetings and the Performance Improvement (PI) Committee meetings. Completed 01/28/2022 and ongoing " The PCC or designee will conduct monthly audits on the daily completion of the behavior logs. The audit results will be	

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F 550	Continued From page 5 be occasionally yelling out from his room. A concurrent query was made to RN2 who was preparing resident medications at her medication cart in the hallway. She stated that R97 occasionally yells out, but it is difficult to assess his needs because of a language barrier. At 09:15 AM, a CNA entered R97's room, who was still occasionally yelling out. R97 stopped yelling and surveyor observed that he looked distressed, lying sideways in his bed and he stated, "Phone!" At 10:04 AM, R97 had still been yelling out and a concurrent query was made with LPN4 at the nursing station. She stated that R97 does not usually yell out, but she had already called her son and was informed that R97's wife was out of town. She continued to say that she will call his brother, but she continued doing her task at the nursing station. At 10:22 AM, the nursing home administrator (NHA) went to visit R97. R97 had still been yelling out. Surveyor noted that when the nursing station phone rang, R97 would yell, "Phone!" At 10:23 AM, a CNA was in R97's room and he was no longer yelling out. After she left the room, R97 started yelling out again. On 12/15/21 at 10:00 AM, R97's care plan, received from the DON on 12/14/21 at 08:00 AM, was reviewed. R97's identified needs for his language barrier and his yelling out behavior were not addressed, therefore there were no individualized interventions for their management. 6) Resident (R)334 is a 74-year-old female admitted to the facility on 10/28/21 for long-term	F 550	reported to the Interdisciplinary team (IDT) meetings and the Performance Improvement (PI) Committee meetings. Completed 01/28/2022 and ongoing " The PCC or designee will conduct monthly audits for individualized resident's care requests and preferences. The audit results will be reported to the Interdisciplinary team (IDT) meetings and the Performance Improvement (PI) Committee meetings. Completed 01/28/2022 and ongoing	

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F 550	Continued From page 6	F 550		

care (LTC). R334's admitting diagnoses included ischemic stroke (when a vessel supplying blood to the brain is blocked, causing brain tissue to die), with resulting left-sided weakness, high blood pressure, diabetes, and a history of breast cancer.

On 12/10/21 at 08:43 AM, observations and a concurrent interview was done with R334 in her room on the fifth floor. Certified Nurse Aide (CNA)4 had just entered the room and R334 asked to "go to the bathroom." CNA4 stated "I will get you the bedpan," to which R334 emphatically and repeatedly refused asking "why, I don't want to use the bedpan, I want to go to the bathroom!" Instead of answering her, CNA4 looked at me and asked, "what should I do, she cannot walk to the bathroom." After CNA4 left the room to find a second CNA to assist her with transferring, R334 stated that staff are "very rude," but that she does not complain or she "get[s] oogie treatment." When asked what she meant by that, R334 stated, "they just plop my food on the table, and they don't listen to me." When CNA4 returned with help, R334 stated "I couldn't hold it anymore, you guys took so long."

On 12/13/21 at 08:06 AM, it was observed that R334 had turned her call light on. Registered Nurse (RN)3 entered R334's room to take her blood pressure prior to preparing her morning medications. As soon as RN3 entered, R334 stated "I need to go to the bathroom." RN3 turned off the call light, and told R334 "you cannot walk, let me go get you a bedpan." R334 became upset and loudly asked, "What? Why? I want to go to the bathroom," then she shouted, "I DON'T WANT A BEDPAN!" RN3 turned his back on R334 so that he was facing the surveyor and

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F 550	Continued From page 7 began explaining that R334 could not walk. Surveyor instructed RN3 that he should be addressing the distressed resident behind him, not the surveyor. R334 had begun making movements towards the right side of the bed, trying to position herself to get out of bed. RN3 turned to her and said he would find someone to help her. Surveyor followed RN3 out of the room, where he turned to his medication cart in the doorway of the next room and began preparing medication for another resident. Surveyor asked RN3 why he turned R334's call light off if he did not help her, and he did not alert another staff member that she needed help. RN3 re-entered R334's room, stated to resident that she could not walk and again told her he would get a bedpan. R334 became upset, yelling, "no, no, I DON'T WANT A BEDPAN, how many times do I have to tell you!" RN3 told the resident he was going to find help and left the room. After RN3 left, R334 turned to me and stated, "he is a jerk, he never listens to me."	F 550		
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	F 584		1/28/22

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F 584	Continued From page 8 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 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 record review, the facility failed to provide a homelike environment for residents that minimized institutional practices, as evidenced by the facility-wide practice of obtaining routine weights between 12:00 AM and 01:00 AM in the morning. This deficient practice affects all residents at the facility scheduled for a routine weight check. Findings include:	F 584	Corrective Actions: " Resident (R) 334□s weights are taken on day shift per resident□s preference. Completed 12/16/2021 " The Patient Care Coordinators (PCC) reviewed all the residents□ preferred times for the monthly weight check.	

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F 584	Continued From page 9 On 12/10/21 at 08:28 AM, while reviewing the weight log binder for fifth-floor residents at the nurses' station, no weight log could be found for resident (R)334, who had been admitted on 10/28/21 for long-term care. The weight documented on her admission assessment was 76.2 kg [kilograms] or 167.64 lbs. [pounds]. A review of R334's electronic health record (EHR) revealed one weight documented on 12/08/21 at 03:08 AM by licensed practical nurse (LPN)3 of 152.6 lbs. No other weights were found documented under "weights" in the EHR. On 12/13/21 at 09:45 AM, an interview was done with LPN3 at the fourth-floor nurses' station. LPN3 stated that the procedure for routine weights for all residents in the facility is for the certified nurse aides (CNA) to weigh the residents between 12:30 AM and 01:00 AM, and the "licensed [nurses]" are responsible to write the weights in the weight binder and document the weights in the EHR. This procedure was confirmed by patient care coordinator (PCC)5, who was standing at the nurses' station at the time. When asked how waking residents up after midnight for a routine weight check contributes to a homelike environment, PCC5 shrugged and stated, "that's the process we've always followed." On 12/14/21 at 11:49 AM, during an interview with the Director of Nursing (DON) in her office, the DON confirmed that the policy for routine weights is for the weights to be measured on the nocturnal shift which starts at 11:00 PM. The DON did acknowledge how the process might be misaligned with providing a homelike environment but stated that was the procedure for routine weights prior to her working at the facility, and	F 584	Completed 12/22/2021 Systemic Change: " The KGC Director of Nursing (DON) or designee re-educated all staff on the updated monthly weight schedule for each resident care unit. Preferred monthly weight schedule was documented in the residents□ care plan. Completed 01/28/2022 and ongoing Monitoring of Corrective Actions: " The PCC or designee will conduct monthly resident interviews to ensure that the routine monthly weights are taken based on the resident□s preference. The audit results will be reported at the Interdisciplinary Team (IDT) meetings and the Performance Improvement Committee meetings. Completed 01/28/2022 and ongoing	

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F 584	Continued From page 10 that she had not received any complaints from the residents. The DON added that if a resident did not want to be weighed at that time, they could request to be weighed at a later time. On 12/14/21 at 12:35 PM, during an interview with R334 in her room on the fifth floor, when asked about being weighed between 12:00 AM and 01:00 AM, R334 stated that she could not remember being weighed since her admission, " ...and I'm glad I can't because who wants to wake up in the middle of the night for that? Not me!"	F 584		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	F 623		1/28/22

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F 623	Continued From page 11	F 623		

(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for

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F 623	Continued From page 12 the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure resident's representative was notified of a transfer or discharge and the reason(s) for the move in writing and in a language and manner they understand. The content of the notice must include a statement of the resident's appeal rights, including the name,	F 623	Corrective Actions: " Resident (R) 30 was transferred to Kuakini Medical Center Emergency Services for outpatient evaluation on 11/30/2021 and returned to Kuakini Geriatric Care, Inc. on 12/01/2021.	

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F 623	Continued From page 13 address (mailing and email), telephone number of the entity which receives such request, information on how to obtain an appeal form, and assistance in completing the form, and submitting the appeal hearing request; the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. Findings include: 1) On 11/30/21 at approximately 04:35 AM, Resident (R)30 had an unwitnessed fall. When staff found R30, she was sitting on the floor, facing her bed, with her left hand holding the back of her head. Blood was noted on the ground and on R30's head. The resident was transferred to an acute care hospital and returned to the facility on 12/01/21. On 12/13/21 at 11:33 AM, while conducting an interview with Social Worker (SW)1, requested a copy of the notification sent to R30's resident representative and the representative of the Office of the State Long-Term Care Ombudsman related to R30's transfer to an acute care hospital on 11/30/21. A copy of the notifications was not provided. On 12/13/21 at 12:05 AM, requested a copy of the notification sent to R30's resident representative and the representative of the Office of the State Long-Term Care Ombudsman from the Director of Nursing (DON). The DON provided a copy of the facility's confidential "Unplanned Discharge/Transfer Notice" form and stated it was the form that is sent out to the State	F 623	Completed 12/14/2021 Systemic Change: " The KGC Director of Nursing (DON) re-educated all Patient Care Coordinators (PCC), Licensed Nurses (LN), and Unit Ward Clerks to send the Notification of Unplanned Discharge and / or Transfer letter to the (1) resident or resident representative and (2) Hawaii State Long-Term Care (LTC) Ombudsman upon discharge or transfer as soon as reasonable and practicable. The re-education also included the sending of a letter to the resident or resident□s representative containing the resident□s appeal rights. Completed 01/28/2022 and ongoing Monitoring of Corrective Actions: " The KGC DON or designee will conduct monthly audit of the Notification of Unplanned Discharges and / or transfers to the (1) residents or resident representative and (2) Hawaii State LTC Ombudsman. The audit results will be reported at the Interdisciplinary Team (IDT) meetings and the Performance Improvement Committee meetings. Completed 01/28/2022 and ongoing	

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F 623	Continued From page 14 Long-Term Care Ombudsman. However, the form did not contain any documentation identifying to whom the notice was sent out to, where it was sent (mail or email), or confirmation that it was sent out to the State Long-Term Care Ombudsman. A letter to the resident's representative containing the resident's appeal rights, including the name, address (mailing and email), telephone number of the entity which receives such request, information on how to obtain an appeal form, and assistance in completing the form, and submitting the appeal hearing request; the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman was not provided. On 12/14/21 after the exit conference, the DON stated that a copy of the notification of transfer to the State Long-Term Care Ombudsman was provided. This surveyor informed the DON to fax all documentation of R30's 11/30/21 transfer notification to the State Long-Term Care Ombudsman and to the resident's representative to the State Agency's office. On 12/17/21 at 08:49 AM, the facility faxed a copy of the facility's confidential "Unplanned Discharge/Transfer Notice" was the same notice previously provided by the facility.	F 623		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the	F 637		1/28/22

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F 637	Continued From page 15 resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to identify and report, within 14 days, a significant change and decline in resident(R)40's physical status. The facility failed to review or revise the care plan without further interventions to improve the resident's decline. The facility also failed to complete a significant change on the Minimum Data Set (MDS) within 14 days of determination of decline. This deficient practice has the potential to affect other residents with significant changes and puts residents at risk for decline in health status and care. Findings: Observation on 12/09/21 at 11:20 PM reveals R40 in his room and lying-in bed. R 40 is a paraplegic. R40 was being assisted with feeding during lunch mealtime by staff. Record review (RR) on 12/13/21 at 10:20 revealed a family medicine note dated 11/22/2021 with notation of a change in R40's personality and being quiet. Review of weight record revealed a significant weight loss in one month of approximately 11 lbs. During an interview on 12/13/21 at 11:02 AM, nurse assessment specialist (NAS) stated that a	F 637	Corrective Actions: " A Comprehensive Review was completed for Resident (R) 40 by Resident Assessment Specialist (RAS) and a new Assessment Reference Date (ARD) was changed and scheduled on 12/16/2021. The assessment includes correction on Minimum Data Set (MDS) sections K and G which includes the Physical Therapy evaluation and recommendations documented on 11/30/2021. Completed 12/16/2021 Systemic Change: " The Resident Assessment Specialist (RAS) or designee completed the change in status screening of all residents in order to identify other residents who may have a decline that requires a Comprehensive review of the MDS. Completed 01/28/2022 and ongoing Monitoring of Corrective Actions: " The RAS will conduct accuracy audits	

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F 637	Continued From page 16 significant change was opened on 11/26/21 for weight loss and changes in his ADLs. R40 was not able to perform personal hygiene or feed himself and was dependent on staff to feed him during his significant change. NAS stated "I have not been able to finish the significant change of condition on the MDS. I am by myself and training a new person." RR on 12/13/21 of the MDS dated 11/26/21 showed an assessment reference date of section D - for poor appetite. Section K, for nutrition did not show a weight loss of 5% or more in the last month, however, R40 experienced a weight loss of -7.7% over a month. Section G for functional status did not show a change in eating habits for intake of nutrition.	F 637	for all MDS assessments completed monthly. The audit results will be reported at the Interdisciplinary Team (IDT) meetings and the Performance Improvement Committee meetings. Completed 01/28/2022 and ongoing	
F 656 SS=F	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		1/28/22

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F 656	Continued From page 17 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 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, interviews, and record review, the facility failed to ensure a comprehensive person-centered care plan was developed and/or implemented for one Resident (R) 84 that includes measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychological needs that are identified during the assessment. This failure could potentially result in unmet needs that could affect the resident's care. Findings include: Resident (R)84 was re-admitted to the facility on 11/08/21 after being hospitalized for methysillin	F 656	Corrective Actions: " Resident (R) 84 expired on 01/03/2022. " The Comprehensive Care Plan for Resident (R) 41 was revised to include communication techniques used to effectively communicate and request care needs to staff, and available option for intervention for interpreter services in Resident (R) 41□s preferred Japanese language. Completed 12/22/2021	

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F 656	Continued From page 18 resistant staff aureua, (MRSA) septicemia an ischial osteomyelitis with VRE wound cultures who presented from with multiple medical diagnosis including E.coli urosepsis, and prerenal above the knee amputation, R84 was re-admitted to the facility with a foley catheter for urinary retention On 12/09/21 at 3:34 PM, observed a catheter bag hanging from R84's bed. On 12/09/21 at 4:15 PM, conducted a record review of R84's Electronic Medical Records (EMR). Review of R84's Physician Orders documented an order written on 11/09/21 to change the catheter every month and as needed. The catheter was implemented for urinary retention and as part of an overall treatment plan to heal a stage 4 pressure ulcer. On 12/13/21 at 11:30 AM, conducted a concurrent review of R84's hard chart and review of the resident's hard chart with CC5. A review R84's care plan (CP) did not document interventions for indwelling catheter. 3) Resident (R)41 is a 93-year-old female admitted on 04/15/21 for physical and occupational therapy, with admitting diagnoses that include community-acquired pneumonia, urinary retention, asthma, dementia, and depression. During an observation and attempted interview with R41 on 12/09/21 at 11:48 AM in her room on the fifth floor, R41 was noted to be sleepy with a flat affect and was not responsive to any greetings or questions. On 12/10/21 at 10:17 AM, a review of R41's minimum data set (MDS) with an assessment reference date (ARD) of 04/21/21 noted question	F 656	" The Comprehensive Care Plan for Resident (R) 20 was updated to include toileting every 2 hours as needed. Therapeutic recreation staff TRS1 was educated on the toileting program by the KGC Director of Nursing (DON). Completed 01/28/2022 " Resident (R) 97□s assessment was completed to identify unwanted behaviors and communication needs. The Comprehensive Care Plan for Resident R 97 was revised and updated to reflect care interventions for behavior and communication techniques appropriate for the resident. Completed 12/22/2021 " The Comprehensive Care Plan for Resident (R) 78 was updated to include the splint application schedule as recommended by the Physical Therapist to prevent the worsening of R 78□s contractures. Completed 12/22/2021 " The Patient Care Coordinators (PCC) or designee reviewed the Comprehensive Care Plans of all the residents to ensure that the Comprehensive Care Plans were current in documenting the residents□ assessments and the residents□ behavior and communication status. For the residents requiring updating of the Comprehensive Care Plans, the PCC) or designee provided updates to the	

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F 656	Continued From page 19 A1100 A. "Does the resident need or want an interpreter to communicate with a doctor or health care staff?" To which it is documented that the resident answered "yes." The same assessment also documented that the resident's preferred language is Japanese. It was also noted in Section V: Care Area Assessment Summary, that "Communication" had been identified as a care area that needed to be addressed. On 12/13/21 at 02:40 PM, during a review of R41's comprehensive care plan, it was noted that the comprehensive care plan included no Communication Plan or any interventions for interpreter services. It was also noted that despite having her anxiety and depression identified and addressed, including starting her on a medication for anxiety, the comprehensive care plan contained no interventions that included addressing R41 in her preferred language. Care plans were found for activities, fall precautions, mood/behavior, pressure ulcer prevention, pain, urinary catheter care, and nutrition/hydration, among others. The only care plan that mentioned Japanese language was her activities care plan which stated, "Remind her [R41] of available supplies of recreational materials for independent use such as Japanese magazines." 4) On 12/10/21 at 10:23 AM, R20 was sitting up in his wheelchair in the solarium participating in an activity. At 11:13 AM, R20 was observed to be sitting up in his wheelchair in the hallway fronting the nursing station. The therapeutic recreation staff (TRS)1 asked R20 if he wanted to go into the solarium for activities, unlocked his wheelchair and started to wheel him towards the solarium. R20 responded by saying that he wanted to go to the restroom. TRS1 stated, "Oh!" parked him back into the hallway, locked the	F 656	residents and their family members and if needed further discussion if needed will be held in the scheduled Care Plan meetings for the residents. Completed 01/28/2022 and ongoing Systemic Change: " The KGC Director of Nursing (DON) or designee re-educated the licensed staff on completing a Comprehensive Care Plan for each resident and appropriate updating. Completed 01/28/2022 and ongoing " The KGC DON or designee re-educated all KGC employees on providing assistance for language translation support including interpreter services. Completed 01/28/2022 and ongoing Monitoring of Corrective Actions: " The PCCs or designee will conduct monthly audits of the residents Comprehensive Care Plans to verify that the current care of the residents are addressed appropriately. The audit results will be reported at the Interdisciplinary Team (IDT) meetings and the Performance Improvement Committee meetings. Completed 01/28/2022 and ongoing	

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wheels of the wheelchair and left. At 11:24 AM, patient care coordinator (PCC)5 wheeled R20 into the television room. At 11:37 AM, R20 was observed in the solarium doing a coloring activity. R20 told TRS1 loudly that he needed to use the restroom. R20's request was again ignored by TRS1 as she told him that lunch was being served.

On 12/14/21 at 07:51 AM, R20's health record was reviewed. The "Queens University Medical Group Nursing Home Progress Note," dated 11/15/21, revealed that R20 was a 78-year-old resident initially admitted to the facility on 08/09/21. It stated that R20 had sustained multiple falls in the facility that had occurred when resident repositioned himself in bed and the plan was to start R20 on every two-hour timed toileting to help alleviate his falls.

The "PharMerica Physician's Order Sheet" revealed an order date of 09/08/21 for "SCHEDULED Q [every] 2 [two] HOURS TIMED TOILETING ..."

The "PharMerica Treatment Notes Report" was reviewed from 11/01/21 to 11/30/21 and 12/01/21 to 12/13/21. Out of the thirty days in November, there were six days (11/17, 11/20, 11/24, 11/25, 11/29, 11/30) with no documentation that R20 was provided toileting. On the days that had documentation, it included: "incontinent," "incontinent, uses urinal," "uses urinal," and "asleep." Out of the thirteen days the report was run for December, there were six days that missed documentation. "Incontinent" was the only entry found for December.

On 12/14/21 at 1:00 PM, query was done with

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CNA5 in the hallway in front of the nursing station about what should be done if a resident asks a TRS to use the restroom and she stated that the TRS should notify the nurse.

On 12/15/21 at 8:00 AM, R20's care plan was reviewed. His "Risk for Falls" care plan and "Falls Care Plan (High Risk) - Red Star" did not have an individualized entry for every two-hour timed toileting to prevent falls. His care plan for "Urinary Incontinence" also described him as "always incontinent of bladder" and had an intervention to "Encourage continence by keeping urinal clean and within easy reach, ready for use."

5) An initial record review for R97 was done on 12/09/21 at 12:42 PM. He is a 57-year-old resident receiving hemodialysis for kidney failure, admitted on 10/25/21. The facility's Minimum Data Set (MDS) report "updated: 10/19/2021" (a recent MDS report was requested of the facility but was never provided) revealed that he is receiving antianxiety and antidepressant medications.

On 12/13/21 at 08:27 AM, R97 was observed to be occasionally yelling out from his room. A concurrent query was made to RN2 who was preparing resident medications at her medication cart in the hallway. She stated that R97 occasionally yells out, but it is difficult to assess his needs because of a language barrier.

At 09:15 AM, a CNA entered R97's room, who was still occasionally yelling out. R97 stopped yelling and surveyor observed that he looked distressed, lying sideways in his bed and he stated, "Phone!"

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F 656	Continued From page 22	F 656		

At 10:04 AM, R97 had still been yelling out and a concurrent query was made with LPN4 at the nursing station. She stated that R97 does not usually yell out, but she had already called her son and was informed that R97's wife was out of town. She continued to say that she will call his brother, but she continued doing her task at the nursing station.

At 10:22 AM, the nursing home administrator (NHA) went to visit R97. R97 had still been yelling out. Surveyor noted that when the nursing station phone rang, R97 would yell, "Phone!"

At 10:23 AM, a CNA was in R97's room and he was no longer yelling out. After she left the room, R97 started yelling out again.

On 12/15/21 at 10:00 AM, R97's care plan, received from the DON on 12/14/21 at 08:00 AM, was reviewed. R97's identified needs for his language barrier and his yelling out behavior were not addressed, therefore there were no individualized interventions for their management.

6) On 12/09/21 at 10:15 AM, an initial observation was done of R78. She was wearing a hospital gown and had a towel roll in each hand. Her upper extremities had contractures (chronic loss of joint mobility caused by structural changes in non-bony tissue, including muscles, ligaments, and tendons). The side rails of her bed were padded and there was a wedge under her right side allowing her to face the left. She was receiving liquid nutrition from a pump on the left side of her bed.

At 2:03 PM of the same day, R78 was still on her left side, the splints for her contractures on a

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F 656	Continued From page 23 chair and bedside table next to the bed. On 12/10/21 at 07:10 AM, R78 was lying on her back in bed with no blanket on and it was noted that her legs also had contractures. At 10:23 AM, R78 was noted to still be lying on her back in bed, the splints for her contractures were not on her extremities. At 12:29 PM, R78 was lying on her back in a 45-degree angle in bed. She was not wearing the splints for her contractures. On 12/14/21 at 10:25 AM, a query was made with LPN4 at the nursing station. She stated that R78 had contractures since her admission. R78 receives passive range of motion (PROM) from the staff and wears the splints on for four hours and off for two hours. On 12/1521 at 10:15 AM, R78's care plan, received from the DON on 12/14/21 at 08:00 AM, was reviewed. There was no entry to indicate the use of splints for R78 to prevent the worsening of her contractures.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 657		1/28/22

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F 657	Continued From page 24 resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure a comprehensive person-centered care plan was developed and/or implemented for residents(R)40 and R30 out of a sample of 28 residents. The facility failed to include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs that are identified during the assessment. This failure could potentially result in unmet needs that could affect the resident's care. Findings include: Observation on 12/10/21 revealed R40 contracted of all extremities. Right foot with toe redness. Record review (RR) on 12/13/21 at 10:20	F 657	Corrective Actions: " The Comprehensive Care Plan for Resident (R) 40 was revised to include the lower extremities contractures and right large toe redness and pain. This revised Comprehensive Care Plan was based on the assessment by the Physical Therapist (PT). Resident (R) 40 was provided a right knee brace for contracture management. The Comprehensive Care Plan for Resident (R) 40□s large toe redness and pain was updated based on the Geriatrician□s recommendations for treatment and care. Completed 12/16/2021 " The Comprehensive Care Plan for	

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F 657	Continued From page 25 revealed a family medicine note dated 11/22/2021 with notation of a change in R40's personality. R40 was quieter than usual and dysphagic. Speech therapy was ordered. Diet was downgraded to diced solid. Four days later, on 11/26/21, a care conference was documented to evaluate for a significant change of condition. R40's weight was documented at 130.0 with no weight loss. Fifteen days later, on 12/06/21, a significant weight loss of approximately 11 lbs. (119.3) was documented. RR on 12/13/21 did not show a careplan for R40's redness to right foot and contractures. R40's legs are contracted and right toe with a new redness. Physician orders in chart dated 11/12/21 showed an X-ray for - (R) entire foot and right large toe, Dx. toe pain. Care plan review reveals no care plan for right toe redness treatment and care. During a confidential interview on 12/13/21 at 12:30 PM with staff who preferred to remain anonymous, staff stated that their charge nurse had retired and she used to take care of all the careplans. She kept them up-to-date, revised, created them. 2) Resident (R)30 was admitted to the facility on 03/31/2019 with diagnosis that include anemia, orthostatic hypotension (a drop in blood pressure upon standing), End-Stage Renal Disease (ESRD) with dependence on hemodialysis, and diabetes mellitus (DM). Review of completed all Minimum Data Set (MDS) documented a quarterly MDS was completed on 08/30/21 and a significant change MDS was completed on 11/22/2021 after R30 returned to the facility from	F 657	Resident (R) 30 was updated and included the newly diagnosed thyroid nodules and revised Estimated Date To Meet Goal for all of the identified Care Plan areas. Completed 12/22/2021 " The Patient Care Coordinators (PCC) or designee reviewed the Comprehensive Care Plans of all the residents for appropriate updating and revision for the resident□s medical, nursing, mental and psychological needs identified during the assessments, and measurable objectives and timeframes. Completed 01/28/2022 and ongoing Systemic Changes: " The KGC Director of Nursing (DON) or designee re-educated the licensed staff on completing a Comprehensive Care Plan for each resident and appropriate updating. Completed 01/28/2022 and ongoing Monitoring of Corrective Actions: " The Patient Care Coordinators (PCCs) or designee will conduct monthly audits of the residents□ Comprehensive Care Plans to verify that the current care of the residents are being provided as prescribed. The audit results will be reported at the Interdisciplinary Team (IDT) meetings and the Performance Improvement (PI) Committee meetings.	

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F 657	Continued From page 26 an acute hospital due to R30 falling and sustaining laceration which required sutures (stitches), sinus infection, and thyroid nodules (discovered during hospitalization). On 12/13/21 at 10:07 AM, conducted a record review and interview with Social Services (SS) staff and the Patient Care Coordinator (PCC). Requested to review R30's comprehensive care plan (CCP). SS and PCC reviewed R30's hard chart with this surveyor and confirmed only a care plan for nutrition was in the resident's hard chart. A binder was later provided which contained R30's CCP. Review of R30's CCP which was provided documented the "Estimated Date To Meet Goal" was 08/30/21 (prior to re-admission) for all of the care plan areas identified. The PCC confirmed R30's comprehensive care plan was not updated to include newly discovered thyroid nodules, could not provide documentation that the whole care plan was reviewed by the appropriate disciplines, and did not contain an updated time frame for an "Estimated Date To Meet Goal" date.	F 657	Completed 01/28/2022 and ongoing	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate	F 676		1/28/22

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F 676	Continued From page 27 treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide the necessary care and services to maintain or improve the activities of daily living (ADLs), specifically toileting, for one resident (R)334 in the sample. As a result of this deficient practice, R334 was hindered from attaining her highest practicable well-being and was placed at risk for a decline in functional abilities and a decreased quality of life. This deficient practice has the potential to affect all the residents at the facility with toileting needs.	F 676	Corrective Actions: " Resident (R) 334□s Occupational Therapy screening was completed for all activities of daily living (ADL) and transfer care there were no new recommendations for the services to provide Resident (R) 334. Resident (R) 334 continues to require total assist with use of Hoyer lift for all transfers and is not recommended for transfer via Hoyer lift to toilet or bed side commode due to safety risks and	

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F 676	Continued From page 28 Findings include: Resident (R)334 is a 74-year-old female admitted to the facility on 10/28/21 for long-term care (LTC) following an ischemic stroke (when a vessel supplying blood to the brain is blocked, causing brain tissue to die), with resulting left-sided weakness. R334's other admitting diagnoses include high blood pressure, diabetes, and a history of breast cancer. On 12/10/21 at 08:43 AM, observations and a concurrent interview was done with R334 in her room on the fifth floor. Certified Nurse Aide (CNA)4 had just entered the room and R334 asked to "go to the bathroom." CNA4 stated "I will get you the bedpan," to which R334 emphatically and repeatedly refused asking "why, I don't want to use the bedpan, I want to go to the bathroom!" Instead of answering her, CNA4 looked at surveyor and asked, "what should I do, she cannot walk to the bathroom." Surveyor asked CNA4 why R334 could not be assisted to the bathroom, to which CNA4 replied that R334 was a two-person, Hoyer-lift (a mobility tool used to help people transfer) for transfers, and that the Hoyer-lift would not fit in the bathroom. Surveyor then asked CNA4 why R334 could not be transferred onto a bedside commode using a Hoyer-lift. CNA4 answered that she would get a bedside commode, the Hoyer-lift and a second staff member to help. When CNA4 returned with help, R334 stated "I couldn't hold it anymore, you guys took so long." On 12/10/21 at 09:22 AM, while sitting at the fifth-floor nurse station, Patient Care Coordinator (PCC)5 approached surveyor and stated that prior to R334 being able to be transferred to a	F 676	potential risk of injury. Resident (R) 334 was given education to request and use a bedpan for toileting needs. Completed 12/10/2021 Systemic Changes: " The Patient Care Coordinators (PCC) or designee conducted an audit of all residents with Hoyer lift transfers to verify that the residents□ mode of transfer technique continues to be current and accurate based on the individual resident□s preference and transfer status and recommendations from the resident□s Occupational Therapy screening. Completed 01/28/2022 and ongoing Monitoring of Corrective Actions: " The PCC or designee will conduct monthly audits for individual resident□s care requests and preferences. The audit results will be reported at the Interdisciplinary Team (IDT) meetings and the Performance Improvement Committee meetings. Completed 01/28/2022 and ongoing	

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F 676	Continued From page 29	F 676		

bedside commode, R334 would need to be referred for an occupational therapy (OT) assessment. Inquired with PCC5 if toileting needs and functional assessment of activities of daily living (ADLs) are not usually done at admission. In answer, PCC5 stated that "this is the first time since admission she [R334] has expressed a desire to use the toilet."

On 12/13/21 at 08:06 AM, it was observed that R334 had turned her call light on. Registered Nurse (RN)3 entered R334's room to take her blood pressure prior to preparing her morning medications. As soon as RN3 entered, R334 stated "I need to go to the bathroom." RN3 turned off the call light, and told R334 "you cannot walk, let me go get you a bedpan." R334 became upset and loudly asked, "What? Why? I want to go to the bathroom," then she shouted, "I DON'T WANT A BEDPAN!"

On 12/13/21 at 08:18 AM, an interview was done with Licensed Practical Nurse (LPN)4 outside of R334's room. When asked, LPN4 confirmed that R334 was continent of bladder and bowel. LPN4 agreed that for the most part, R334 knew when she had to go and was aware of when she had already gone.

On 12/14/21 at 11:37 AM, during a review of R334's OT [occupational therapy] Evaluation & Plan of Treatment, done on 11/01/21 by OT (occupational therapist)1, it was noted that OT1 had documented R334's functional skills assessment for toileting as "Total Dependence w/o [without] attempts to initiate ..." OT1's plan for R334 included occupational therapy sessions five (5) times a week for eight (8) weeks for a total of forty (40) sessions; and targeted three (3)

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F 676	Continued From page 30 short-term goals and one (1) long-term goal, none of which had to do with toileting. After nine (9) documented sessions, OT1 discharged (and ended) R334 from occupational therapy on 11/15/21, stating, " ...Patient [R334] has reached maximum potential with skilled services." OT1's discharge recommendations for R334 were, "Recommend 24 HR [hour] SUP [supervision] and assist ADLs [activities of daily living]." R334's Therapy Screening Form for whether a therapy evaluation should be conducted to evaluate R334 for bedside commode transfer via Hoyer-lift, completed by OT1 on 12/10/21, was also reviewed at this time. OT1 documented that a therapy evaluation was not recommended, with "Comments: Pt [R334] remains at baseline for all ADLs and transfers. Pt not appropriate for toilet transfers due to extensive assist/requiring hoyer lift." It was noted that no prior documentation from occupational therapy was found specifying that R334 required a Hoyer-lift for transfers, yet she was observed being transferred from bed to wheelchair using a Hoyer-lift on several occasions.	F 676		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to	F 688		1/28/22

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F 688	Continued From page 31 prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure two residents (Resident 59 and Resident 72) in the sample received the appropriate treatment, equipment, and services to increase or prevent further decrease in range of motion (ROM). As a result of this deficient practice, both residents have been hindered from reaching their highest practicable well-being. This deficient practice has the potential to affect all the residents at the facility with ROM deficits. Findings include: 1) Resident (R)59 is an 87-year-old male admitted to the facility on 09/07/16 for long-term care (LTC) with diagnoses including recurrent syncope (fainting), functional quadriplegia (refers to complete immobility due to severe physical disability or frailty), malnutrition, high blood pressure, and osteoarthritis in his left wrist. On 12/10/21 at 09:02 AM, an observation was done of R59 in the common room across from the fifth-floor nurse station. R59 was seated in a wheelchair, his upper torso leaning heavily towards the right, with his head tilted so far to the right that his ear was almost touching his shoulder. R59's left wrist was observed to be severely contracted (a condition of shortening	F 688	Corrective Actions: " A Comprehensive Review was completed for Resident (R) 59 with an Assessment Reference Date (ARD) of 12/28/2021 and found no decline on Resident (R) 59□s performance on bathing, transfer, and worsening of the neck and left wrist contractures. The assessment included the Rehabilitation services evaluation completed on Resident (R) 59□s neck and left wrist contractures with no new recommendations given. Completed 12/28/2021 " A Comprehensive Review was completed for Resident (R) 72 with an Assessment Reference Date (ARD) of 01/11/2022 and found no decline on Resident (R) 72□s bilateral ankle contractures. Bilateral heel boots were initiated and included on the Comprehensive Plan of Care based on the Physical Therapists recommendations. Completed 01/28/2022	

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F 688	Continued From page 32 and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints). A half-hour later, despite the presence of several staff interacting with the residents in the common room, R59 was observed to still be awkwardly positioned with his upper torso leaning heavily to the right. On 12/10/21 at 09:35 AM, during a review of R59's nursing progress notes, a minimum data set (MDS) progress note was found, dated 10/12/21, that documented an activities of daily living (ADL) decline in bathing and transfer, and requested a new therapy screening be conducted. The last physical or occupational therapy found documented in R59's chart ended in July 2021. On 12/14/21 at 08:01 AM, an interview was done with a certified nurse aide (CNA)5 near the fifth-floor common room. When asked, CNA5 stated that in the past year, she could not remember R59 ever having a splint or brace for his neck, torso, or left wrist. She could also not recall seeing R59 receiving restorative nursing or therapy services for his neck or wrist but stated she does see R59 being ambulated and doing range of motion (ROM) exercises "once in a while." Stated she has noticed a decline in R59's functioning. On 12/14/21 at 09:27 AM, an interview was done in the conference room with the Director of Rehab [rehabilitation] Services (DOR). After reviewing R59's rehabilitation (rehab) services records, the DOR confirmed that R59's neck and wrist contractures had not been addressed since 2019 and that R59 had no current orders, nor refused any orders for any wedges, braces, or	F 688	Systemic Change: " The Resident Assessment Specialist (RAS) or designee completed the change in status screening of all residents to identify other residents who may have a decline requiring a Comprehensive Review Minimum Data Set (MDS). Completed 01/28/2022 and ongoing " The Patient Care Coordinators (PCC) or designee reviewed all residents with contractures and found no residents with a decline or worsening of their contractures. Completed 01/28/2022 and ongoing Monitoring of Corrective Actions: " The RAS will conduct an accuracy audit for all completed MDS assessments on a monthly basis. The audit results will be reported at the Interdisciplinary Team (IDT) meetings and the Performance Improvement Committee meetings. " The PCC□s or designee will conduct a quarterly audit of all residents with contractures to identify any potential decline. The audit results will be reported at the Interdisciplinary Team (IDT) meetings and the Performance Improvement Committee meetings. Completed 01/28/2022 and Ongoing	

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F 688	Continued From page 33	F 688		

splints for his neck, wrist, or torso.

2) R72 is a 66-year-old female admitted to the facility on 05/21/21 for long-term care. R72's admitting diagnoses include past history of stroke, seizures, insulin-dependent diabetes, dysphagia (difficulty swallowing), and hyperlipidemia (elevated lipids). R72 receives nutrition and medications via a gastric tube and is almost fully dependent in all activities of daily living.

On 12/09/21 at 01:04 PM, during an observation in her room on the fifth floor, R72 was noted to have severe contractures to both knees and both ankles. Wedge pillows were observed on her bed but were not positioned under or around her, but rather sitting unused to right side and foot of the bed. No splints, braces, or protective boots were observed anywhere in the room.

On 12/13/21 at 01:30 PM, during an interview with licensed practical nurse (LPN)4 at the fifth-floor nurses' station, LPN4 stated that there were two (2) restorative nurse aides (RNA) on staff. One was out sick, and the other was scheduled to "work the floor," meaning she was being used as a certified nurse aide (CNA) and not as an RNA, for that day. LPN4 could not recall when she last saw either of the RNAs on the schedule as RNAs, as opposed to being used as CNAs.

On 12/14/21 at 09:27 AM, an interview was done in the conference room with the Director of Rehab [rehabilitation] Services (DOR). After reviewing R72's rehabilitation (rehab) services records, the DOR confirmed that on 06/04/21, when R72 was discharged from Physical Therapy

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F 688	Continued From page 34 (PT) services, the Therapist had recommended "use of heel protection boots to prevent further ROM [range of motion] loss/contracture ..." The DOR stated that the Therapist should have written an order for the device [heel protection boots] in R72's chart. The DOR also confirmed, after reviewing R72's physician orders, that there was no current order for the heel protection boots, and that without it, there was a risk that R72's ankle contractures had worsened.	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore	F 690		1/28/22

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F 690	Continued From page 35 continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide R20 the basic human need of toileting, which caused him to become agitated, increases his ability to become incontinent, to have falls and to become more dependent on staff. This deficient practice robs R20 of his capability to perform his activity of daily living of toileting and is a failure of the facility to provide an environment that promoted and maintained R20's quality of life. Finding includes: On 12/10/21 at 10:23 AM, R20 was sitting up in his wheelchair in the solarium participating in an activity. At 11:13 AM, R20 was observed to be sitting up in his wheelchair in the hallway fronting the nursing station. The therapeutic recreation staff (TRS)1 asked R20 if he wanted to go into the solarium for activities, unlocked his wheelchair and started to wheel him towards the solarium. R20 responded by saying that he wanted to go to the restroom. TRS1 stated, "Oh!" parked him back into the hallway, locked the wheels of his wheelchair and left. At 11:24 AM, patient care coordinator (PCC)5 wheeled R20 into the television room. At 11:37 AM, R20 was observed in the solarium doing a coloring activity.	F 690	Corrective Actions: " Assessment of the bowel and bladder status for Resident (R) 20 was completed. The Comprehensive Care Plan for Resident (R) 20 was updated to include toileting every 2 hours and incontinent care as needed for fall prevention. Completed 01/28/2022 " The therapeutic recreation staff TRS1 was educated on (1) the correct approach to addressing Resident (R) 20□s request for assistance and to ensure that residents□ request are communicated timely to the nursing staff including requests to use the restroom, and (2) the toileting program by the Nursing Home Administrator. Completed 01/28/2022 " The Patient Care Coordinators (PCC) or designee reviewed all the residents in order to identify residents for the toileting program. The residents□ Comprehensive Care Plans were reviewed and updated	

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F 690	Continued From page 36 R20 told TRS1 loudly that he needed to use the restroom. R20's request was again ignored by TRS1 as she told him that lunch was being served. On 12/14/21 at 07:51 AM, R20's health record was reviewed. The "Queens University Medical Group Nursing Home Progress Note," dated 11/15/21, revealed that R20 was a 78-year-old resident initially admitted to the facility on 08/09/21. It stated that R20 had sustained multiple falls in the facility that had occurred when resident repositioned himself in bed and the plan was to start R20 on every two-hour timed toileting to help alleviate his falls. The "PharMerica Physician's Order Sheet" revealed an order date of 09/08/21 for "SCHEDULED Q [every] 2 [two] HOURS TIMED TOILETING ..." The "PharMerica Treatment Notes Report" was reviewed from 11/01/21 to 11/30/21 and 12/01/21 to 12/13/21. Out of the thirty days in November, there were six days (11/17, 11/20, 11/24, 11/25, 11/29, 11/30) with no documentation that R20 was provided toileting. On the days that had documentation, it included: "incontinent," "incontinent, uses urinal," "uses urinal," and "asleep." Out of the thirteen days the report was run for December, there were six days that missed documentation. "Incontinent" was the only entry found for December. On 12/14/21 at 1:00 PM, query was done with CNA5 in the hallway in front of the nursing station about what should be done if a resident asks a TRS to use the restroom and she stated that the TRS should notify the nurse.	F 690	as appropriate. Completed 01/28/2022 Systemic Change: " The KGC Director of Nursing (DON) or designee re-educated all the nursing staff on Bowel /Bladder Incontinence program. Completed 01/28/2022 and ongoing " The Nursing Home Administrator educated the Therapeutic Recreational Activity Staff to notify the nursing staff of any resident needs that are brought to their attention by the residents including requests to use the restroom. Completed 01/28/2022 and ongoing Monitoring of Corrective Actions: " The PCC or designee will conduct monthly audits of the resident□s toileting program for a three-month period. The audit results will be reported at the Interdisciplinary Team (IDT) meetings and the Performance Improvement Committee meetings. Completed 01/28/2022 and ongoing	

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F 690	Continued From page 37 On 12/15/21 at 8:00 AM, R20's care plan was reviewed. His "Risk for Falls" care plan and "Falls Care Plan (High Risk) - Red Star" did not have an individualized intervention entered for every two-hour timed toileting to prevent falls. His care plan for "Urinary Incontinence" also described him as "always incontinent of bladder" and had an intervention to "Encourage continence by keeping urinal clean and within easy reach, ready for use."	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide care and services to	F 692	Corrective Actions:	1/28/22

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F 692	Continued From page 38 prevent significant weight loss or to identify the need for dietary evaluation and intervention for two residents (Resident 334 and Resident 40), as evidenced by an unrecognized significant weight loss of 15.04 pounds (lbs.) or 8.97% in six (6) weeks for Resident (R)334, R40. As a result of this deficient practice, the facility placed these residents at risk for avoidable declines and injuries. This deficient practice has the potential to affect all residents at the facility. Findings include: 1) On 12/10/21 at 08:28 AM, while reviewing the weight log binder for fifth-floor residents at the nurses' station, no weight log could be found for resident (R)334, who had been admitted on 10/28/21 for long-term care. The weight documented on her admission assessment was 76.2 kg [kilograms] or 167.64 lbs. [pounds]. A review of R334's electronic health record (EHR) revealed one weight documented on 12/08/21 at 03:08 AM by licensed practical nurse (LPN)3 of 152.6 lbs. No other weights were found documented under "weights" in the EHR. On 12/10/21 at 08:51 AM, during an interview with R334 in her room, R334 stated she "thinks" she lost weight since she was admitted but does not remember being weighed. On 12/13/21 at 09:30 AM, during an interview with licensed practical nurse (LPN)4 and Unit Clerk (UC)5, and a concurrent record review of R334's hard chart, Kardex, and EHR, at the fifth-floor nurses' station, LPN4 and UC5 confirmed that there were no weights found in the weight log binder for R334, no documentation of routine weights in her EHR except for the one	F 692	" The weight record for Resident (R) 334 indicated an admission weight of 167.74 lbs. and a current weight of 161.8 lbs. on 01/02/2022 and 160.8 lbs. on 01/25/2022. The Registered Dietician (RD) completed a review on 12/13/2021 and the Comprehensive Care Plan was updated. The accuracy of the 11/08/2021 weight of 157.52 lbs. is questionable. Completed 01/28/2022 " A Comprehensive Review was completed for Resident (R) 40 the new Assessment Reference Date (ARD) was changed and scheduled on 12/16/2021. The assessment included a decline on MDS section K Nutritional Status. The Registered Dietician (RD) evaluation was completed and found no change on Resident (R) 40□s meal and fluid intake at 100%. A complete metabolic Panel was completed on 12/15/2021 and found to be nutritionally stable with electrolytes, BUN, albumin, and protein levels within normal ranges. The Nutrition Care Plans were reviewed and updated on 12/16/2021 Completed 01/28/2022 Systemic Change: " The Patient Care Coordinators (PCC) or designee reviewed all the residents□ weight records in each resident care unit to ensure that the weight records are complete, and the RD notifications are forwarded for all weight deviations of 3% or more. The residents□ Comprehensive	

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F 692	Continued From page 39 weight on 12/08/21, and no dietary assessment found in R334's hard chart. LPN4 expressed confusion why they could not be found, stating "they should all be there." UC5 stated that the standing orders for routine weight checks [following admission] is "once a day for three (3) days, then once a week for four (4) weeks, then once a month after that." UC5 also expressed confusion as to why the documentations could not be located. A review of R334's nurse progress notes found no documentation of any weight loss being documented, reported, or referred to dietary. On 12/13/21 at 11:20 AM, UC5 presented the surveyor with a copy of R334's weight log, stating, "it was found on the sixth floor, it should have been transferred down here with the rest of her records, but somehow they missed it." A review of the weight log documented the following weights: 10/29/21 [admission] 76.2 kg [167.74 lbs.] 10/30/21 76.5 kg [168.3 lbs.] 10/31/21 74.2 kg [163.24 lbs.] 11/01/21 74.6 kg [164.12 lbs.] 11/08/21 71.6 kg [157.52 lbs.] 11/13/21 73.7 kg [162.14 lbs.] The weight log also documented the following procedure: " ...5. Notify RD [Registered Dietician] using RD referral form if 3% or more weight loss/gain ..." A review of R334's Nurse's Admission Record, dated 11/16/21, from when R334 transferred down to the fifth floor revealed no "admission" weight documented. LPN4 stated the nurse who admitted R334 to the floor should have weighed	F 692	Care Plans were reviewed and updated as appropriate. Completed 01/28/2022 and ongoing Monitoring of Corrective Actions: " The PCC or designee will conduct a monthly audit of all residents weight records, RD referral for weight deviations of 3% or more, and Nutrition Care Plans for accuracy. The audit results will be reported at the Interdisciplinary Team (IDT) meetings and the Performance Improvement Committee meetings. Completed 01/28/2022 and ongoing	

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F 692	Continued From page 40 her and documented it on the Admission Record. No other weights were found documented until the 12/08/21 EHR documentation of 152.6 lbs. On 12/13/21 at 11:40 AM an interview was done with the Registered Dietician (RD) at the fifth-floor nurses' station. The RD stated she had received no dietary referral regarding R334's weight loss prior to "today." 2) Record review (RR) on 12/13/21 at 10:20 revealed a family medicine note dated 11/22/2021 with notation of a change in R40's personality. R40 was quieter than usual and dysphagic. Speech therapy was ordered. Diet was downgraded to diced solid. Four days later, on 11/26/21, a care conference was documented to evaluate for a significant change of condition. R40's weight was documented at 130.0 with no weight loss. Fifteen days later, on 12/06/21, a significant weight loss of approximately 11 lbs. (119.3) was documented. (Ref F657) RR did not show the care plan for nutrition updated or revised to accommodate for a significant change in nutrition. During a confidential interview on 12/13/21 at 12:30 PM with staff who preferred to remain anonymous, staff stated that their charge nurse had retired, and she used to take care of all the care plans. She kept them up to date, revised, created them. (Ref F657)	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who	F 695		1/28/22

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F 695	Continued From page 41 needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to implement procedures to maintain respiratory suctioning equipment for Resident (R) 126. As a result of this deficient practice, R126 who is a resident with a tracheostomy and chronic respiratory failure, was put at potential harm for adverse health consequences. Findings Include: On 12/09/21 at 11:41 AM, Resident (R) 126 was observed sleeping on his back in bed. R126 had a tracheostomy with a humidified trach collar. A suction canister with a yankauer (suctioning tool used for oral secretions) was connected to the wall next to his bed. There were 100 ml of yellow fluid inside of the suction canister. There was no date on the canister. On 12/10/21 at 08:19 AM in R126's room, surveyor observed 100 ml yellow fluid in the suction canister with no date on the canister. On 12/10/21 at 10:30 AM, R126's record was reviewed. R126 was admitted to the facility on 05/20/16. R126's diagnoses include seizures, chronic respiratory failure, tracheitis (inflammation of the trachea) due to methicillin-resistant staphylococcus aureus colonization, history of stroke, difficulty swallowing, and right sided weakness. He has a	F 695	Corrective Actions: " The KGC Nursing procedure for changing the suction canisters was updated to include (1) when the suction cannister is changed and (2) the dating the suction canister when changed. Completed 01/28/2022 " The Patient Care Coordinators (PCC) or designee reviewed all the residents with a suction canister and found no other residents who were potentially affected by the deficient practice of not changing the suction cannister and/or not dating the suction canister when changed. Completed 12/14/2021 Systemic Change: " The KGC Director of Nursing (DON) or designee re-educated all staff on the updated procedure for changing the suction canisters and dating the suction canister when changed. Completed 01/28/2022 and ongoing Monitoring of Corrective Actions:	

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F 695	Continued From page 42 tracheostomy with a humidified trach collar since 2014. He has a gastrostomy tube for tube feedings five times a day. R126's record indicated physician orders to "Deep suction as needed for mucus," and "Suction as needed per facility protocol." On 12/14/21 at 10:30 AM, review of the R126's Medication Administration Record indicated that R126 was not suctioned from 12/01/21 thru 12/10/21. On 12/10/21 at 08:39 AM, in an interview with Patient Care Coordinator (PCC) 6, PCC6 stated, "The canister should be changed and dated by the nurses every Friday at 06:00 AM. We don't chart to show the canister was changed." On 12/13/21 at 08:41 AM, in an interview with Respiratory Therapist (RT), RT stated, "The nurses are responsible for changing nasal cannula tubing and suction canisters. They (nurses) will order from me if they need more." On 12/13/21 at 02:52 PM, in an interview with PCC6, PCC6 stated, "I interviewed the Thursday (12/09/21) night shift and Friday (12/10/21) day shift and they said they didn't suction R126 or change the suction canister. R126 is rarely suctioned because he doesn't like it and he has a strong cough to cough his mucus out. The fluid in the canister may have come from oral care or when he coughed mucus out. We should add when to change the suction canister to our written procedures and that we should date when the canister was changed."	F 695	" The PCC or designee will conduct a monthly audit of the changing of suction canisters. The audit results will be reported at the Interdisciplinary Team (IDT) meetings and the Performance Improvement Committee meetings. Completed 01/28/2022 and ongoing	
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis.	F 698		1/28/22

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F 698	Continued From page 43 The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a resident who requires dialysis receives services consistent with professional standards of practice. The facility staff did not properly assess one Resident (R) 14 for pre and post weight and vital signs prior to going to dialysis and returning from dialysis during two separate dialysis treatments. This failure places the resident at risk for illness and or harm. Findings include: R14 was admitted on 08/25/21 with diagnosis that include heart disease, malnutrition, End-Stage Renal Disease (ESRD) dependent on hemodialysis, stage 4 pressure ulcer, diabetes mellitus (DM), hypertension, and a right knee stump infection. Review of R14's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/25/21 documented in Section O: Special Treatments, Procedures, and Programs that R14 receives dialysis treatment. On 12/10/21 at 11:45 AM, conducted a record review of R14's medical health information in the resident's hard chart and electronic health record (EHR). Review of the pharmacy "Vital Report", contains the resident's pre and post hemodialysis weights, no post weight was documented on 11/05/21 and no pre-dialysis weight was	F 698	Corrective Actions: " The KGC Nursing policy and procedure on Dialysis procedures was reviewed and updated. The medical health information for Resident (R) 14 was reviewed and updated to include the documentation on the pre- and post-dialysis weight, vital signs, assessments of resident level of consciousness (LOC), and vascular access site in the pharmacy Vital Report EZMAR. Completed 12/16/2021 " The Patient Care Coordinators (PCC) or designee reviewed all Dialysis residents and the documentation on their medical health information have been updated to reflect pre- and post-dialysis weight, vital signs, assessments of resident LOC, and vascular access site in the pharmacy Vital Report EZMAR. Completed 12/16/2021 and ongoing Systemic Changes: " The Patient Care Coordinators (PCC) re-educated all of the nursing staff on the required pre- and post- dialysis	

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F 698	Continued From page 44 documented on 12/01/21 and 12/08/21. Additionally, on 12/08/21, staff did not document R14's vital signs, level of consciousness, or assessment of the resident's vascular access site. On 12/14/21 at 09:37 AM, conducted an interview with Patient Care Coordinator (PCC)5 regarding pre and post dialysis weights for R14. PCC5 confirmed R14's post dialysis weight on 11/05/21 and pre-dialysis weight on 12/01/21 and 12/08/21 was not documented in the pharmacy software or in R14's medical health information (progress notes, hard chart, Kardex, dialysis communication sheet, or binders etc.). Review of the facility's policy and procedure on Dialysis procedures document documented pre-dialysis staff should obtain the resident's weight and upon returning to the facility (post-dialysis) staff should obtain the resident's vital signs, level of consciousness and check the resident's vascular access site.	F 698	documentation for Dialysis residents. Completed 01/28/2022 and ongoing Monitoring of Corrective Actions: " The PCC or designee will conduct monthly audits of the Dialysis residents documentation of pre- and post-dialysis assessment and documentation. The audit results will be reported at the Interdisciplinary Team (IDT) meetings and the Performance Improvement Committee meetings. Completed 01/28/2022 and ongoing	
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 725		1/28/22

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F 725	Continued From page 45 §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 and interview, the facility failed to ensure there was sufficient nursing staff to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, in addition to their physical, mental, and psychosocial well-being. As a result of this deficient practice, the residents experienced a decreased quality of life and were unable to attain their highest practicable well-being. Findings include: 1) Cross-reference to findings from F688 ROM/Mobility. The facility failed to provide sufficient staffing to meet the range of motion/mobility needs of resident (R)59 and R72. With two restorative nurse aides staffed for the entire facility, who were frequently pulled from their RNA assignments to cover as certified nurse aides (CNA)s on the floor, two residents experienced a decline in function.	F 725	Corrective Actions: " Kuakini Geriatric Care, Inc. (KGC) is continuing its staff recruitment and hiring efforts under very difficult healthcare workforce shortages in the state and U.S. KGC□s initiatives include the following: 1. The use of staff contracted from external staffing agencies for short-term staffing coverage while recruiting to fill vacant positions. There are current shortages in available staff from external agencies due to statewide and national demand by hospitals and post-acute care facilities. Completed 12/14/2021 and ongoing 2. There are Positions for 12 CNA and 7 licensed staff positions approved by KGC Administration and posted for recruitment	

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F 725	Continued From page 46 2) On 12/09/21 at 08:51 AM, during an interview with resident (R)334 in her room on the fifth floor, R334 stated that she frequently waits a long time for help when she needs it, and when staff do finally arrive, after sometimes waiting thirty to forty-five minutes, staff seem "rushed and don't want to help me." 3) On 12/10/21 at 07:58 AM, an observation was done in the fifth-floor dining room [labeled the "Solarium"]. Six residents were seated in their wheelchairs around a long table near the window, with no staff in sight. The sun was shining brightly through the window, and the room temperature felt uncomfortably warm. An anonymous resident waved the surveyor over and stated, "it's getting really hot in here, can we go back to our rooms? I moved myself over out of the sun, but not everyone can do that." R334 also waved the surveyor over and stated, "I want to go back to my room now, but I don't know how to get there. Where did everyone go? They just left us and didn't come back." Surveyor stepped out of the dining room but could not immediately find any staff around for assistance. Surveyor walked over to the nurses' station and informed the patient care coordinator (PCC)5 there that the residents in the dining room were getting hot and needed assistance back to their rooms. 4) On 12/14/21 at 10:54 AM, an observation was done of R5 in his room on the fifth floor. While Surveyor was still outside the room in the hall, R5 was noted to be loudly yelling for fifteen minutes for assistance to get out of bed. When staff responded, surveyor followed licensed practical nurse (LPN)4 into the room. Surveyor observed at this time that R5's call button had been placed	F 725	and hiring efforts currently. Completed 12/14/2021 and ongoing 3. KGC□s resident care unit 4 (47 beds) has been temporarily closed until sufficient nursing staff are hired to staff the unit. Completed 12/31/2021 and ongoing Systemic Changes: " The Patient Care Coordinators (PCC) or designee will monitor and track the daily staffing for each resident care unit and evaluate the impact of staffing on providing quality services to the residents and assuring resident safety. Completed 12/14/2021 and ongoing " The KGC Director of Nursing (DON) or designee will analyze the staffing needs for each resident care unit on a monthly basis and initiate personnel request forms for the recruitment of staff as required. Completed 12/14/2021 and ongoing " The Kuakini Staffing Services will contact all KGC employees for voluntary overtime and the external staffing agencies for contract staff to assist in filling the staffing needs of the resident care units. Completed 12/14/2021 and ongoing " The KGC Administration will limit	

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F 725	Continued From page 47 over the top of a large oxygen tank positioned at least three feet from his bed and was well out of reach. LPN4 spoke to the resident and told him she would find someone to help him up. LPN4 was about to leave the room when Surveyor asked her where R5's call button was. LPN4 located it on the oxygen tank and positioned it next to R5 on the bed before leaving. When asked, LPN4 could not explain why the call button was placed there, nor why R5 had to yell out loudly for assistance for fifteen minutes. 5) Interview on 12/09/21 at 10:03 PM with Resident (R106) when queried regarding staffing, R106 stated "they are short staffed and work really hard. They really care for their patients. I don't mind waiting because the staff are so busy." Observation on 12/09/21 at 11:30 PM was done of mealtime on ICF 3rd floor, rooms 308 through rooms 319, identified as mostly isolation rooms. Observation of Nurse's aide (NA)1 who was alone and passing trays. NA1 gowned up and masked to enter room 312. Resident in room 312 required feeding assistance. NA1 assisted room 312 for six minutes. NA1 then came out of Room 312 and masked and gowned and went into room 313. NA1 spent 7 minutes to assist room 313. NA1 then gowned and masked for room 315. NA1 spent 5 minutes in room 315. After 32 minutes, the only two available Registered Nurses (RN) on the floor came to finish and help pass the trays to the remainder of the rooms. CNA#2 came at 12:30 to help pass trays and assist with feeding residents. Interview on 12/09/21 at 12:30 PM with NA2 who was queried regarding the help on the floor with mealtime. NA2 stated that "I am from the other side. This side is hard. This side are all assist	F 725	admissions to KGC□s SNF and ICF based on available nursing staff and available contract staff from external agencies to provide the coverage for the resident care units. Completed 12/14/2021 and ongoing " The PCC or designee will re-educate all nursing staff on (1) conducting hourly rounding during the day shift, and (2) conducting two hour rounding during the night shift in order to check the residents for the 4 Ps (pain, potty, positioning, and possessions). Completed 01/28/2022 and ongoing " The KGC management will continue to monitor the staff attendance, work performance, and competencies which may require progressive disciplinary actions when the staff are not meeting their job expectations. Completed 01/28/2022 and ongoing Monitoring of Corrective Actions: " The KGC management or designee will conduct random interviews of residents on each resident care unit on a monthly basis. The results of the interviews will be reported at the Interdisciplinary Team (IDT) meetings and the Performance Improvement Committee meetings. Completed 01/28/2022 and ongoing	

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F 725	Continued From page 48 feeding. The other side is where the residents are mobile. Interview with RN1 on 12/09/21 at 12:40 PM who was queried regarding adequate staffing for mealtime. RN1 stated "We are short. Today, we are supposed to have 3 RNs but we have 2. Interview on 12/10/21 at 03:01 PM with Administrator who stated that he goes to nurse's aide classes every week, "the mom and pop kind." Administrator stated he was planning to start a nurse's aide training class. "It's a crisis." Observation on 12/09/21 at 03:10 that one NA staying until 11:30 at night because staffing was short. An anonymous staff member stated that "RNs have come in as NAs to help with the shortage. During an interview on 12/13/21 at 11:30 AM, talked with an anonymous staff member who stated that he/she has been working the floor for a long time and not able to do restorative care. During a confidential interview on 12/13/21 at 12:30 PM with staff who preferred to remain anonymous, staff stated that their charge nurse had retired and she used to take care of all the careplans. She kept them up-to-date, revised, created them. (Ref F657)	F 725		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to	F 726		1/28/22

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F 726	Continued From page 49 provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review (RR), the facility failed to ensure nurse competency in medication administration, identifying a change in condition, and appropriate standard of practice during wound care for three residents in the sample. This deficient practice placed the residents at risk for avoidable declines in health status and decreased quality of care and has the potential to affect all the residents at the facility.	F 726	Corrective Actions: " Resident (R) 21 is not on the Resident Sample List that was provided by the DOH surveyor. " Resident (R) 116□s heart rate was verified via radial pulse and was found to be within normal range at 58 beats per minute.	

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F 726	Continued From page 50 Findings include: 1) On 12/13/21 08:22 AM, an observation was done of registered nurse (RN)3 conducting his morning medication pass. RN3 entered the room of resident (R)21 on the fifth floor. While administering her olopatadine eye drops (an eye drop used to relieve itching caused by allergies), one drop in each eye, RN3 was observed asking R21 to look up while he held the dropper bottle above each eye and squeezed it. RN3 did not hold down R21's bottom eyelid to form a "pocket" to receive the drop. 2) On 12/13/21 at 08:36 AM, observations continued of RN3 conducting his morning medication pass. RN3 was observed taking the blood pressure of R116 as she sat in the television room across from the fifth-floor nurses' station. The automatic blood pressure machine displayed R116's blood pressure as 127/60, and her heart rate as 39 beats per minute. RN3 wheeled the blood pressure machine displaying this information out of the room and to his medication cart, where he began preparing R116's medications. After administering her medications, RN3 returned to his medication cart and began documenting the medications he had just given. At 08:44 AM, as he was preparing to move on to another resident's medications, surveyor asked RN3 what was R116's heart rate. RN3 checked the machine and noted it was 39. Surveyor asked RN3 if 39 was a normal heart rate for R116, and RN3 stated "no, that's too low, I will double-check it manually." After manually palpating her radial pulse for one minute, RN3 reported R116's heart rate as 58 beats per minute. RN3 acknowledged that he should have	F 726	" Resident (R) 14□s wound dressing was corrected prior to the end of the observation. Completed 01/28/2022 Systemic Change: " The KGC Director of Nursing (DON) or designee re-evaluated all the licensed nurses for their competency in eye drop medication administration, vital signs taking, and wound care dressing changes. Completed 01/28/2022 and ongoing Monitoring of Corrective Actions: " The PCC or designee will conduct two random monthly audits of eye drop medication administration, vital signs taking, and wound care dressing changes. The audit results will be reported at the Interdisciplinary Team (IDT) meetings and the Performance Improvement Committee meetings. Completed 01/28/2022 and ongoing	

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F 726	Continued From page 51	F 726		

noted the abnormally low heart rate and re-checked it manually prior to administering her medications, stating "that's my bad."

On 12/14/21 at 12:26 PM, during an interview with the Director of Nursing (DON) in her office, the DON stated that she would expect any staff member, whether a licensed nurse or a certified nurse aide, to re-check a resident's heart rate if it is below 60 beats per minute. The DON also stated that all staff who administer medications are trained in the proper administration of eye drops and provided surveyor with a copy of the Policy and Procedure (P&P) for Medication Administration Eye Drops, dated 10/07. A review of the P&P noted the following: " ...8. Pull the lower eyelid down and away from the eyeball to form a pocket ..."
" ...10. Instruct resident to look upward, and place one drop into the pocket ..."

3) On 12/10/21 at 11:28 AM, observed Registered Nurse (RN)8 changing R14's sacral stage 4 pressure wound dressing. While cleaning the wound bed, RN8 used the same swab tip in multiple areas of the wound bed in a back-and-forth motion. The swab should have been discarded after one swipe from one edge of the wound bed to the other edge (in one direction) to avoid potential cross contamination of the wound bed. While placing the Therahoney sheet over the wound bed, RN8 used a Q-tip type swab to push the Therahoney sheet under the inside edge of the wound bed where there was no undermining or tunneling. By doing this, RN8 caused further damage or distress to the wound edge. The images depicting the application of the the Therahoney sheet shows it covering the wound bed edge. RN8 then attempted to cover

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F 726	Continued From page 52 the pressure wound, with the adhesive of the bandage in direct contact with the edge of the wound bed. This surveyor inquired if the bandage adhesive should be in direct contact with the wound edge. RN8 confirmed the adhesive should not be in direct contact with the wound edge and applied a larger bandage that could appropriately cover the pressure wound. At 12:05 PM, shared observations made of RN8 changing R14's sacral wound dressing with the acting Wound Nurse (WN). The WN confirmed RN8 should not have used the same Q-tip swab to clean multiple areas of the wound bed, pushed the Therahoney sheet under the inside of the wound bed edge with no tunneling present, or placed the bandage adhesive directly onto the edge of the wound.	F 726		
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from	F 825		1/28/22

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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
F 825	Continued From page 53 participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure Resident (R)135 received rehabilitative services to assist the resident to restore his/her highest practical level of physical functioning. This deficiency has the potential to affect the all resident's needing rehab services quality of life. Findings include: Resident (R) 135 was admitted to the facility on 11/09/21 for rehabilitation services after falling at home and having surgery to her left hip. Review of R135's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/09/21 documented R135's Brief Interview for Mental Status (BIMS) score of 13 indicates the resident is cognitively intact. Section O: Special Treatments, Procedures, and Programs documented R135 started both Occupational Therapy (OT) and Physical Therapy (PT) services on 11/10/2021 (no end date for OT or PT documented) On 12/13/21 at 08:05 AM, during an interview with R135, the resident stated that she had been receiving PT at the facility after falling at home (which was related to a worker's compensation claim) and required surgery on her left hip. The resident explained that upon admission she had been receiving PT services, but those services were discontinued due to a billing mix up and not because she had completed therapy as ordered. R135 appeared distressed and teary-eyed when	F 825	Corrective Actions: " Resident (R) 135 was evaluated by the Rehabilitation Services and was started on skilled rehabilitation on 12/14/2021. Completed 12/14/2021 " The Director of Rehabilitation (DOR) or designee reviewed all residents discharged from skilled rehabilitation services who remained as a resident at the KGC Intermediate Care Facility (ICF) during the last 2 months. The DOR identified no other resident besides Resident (R) 135 who was affected by the deficient practice. Completed 01/28/2022 Systemic Changes: " The KGC Director of Nursing (DON) provided education to the Director of Rehabilitation (DOR) on the Restorative Program requirement for all residents discharged from the skilled rehabilitation services and transferred to the KGC Intermediate Care Facility (ICF). Completed 01/28/2022 and ongoing Monitoring of Corrective Actions:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125026	A. BUILDING _____ B. WING _____	12/14/2021

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F 825	Continued From page 54 speaking about not receiving PT services. On 12/13/21 at 08:15 AM, conducted a review of R135's Medical Records (MR). Review of a Physician's Order documented an order for "PT Clarification: PT eval (evaluation) complete. PT (physical therapy) RX (order) 5x(times)/wk (week) x 8 wks (five times a week for eight weeks)". Review of R135's Interdisciplinary Team (IDT) MDS (minimum data set)/Care Conference Record on 11/12/21 documented an IDT goal as, "Pt (patient) able to do self-care and mobility." Review of R135's chart did not contain any physical therapy progress notes. During an interview with social worker (SW) and Unit Manager (UM) on 12/13/21 at 09:34 AM, SW confirmed when R135 was admitted to the hospital, it was not identified as a worker's compensation billing and was informed by admission staff that it would take 10 days for the payment source to change over to worker's compensation and PT services was stopped due to insurance payment issues. UM stated that when a resident is finished with PT, they are referred to the Restorative Nurse Aides (RNA) for services on the same day it is discontinued. On 12/13/21 at 10:28 AM, conducted an interview with the Director of Rehab (DOR). DOR acknowledged that R135 was discharged from physical therapy on 12/05/21, had not achieved all her PT goals, and still needed PT services. DOR stated R135 should have been referred to the RNA program for assistance with her range of motion the day of discharged from PT services. At 10:40 AM, DOR provided a Therapy to Restorative Nursing Communication (used to refer residents recently discharged from PT/OT	F 825	" The DOR will conduct monthly audits of the residents discharged from the skilled rehabilitation services and transferred to the KGC ICF with the Restorative Nursing program. The audit results will be reported at the Interdisciplinary Team (IDT) meetings and the Performance Improvement Committee meetings. Completed 01/28/2022 and ongoing	

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F 825	Continued From page 55	F 825		

services to restorative services) form that documented R135 was not referred to RNA services until 12/12/21.

During an interview on 12/14/21 at 08:00 AM, both of the facility's RNA staff confirmed they did not receive a Therapy to Restorative Nursing form to date. RNA1 stated the process is such that when a resident has completed their OT/PT program the rehab staff should hand-off the resident to the restorative program which will last approximately 2 months for at least twice a week. The referral is usually accompanied by a physician order. Inquired with RNA1 if R135 was referred to the restorative program. RNA1 reviewed documentation and confirmed R135 was discharged from OT/PT on 12/06/21, the physician order was written on 12/08/21, the referral was completed by rehab staff on 12/12/21, and the referral was submitted to the restorative program on 12/13/21. There was a 6-day period during which R135 was not receiving services to maintain/restore the resident's highest practical level of physical functioning.

On 12/14/21 at 10:19 AM, conducted an interview with R135. R135 reported that prior to being discharged from PT, her right leg has started to buckle, and gait is wobbly. R135 stated she had only walked up an down the hallway a total of 3 times during her entire stay and feels that she has lost stamina with standing since she was not receiving rehab services.

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E 000	Initial Comments A recertification survey was conducted by the Office of Health Care Assurance on 12/9/21 - 12/14/21. The facility was found to be in substantial compliance with §483.73, Requirement for Long-Term Care (LTC) Facilities of Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types, State Operations Manual.	E 000		

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

Electronically Signed | 02/04/2022

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.

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	125026	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/11/2022**

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K 000	INITIAL COMMENTS THIS FACILITY MET THE REQUIREMENTS OF THE 2012 EDITIONS OF: NFPA 99, HEALTH CARE FACILITIES CODE AND NFPA 101, LIFE SAFETY CODE, CHAPTER 19, EXISTING HEALTH CARE OCCUPANCIES.	K 000		

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

Electronically Signed | 01/27/2022

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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		

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