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	125065	A. BUILDING _____ B. WING _____	05/10/2021

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LEGACY HILO REHABILITATION & NURSING CENTER	563 KAUMANA DRIVE HILO, HI 96720

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance on May 10, 2021. The facility was found not to be in substantial compliance with 42 CFR 483, Subpart B. On April 30, 2021, the Administrator was notified of substandard quality of care at F679, Activities. The facility did not assure all residents were provided with a person-centered activity assessment which encompassed their personal choices, preferences for activities, interests, hobbies, and need for accommodations which would result in providing residents with a meaning activity program to enhance their quality of life while residing in the facility. A facility reported incident (ACTS) #8352 was investigated and substantiated. Survey Dates: April 27 through April 30, 2021 and May 10, 2021 (Extended Survey) Survey Census: 69 Sample Size: 22	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident	F 550		5/28/21

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

Electronically Signed | 05/28/2021

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F 550	Continued From page 1 with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interviews, the facility failed to treat one Resident (R)51 with dignity, respect, and kindness. R51 shared an experience that upset her when a staff member did not acknowledge her statements of feeling sick and contradicted her about her diet in front several people	F 550	1. DON met with R51 to ensure he/she received support and offered counseling if desired. The RN involved is no longer employed at the facility. The physician involved stated it was only himself and the nurse in the room. He further stated the	

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F 550	Continued From page 2 including a physician. As a result of this interaction, R51 said she felt "humiliated and embarrassed." There is the potential that any resident residing in the facility could be treated with disrespect which may affect their psychological well-being. Findings include: R51 is an 85-year-old female admitted to the facility for healing of a coccyx fracture. Additional diagnoses included basal cell carcinoma on right side of nose, heart failure, acute kidney failure, hypertension, depression, and transient ischemic attack. R51's care plan (CP) was reviewed on 04/28/21 which revealed the nutritional approach; "provide menu selection and honor food preferences: fresh fruits, fresh veggie tray, no beef." On 04/28/21 at 08:11 AM during an interview with R51, she was pleasant, communicated well and easily carried on a conversation. When asked how the food was at the facility, R51 said she did not eat beef and would like more organic foods. R51 said she had been accidentally served beef over the weekend and ate it before she realized it was beef. R51 said beef makes her very sick and after she ate it she was sick for 24 hours. R51 was unsure of the day, but thought it was Monday when a Registered Nurse (RN) embarrassed her in front of a physician (MD) and "an audience." R51 told the MD she had been very sick because she accidentally ate beef, and the RN in front of everyone; " She's (R51) exaggerating, She eats beef all the time. R51 said; "I couldn't believe a professional would say that." R51 said she felt "berated, humiliated and embarrassed, like I was lying, I have never eaten beef here."	F 550	nurse was very apologetic regarding the dietary error and immediately left to notify dietary. The physician said this was the end of the conversation. Dietary reviewed R51's likes and dislikes with resident. Dietary staff were inserviced regarding R51 preferences and his/her request not to receive any beef in his/her meals. 2. The alleged practice has the potential to affect facility residents with specific dietary requirements / preferences. 3. Direct care staff and staff participating in meal service and delivery were re-inserviced regarding monitoring meal tickets and meals prior to delivery to ensure compliance by the unit managers / DON / RD / designee. Facility staff were inserviced regarding resident rights regarding privacy and dignity by the DON/ Staff Development Coordinator / unit managers / designee. Inservices will be ongoing as needed. 4. Unit managers / designee will audit through observation of meal tickets and meals three times a week for a minimum of 12 weeks to ensure compliance. Results of these audits will be brought to QAPI monthly for review and recommendations for a minimum of three months or until compliance is achieved.	

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F 550	Continued From page 3 On 04/29/21 at 10:28 AM during an interview with the Dietary Manager (DM), she said the kitchen was aware R51 did not want beef and validated it was in the system as her preference. The DM confirmed beef had been on the weekend menu. On 04/30/21 reviewed the facility admission documents provided to residents which included information on resident rights. Included in the documents were the statements: "The resident has a right to a dignified existence...," and "The resident had the right to be treated with Respect and Dignity..." On 04/30/21, reviewed the facility policy titled "Resident Rights in the facility" revision date December 2016. The policy statement was "Employees shall treat all residents with kindness, respect and dignity. The "Policy Interpretation and Implementation," included "1. Federal and state laws guarantee certain basis rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity ...."	F 550		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a	F 583		5/28/21

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F 583	Continued From page 4 private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on interviews and document review, the facility failed to provide the right of personal privacy to one resident (R)36 of a sample size of 22. R36 said the staff did not honor her request on multiple occasions to close the blinds for privacy while they were providing care. As a result of this deficiency, R36's right to privacy was denied and she felt embarrassed and exposed which could potentially affect her psychological well-being. All residents could be affected if personal privacy is not provided. Findings include:	F 583	1. The DON met with R36 to ensure he/she received support and offered counseling if desired. Unit staff were inserviced regarding resident rights regarding privacy and dignity and on closing blinds when rendering care by the DON/ Staff Development Coordinator / unit managers / designee. Inserviced will be ongoing as needed. 2. The alleged practice has the potential to affect facility residents. 3. Facility staff were inserviced regarding resident rights regarding privacy and dignity and on closing blinds when	

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F 583	Continued From page 5 R36 an 88-year-old female admitted to the facility after a cerebral infarction (stroke) affecting her left side. She is alert, cognitively intact and communicates well. R36 had occasional incontinence and wore a brief. She required assistance with activities of daily living, which included changing her brief and cleaning of the perineal area in a meticulous manner to prevent urinary tract infections and skin breakdown. On 04/27/21 at approximately 09:30 AM, observed R36n her room at which time surveyor commented on the nice view she had from her room. R36cknowledged it was nice but said the staff do not close the blinds when they provide care. R36 went on to say, "My backside is out for everyone to see." She said when she asked to have the blinds closed, the Registered Nurse commented that it was a beautiful day outside and that we should leave the blinds open. At that time, surveyor noted there was a cement sidewalk around the facility outside the window. On 04/30/21, reviewed the documents provided to residents at the time of admission which included a section on Privacy and Confidentiality which said; "The resident has a right to personal privacy and confidentiality of his or her personal and medical records. Personal privacy includes accommodations..." On 04/30/21, reviewed the facility policy titled "Resident Rights in the facility" revision date December 2016. The policy statement was "Employees shall treat all residents with kindness, respect and dignity." Surveyor walked the cement sidewalk outside R36's room and observed you could see inside	F 583	rendering care by the DON/ Staff Development Coordinator / unit managers / designee. Inservices will be ongoing as needed. 4. Unit managers / designee will audit through observation during rounds three times a week for a minimum of 12 weeks to ensure compliance. Results of these audits will be brought to QAPI monthly for review and recommendations for a minimum of three months or until compliance is achieved.	

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F 583	Continued From page 6 the room if the blinds were open. In addition, several observations were made during the four-day survey of staff and visitors using the sidewalk around the facility.	F 583		
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. (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;	F 623		5/28/21

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F 623	Continued From page 7	F 623		

(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 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

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F 623	Continued From page 8 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 record review and interview with staff member, the facility failed to notify the resident's representative before transferring Resident (R)21 to the hospital, and written reason for the transfer to R21's representative. The facility also failed to notify the Office of the State Long-Term Care Ombudsman. Findings include: Review of R21's hospital discharge summary notes R21 was admitted to the hospital on 02/11/2. Concurrent review of the facility's Notice of Resident Discharge/Transfer form on 04/30/21 at 09:25 AM with Social Services Associate	F 623	1. Social Service Assistant was re-inserviced regarding necessary notifications needed for discharge and transfers to the hospital by the administrator/designee. Inservices will be ongoing as needed. 2. The alleged practice has the potential to affect facility residents being discharged to the hospital. 3. Social Service Assistant, Unit managers, Interdisciplinary staff were re-inserviced regarding necessary notifications needed for discharge and transfers to the hospital by the administrator/designee. Inservices will be	

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F 623	Continued From page 9 (SSA), R21's effective transfer/discharge date was 02/10/21 and R21 signed and dated the form on 02/24/21. SSA confirmed the resident's representative and Ombudsman did not receive a copy of the transfer notice.	F 623	ongoing as needed. 4. Administrator / designee will monitor compliance through weekly audits of hospital transfers/discharges for a minimum of 12 weeks. Results of these audits will be brought to QAPI monthly for review and recommendations for a minimum of three months or until compliance is achieved.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which	F 625		5/28/21

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F 625	Continued From page 10 specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff member, the facility failed to provide a written bed hold notice to Resident (R)21 and R21's representative within 24 hours of being transferred to the hospital. Findings include: Review of the facility's Notice of Resident Discharge/Transfer form dated 02/24/21, R21's effective/discharge date to a hospital was 02/10/21. Review of the hospital discharge summary notes R21 was admitted on 02/11/21. A review of the facility's policy and procedures for Bed Holds and Returns notes prior to transfers, resident/guests or resident/guest representative will be informed of the bed-hold and return policy. Interview with Administrator on 04/30/21 at 09:17 AM, Administrator stated there is no documentation that R21 or R21's representative received a written bed hold notice upon transfer to the hospital.	F 625	1. Social Service Assistant and Licensed nursing staff were re-inserviced regarding necessary notifications of bedhold for discharge and transfers by the administrator/designee. Inservices will be ongoing as needed. 2. The alleged practice has the potential to affect facility residents being transferred/discharged to the hospital. 3. Social Service Assistant, Unit managers, Interdisciplinary staff, licensed nursing staff were re-inserviced regarding necessary notifications of bedhold for discharge and transfers by the administrator/designee. Inservices will be ongoing as needed. 4. Administrator / designee will monitor compliance through weekly audits of hospital transfers/discharges for a minimum of 12 weeks. Results of these audits will be brought to QAPI monthly for review and recommendations for a minimum of three months or until compliance is achieved.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident	F 655		5/28/21

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F 655	Continued From page 11 that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to develop a baseline care plan that	F 655	1. Residents' 51, 219 and 224's care plans were reviewed and updated as	

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F 655	Continued From page 12 provided effective and person-centered care for three residents (R)51, R219, and R224 in the sample. Specifically, despite identifying R51's, R219's, and R224's immediate medical needs, the facility failed to develop, implement and modify resident-specific interventions that thoroughly addressed those needs. As a result of these deficient practices, the facility placed these residents at risk for avoidable declines and injuries. This deficient practice had the potential to affect all new admissions to the facility. Findings include: 1) R51 is an 85-year-old female who had a fall at home that resulted in a coccyx fracture. After discharge from the hospital, she was transferred to the facility on 02/09/21 for rehabilitation. Additional diagnoses included basal cell carcinoma on right side of nose, heart failure, acute kidney failure, hypertension, depression, and transient ischemic attack. R51 is alert and oriented with some forgetfulness at times. On 04/28/21 reviewed R 51's Comprehensive and Baseline Care Plan (CP) which revealed the Comprehensive CP was initiated the day of admission 02/09/21, but was incomplete. Several areas in the "Baseline Needs Category Approach" section were not completed to personalize the plan to R51's specific needs on admission. The incomplete areas of the CP for baseline status read as follows: "Bladder: (Continent, incontinent, appliance: specify and include size)" "Bowel: (continent, incontinent, appliance: specify)" "Incontinent product: (brief, pad, pull-up) size"	F 655	needed. MDS Coordinator and unit managers were re-inserviced regarding baseline care plans by the DON/designee. Inservices will be ongoing as needed. 2. The alleged practice has the potential to affect new admissions to the facility. 3. Licensed nursing staff and the interdisciplinary team were re-inserviced regarding baseline care plans by the DON /SDC/designee. Inservices will be ongoing as needed. 4. MDS Coordinator / DON / Unit Managers/ designee will monitor compliance through audit of new admissions' baseline care plans three times weekly for a minimum of 12 weeks. Results of these audits will be brought to QAPI monthly for review and recommendations for a minimum of three months or until compliance is achieved.	

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F 655	Continued From page 13 "I have (partial (upper, lower) denture(s), full (upper, lower) denture(s)) " "My hearing is (adequate, impaired) I need (glasses, contacts, magnifying glass, nothing) to improve my vision." "Bathing: (Independent, Set-up, Assist of 1, Assist of 2. Total dependence)" "Bed mobility: (independent, Set-up, Assist of 1, Assist of 2, Total dependence)" "Grooming/hygiene: (independent, Set-up, Assist of 1, Assist of 2, Total dependence)" "Locomotion: (independent, Set-up, Assist of 1, Assist of 2, Total dependence)" "Shower/Bath Preferred day/Time" "Toileting: (independent, Set-up, Assist of 1, Assist of 2, Total dependence)" "Transfer: (independent, Set-up, Assist of 1, Assist of 2, Total dependence)" "Walking: (independent, Set-up, Assist of 1, Assist of 2, Total dependence)" On 04/29/21 at 04:51 PM during an interview with the Director of Nursing (DON), a review of R51's Comprehensive and Baseline CP was completed. The DON agreed R51's CP was incomplete. 2) R219 is a 61-year-old male admitted on 04/13/21 for long-term care. R219 had been admitted to a single room on the short-term rehab wing for a 14-day quarantine per the facility's COVID-19 protocol. R219's diagnoses include chronic respiratory failure, chronic obstructive pulmonary disease (COPD), human immunodeficiency virus disease (HIV), and moderate persistent asthma. R219 had a previous admission to the facility for short-term rehab from 01/26/21 to 03/09/21.	F 655		

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On 04/30/21, a review of R219's baseline care plan revealed that every problem, goal, and intervention identified and planned had been carried forward from his previous admission.

On 04/30/21 at 10:22 AM, an interview was done with the DON in her office. When asked about care plans, the DON acknowledged that care plans should always be new, not carried over from previous admissions. The DON stated there was no reason to use an old care plan and made a note to address the problem as part of a performance improvement plan.

3) R224 was an 83-year-old female admitted on 04/21/21 for post-surgical care following a colostomy (an artificial opening in the abdominal wall through which the healthy end of the large intestine is attached) placement. R224 had been admitted to a single room on the short-term rehab wing for a 14-day quarantine per the facility's COVID-19 protocol. R224's diagnoses include dementia, hypertension (high blood pressure), sick sinus syndrome (irregular heart rhythms), muscle weakness, and difficulty in walking.

On 04/29/21 at 08:20 AM, an interview was done with Registered Nurse (RN)2. In response to a request to observe R224's colostomy care, RN2 stated that due to R224's dementia, she had pulled her colostomy bag off the previous night and so the colostomy care had already been done. RN2 went on to explain that since the colostomy was new, R224 would frequently forget that it was there or what it was for and would try to scratch or pull at her colostomy bag. RN2 stated that R224 required a lot of reminding and redirection to leave the colostomy alone.

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F 655	Continued From page 15 On 04/30/21, a review of R224's baseline care plan revealed no identified problems, goals, or planned interventions that addressed colostomy care or teaching, despite that being the primary reason R224 had been admitted. Further review noted her dementia was also not included in the care plan. On 04/30/21 at 10:22 AM, an interview was done with the DON in her office. When asked about R224's care plan, the DON stated she could give no reason why her colostomy and dementia were not included as part of R224's care plan and agreed that they were immediate needs that should have been addressed at admission.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		5/28/21

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F 656	Continued From page 16 (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, record review, and interview with staff members the facility failed to develop and implement a comprehensive person-centered care plan for 11 of 22 residents in the sample. The facility did not identify the risk of declination of care poses, document efforts by the interdisciplinary team to educate the resident and document the facility's failed attempts to find alternative means to address care and treatment in the comprehensive care plan for resident (R)53 who refuses care and treatment. The facility failed to develop and implement the comprehensive care plan to prevent Urinary Tract Infections (UTIs) for R21 and R27 after	F 656	1. Residents 10, 21, 27, 28, 29, 51, and 53's care plans were updated to reflect current needs. The findings cited 11 of 22 residents, however only 7 residents were actually identified in the findings. These were addressed. DON/MDS Coordinator / designee re-inserviced unit managers and the interdisciplinary team regarding person centered comprehensive care planning. Inservices will be ongoing as needed. 2. The alleged practice has the potential to affect facility residents. 3. Licensed nursing staff, Activity staff and Social Service staff were re-inserviced regarding person centered comprehensive care planning. Inservices	

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F 656	Continued From page 17 hospitalization for UTI. As a result, the residents are at risk for recurrence of UTI and potential for rehospitalization. The facility did not assure R51's care plan for discharge lacked documentation of the discharge planning process. Based on individual activities assessment, the facility did not assure residents (R28, R29, R27, and R10)were provided with an individualized, person-centered care plan to meet their activity interests and needs. As a result of this deficiency, the residents are at risk of not reaching their highest practical level of mental and psychosocial well-being with the potential for more than minimal harm. Findings include: 1) R53's initial admission to the facility was 09/30/19. Diagnoses include but are not limited to low back pain, benign prostatic hyperplasia with lower tract symptoms, unspecified insomnia, dental caries, shortness of breath, unspecified malignant neoplasm of bladder, shortness of breath, other specified disorders of teeth and supporting structures, and dehydration. On 04/27/21 at 11:14 AM observed R53's door closed. After knocking on R53's door, R53 yelled from his bed for surveyor to come in. Upon opening the door an immediate unidentified unpleasant odor could be smelled from R53's room. Observed R53 seated on his bed looking through paperwork, the room was dark with minimal air circulation. On a second observation on 04/28/21 at 08:13	F 656	will be ongoing as needed. Inhouse residents' care plans were reviewed and updated as needed. 4. MDS Coordinator / DON / Unit Managers/ designee will monitor compliance through audit of care plans weekly for a minimum of 12 weeks. Results of these audits will be brought to QAPI monthly for review and recommendations for a minimum of three months or until compliance is achieved.	

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AM, observed R53 in his room independently eating breakfast in the dark with minimal air circulation. Prior to entering, R53's door was closed and upon entrance the same unpleasant odor could be smelled from R53's room.

Interview with Housekeeping Manager (HM) on 04/28/21 at 03:28 PM in front of R53's room, HM agreed that R53's room has an unpleasant smell and stated housekeeping cleans his room every day but does not know why his room smells. HM explained when R53 takes a shower staff try to open the windows to air out the room and when he returns from his shower, staff close the windows back up because R53 does not like his windows open. HM further stated that staff also tried putting air fresheners in his room but he did not like the air fresheners.

On 04/29/21 at 08:01 AM interviewed Certified Nursing Aide (CNA)2 about the smell from R53's room, CNA stated the smell is due to R53 refusing to shower and refusing assistance when incontinent. CNA explained that R53 showers about once a week due to his refusal. CNA proceeded to walk to R53's room and stated she will try to provide incontinence care now. CNA knocked on R53's door and waited for R53 to acknowledge her to come in. Surveyor entered the room and stayed next to the door as CNA approached R53 and asked R53 if she can provide care. CNA offered and R53 refused. CNA approached surveyor and stated when R53 refuses she tries to ask another staff member to come in with her and asks again. Sometimes R53 will yell and curse at staff when trying to provide care.

On 04/30/21 at 08:16 AM interviewed Registered

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Nurse (RN)3 regarding R53 refusing care. RN stated R53 does not want anyone in his room refuses, personal care and treatment, and it is a struggle to take his vitals due to refusal.

Interview with DON, with Nurse Manager (NM) and unidentified staff present on 04/29/21 at 03:05 PM, DON stated the facility did not document strategies to address R53's refusal of care and treatment.

Concurrent review of R53's care plan in the former electronic health record (EHR) and the current EHR was done with the Director of Nursing (DON) on 04/30/21 at 08:28 AM. Although the facility identified R53 is " ...at risk for skin breakdown r/t [related to] bowel and bladder incontinence, impaired physical and functional mobility, refusal of care" in the care plan, the care plan does not address the care or services being declined, the risk of the declination poses, document efforts by the interdisciplinary team to educate the resident and document the facility's failed attempts to find alternative means to address care and treatment. DON stated in the future they will document.

2) Cross with F690.

Interview with R21 on 04/28/21 at 10:46 AM stated she was recently hospitalized due to a urinary tract infection (UTI).

Review of R21's discharge summary indicates R21 was hospitalized and admitted on 02/11/21 and discharged back to the facility on 02/16/21. The discharge summary final diagnosis included congestive heart failure, atrial flutter, and UTI.

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Review of physician's order for R21 on 01/09/21 as needed, "If resident has 2-3 symptoms of UTI: dip urine PH strips, if positive collect urine specimen for UA with C&S and send to lab. May straight cath. If unable to obtain clean catch ..."

Concurrent record review with DON on 04/20/21 at 08:28 AM of R21's former and present EHR, R21's care plan does not address interventions to prevent UTI after re-admittance from a hospital to the facility.

3) R10's initial admission to the facility was on 04/12/18. Diagnoses include but are not limited to unspecified hypothyroidism, essential (primary hypertension), unspecified hyperlipidemia, unspecified Vitamin D deficiency, unspecified dementia without behavioral disturbance, unspecified single episode major depressive disorder, and adjustment disorder with other symptoms.

Review of R10's quarterly Minimum Data Set (MDS) with an assessment reference date of 01/30/21, R10 scored a 10 (moderate cognitive impairment on the Brief Interview for Mental Status.

Interview with R10 on 04/27/21 at 10:39 AM stated she would like to see more activities, "I like to go out, I am really pissed off about it! They don't even ask us if there is anything we want to do .... They treat us like morons, I feel like we are in prison ..." R10 further explained, she would like to go outside, go for a walk, sit outside in the sun, go to the store or church.

Review of R10's care plan updated on 02/19/21,

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R21 is " ...at risk for (decreased, little or no) activity involvement r/t [related to] general weakness or no interest." An intervention included in R10's care plan includes "Allow me to sit out in the courtyard in line sight to catch some sun ..."

Review of R10's activity participation from 04/01/21 to 04/29/21, the facility did not offer R10 to sit outside in the courtyard.

4) R51 is an 85-year-old female who had a fall at home that resulted in a coccyx fracture. After discharge from the hospital, she was transferred to the facility on 02/09/21 for rehabilitation. Additional diagnoses included basal cell carcinoma on right side of nose, heart failure, acute kidney failure, hypertension, depression, and transient ischemic attack. R51 is alert and oriented with some forgetfulness at times.

On 04/28/21 during an interview with R51, she said at the time of admission her intent was to return home after rehabilitation. R51 said she had help at home before the fall and felt she could go with some additional resources. R51 went on to say now she can barely walk, and the decision had been made she would remain at the facility for long term care.

A review of R51's CP was conducted on 04/28/21 which revealed the following:
The "Baseline Needs" included "Admit: I require a Baseline Care Plan that covers my admission and discharge goals ... The goal is discharge to my home."
The Social Services Problem Baseline Needs section initiated on admission (02/09/21) had only

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the goal "Resident will have services coordinated to ensure optimal care and discharge goals." The "Approach ... Barriers to Resident's Discharge /Goals" was not completed.

On 04/29/30 at approximately 09:00 AM during an interview with Social Services Associate (SSA), she said social services does not do anything with resident care plans and was not sure who was responsible to complete them.

On 04/29/30 at 09:16 AM during an interview with the Business Service Representative (BSR), she said she had been involved with assisting R51 and her daughter to obtain approval for long term care. BSR reviewed her personal notes and said R51 had been approved to stay at the facility and would not be returning home.

On 04/29/21 at approximately 05:00 PM during an interview with the Director of Nursing (DON), she said the MDS coordinator had always done the care plans, but the nurses were going to be doing them and they were in the process of this change. The DON agreed R51's CP lacked documentation of the discharge planning process, and said she would expect to see this in the comprehensive CP.

If discharge to the community is determined not to be feasible, the facility must document who made the determination, why and update the comprehensive care plan and discharge plan as appropriate.

5) Cross Reference to F679. Based on an activities assessment, R29's care plan did not include was not person-centered to reflect R29's

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F 656	Continued From page 23 activity preferences for watching television, what the resident likes to do during one to one visits, the type of activities that empowers her to make choices and encourage self-expression and how to address needed adaptations related to her vision loss during activities. 6) Cross Reference to F679. There is no documentation of an activity assessment/evaluation which is specific to R27 to develop a comprehensive person-centered care plan for activities. The care plan does not specify which religious programs to offer; how to develop new activities; what television programs she may like to watch; and what activities to engage R27 in during 1:1 visits. 7) Cross Reference to F679. Based on an activities assessment which identified R28's interest, preferences for activities, and social history, R28's care plan does not reflect his personal preferences for activities, what activity to engage him in during one to one activities, what materials to provide for individual activities, and behaviors that may be triggered during activities. 8) Cross Reference to F690. R27 was admitted to the hospital for sepsis related to a urinary tract infection. A review of the record and interview with staff member confirmed the facility did not assure a care plan was developed to prevent recurrence of urinary tract infections.	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-	F 657		5/28/21

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F 657	Continued From page 24 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of 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, record review, and interview with staff member the facility failed to review and revise resident (R)53's care plan to include changes in psychotropic medications and monitor side effects and behaviors associated with the psychotropic medication prescribed. Findings include: R53's initial admission to the facility was on 09/30/19. Diagnoses include but are not limited unspecified dementia without behavioral disturbance, over specified depressive episodes,	F 657	1. Resident 53's care plan was updated to reflect medication changes. Interdisciplinary team was re-inserviced regarding care planning and psychotropic medication changes by the DON/designee. Inservices will be ongoing as needed. 2. The alleged practice has the potential to affect residents with psychotropic medication changes. 3. DON/SDC/designee re-inserviced licensed nursing staff regarding updating care plans regarding psychotropic	

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F 657	Continued From page 25 unspecified insomnia, and psychotic disorder with delusions due to known physiological condition. Review of R53's physician's orders, R53 was prescribed Quetiapine (Seroquel) tablet 50 mg at bedtime for insomnia to start on 01/09/21. Concurrent review of R53's care plan in the previous electronic health record (EHR) and present EHR was done with the Director of Nursing (DON) on 04/30/21 at 08:28 AM. The DON agreed the care plan has not been reviewed and revised to include the monitoring of side effects and behaviors (insomnia) related to use of quetiapine.	F 657	medication changes. Inservices will be ongoing as needed. 4. DON/unit managers/ designee will monitor compliance through audits of care plans weekly for a minimum of 12 weeks. Results of these audits will be brought to QAPI monthly for review and recommendations for a minimum of three months or until compliance is achieved.	
F 679 SS=F	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, interview with residents, resident representative and staff members, record review and a review of the facility's policy and procedures, the facility failed to assure based on a comprehensive assessment and care plan, 8 of 9 (Residents 36, 219, 226, 224, 10, 29, 27, and 28) residents in the sample and randomly	F 679	1. Residents 10, 27, 28, 29, 36, 219, 224 and 226 were re-assessed for activity preferences and desires. These residents are off of quarantine at present and are now considered green zone residents. This affords them greater freedom of movement and the ability to participate in	5/28/21

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F 679	Continued From page 26 observed residents were provided with an ongoing activity program to support residents in their choice of activity, both facility sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident. The facility did not assure a system is in place to assess residents for activities, develop a person-centered care plan and implement an individualized activity program. The facility did not ensure a person-centered assessment tool and/or system was in place to identify residents' need for social engagement and meaningful activities. The facility utilized Section F. Preferences for Customary Routine and Activities from the Minimum Data Set (MDS) to develop a care plan. Review found residents were primarily coded for preferences and activities as "somewhat important". The facility does not have an in depth activity assessment to identify what activities are important to the resident to enhance their quality of life. As a result of this system failure residents are at risk for experiencing a decline in their psychosocial well-being and self-esteem. This deficient practice has the potential to affect all residents that reside in the facility. Findings include: 1) R36 is an 88 year old female admitted to the facility on 03/11/21 for rehabilitation after a cerebral infarction affecting her left non-dominant side. She is non-ambulatory and needs assistance with her activities of daily living such as bathing and bed mobility. R36 requires two person assist for transfer to the wheelchair. She	F 679	group activities as desired. Care plans were updated as needed. The Activity Director and assistants were re-inserviced on assessment, documentation, care planning, 1 to 1 visits, activity calendars and offering appropriate activities based on assessments and in-room quarantine by the Director of Clinical Informatics and the VP of Clinical Services. Inservices will be ongoing as needed. 2. The alleged practice has the potential to affect facility residents. 3. Facility residents activity documentation, care plans and activity participation were reviewed for compliance. The Interdisciplinary Team and direct care staff were re-inserviced regarding 1 to 1 visits, activity calendars and offering appropriate activities based on assessments and in-room quarantine by the VP of Clinical Services / Administrator / Activity Director / designee. Inservices will be ongoing as needed. 4. The Administrator / designee will monitor compliance through observations on daily rounds and medical record reviews 3 x weekly for a minimum of 12 weeks. Results of these audits will be brought to QAPI monthly for review and recommendations for a minimum of three months or until compliance is achieved.	

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is alert, communicates well and able to verbalize her needs.

On 04/28/21 08:48 AM observed R36 sitting in a chair in her room. R36 communicated well and was able to verbalize why she was at the facility and discussed her rehabilitation. During an interview at that time, inquired what activities she was involved in and how she kept busy. R36 replied, "We don't do anything."

On 04/28/21 reviewed R36's CP with start date 03/09/21.
The CP identified the goal; "I will express satisfaction with type of activities and level of activity involvement when asked through the review date. I will receive daily 1 on 1 visits and I will participate in activities of my own choosing."
The approaches documented for this goal included:

"Assess and document my prior level of activity involvement and interests by talking to me, caregivers, family and significant others."
"Encourage on-going family involvement. Invite my family. significant others to attend special events, activities, meals."
"Ensure the activities that I attend are compatible with physical and mental capabilities, known interests and preferences, individuals needs and abilities, adapted as needed and age appropriate." "Explain to me the importance of social interaction and leisure activity time."
"I need assistance/escort to activity functions."
"Introduce me to residents with similar background, interests and abilities. Encourage interaction with other residents."
"Invite me to scheduled activities."
"Modify my daily schedule and treatment plan

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when possible to accommodate activity participation." "Provide a program of activities that empowers me to make choices and encourage self-expression and responsibility."
"Provide me daily in-room visits and 1:1 activities."
"Provide me with activities calendar. Notify me of any changes to activities calendar."
"Provide me with materials for individual activities. I like the following activities: watching TV I like to sleep."

On 04/29/21 at 10:00 AM, observed R36 sitting by the nursing station in a wheel chair.

On 04/30/21 at 0:915 observed R36 lying in bed. During a second interview at that time, when surveyor mentioned it was nice to see her up in the wheelchair the day before (04/29/21) by the station, R36 said, "Yea, I asked them to take me there so I could get out of my room." R36 said no one had been doing 1:1 activities with her and again stated; "There is nothing to do."

RR on 04/29/30 of R36's "Activity History Report" from 03/12/21 through 3/31/21 revealed the following documentation:
03/12/21 07:58 AM: "One to one ...invited and let resident know about daily activities. Offered resident books/magazines. Also asked resident if there is anything we can provide for them."
03/15/1 07:43 AM: "One to one ...invited and let resident know about daily activities. Offered resident books/magazines. Also asked resident if there is anything we can provide for them"
03/15/21 12:51 PM: "Worship Services ...Printed out and gave resident a copy of a requested prayer."
03/16/21: 12:35 PM: "One to one ...invited and let

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resident know about daily activities. Offered resident books/magazines. Also asked resident if there is anything we can provide for them"
03/17/21 10:07 AM: "Book club/Reading ...gave resident their mail"
03/17/21 03:34 PM: "Celebrations ...offered resident ice cream/jello for St. Patty's day."
03/23/21 09:49 AM "One-On-One ... let resident know about daily activities, also asked resident if there is anything we can do or provide for them."
03/25/21 08:46 AM "One-On-One visited resident and asked if there is anything we could provide for them. Also asked if they wanted any books word search puzzles or magazines"
03/25/21 04:02 PM: "Small Group Bingo ...Invited resident to small group bingo in large dining room, resident refused"
03/26/21 09:43 AM: "Room Change ...Assisted floor aide with resident's room change and moving her personal belongings."
03/27/21 03:40 PM: "Outdoor visit ...Took resident outside for scheduled visit with family"
03/31/21 09:45 AM: "One-On-One ...staff visit ...Brought resident the menu and the activities calendar for April"

Although activities was addressed in R36's CP, there was not a personalized activities program developed for R36 and there was not a comprehensive assessment of her interests. Review of the activity log noted above revealed R36 had been involved in little or no activities with only one refusal to participate documented. The one to one visits lacked documentation of meaningful interactions and activities.

2) R219 is a 61-year-old male admitted on 04/13/21 for long-term care. R219 had been

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admitted to a single room on the short-term rehab wing for a 14-day quarantine per the facility's COVID-19 protocol. R219's diagnoses included chronic respiratory failure, chronic obstructive pulmonary disease (COPD), human immunodeficiency virus disease (HIV), and moderate persistent asthma.

On 04/27/21 at 11:37 AM, R219 was observed sitting alone quietly in his wheelchair, facing the doorway of the room. During an interview at that time, when asked about activities, R219 stated that there were "no activities in the yellow zone [14-day quarantine area for new admissions]." Since it was his fourteenth day after admission, R219 expressed frustration and disbelief that he was still being confined to his room, stating he would like to go outside, and he would like to have visitors, but was told he could not do so until he had been changed to long-term care status. R219 said he was not given a clear answer when that would happen, and he found that very upsetting, stating "I always have to ask somebody else because the person I ask never seems to have an answer." R219 stated he does not like watching TV and prefers to spend time on his laptop computer. He complained that the Wi-Fi signal was "horrible", and that he had to purchase his own Wi-Fi booster and cable extension so that he could "catch the Wi-Fi signal" from anywhere in his room, otherwise he would only be able to connect near the doorway.

On 04/29/21 at 10:05 AM, an interview was done with Registered Nurse (RN)2 at the nurse's station of the short-term rehab wing. When asked about activities, RN2 stated that activities for new admissions were limited. Said she had seen activities staff enter the rooms of new

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residents and offer magazines and seen some of the residents do window visits but had not seen the residents on her side of the facility do much else besides watching television.

On 04/29/21 at 10:13 AM, an interview was done with the Activities Director (AD) at the nurse's station of the short-term rehab wing. AD stated that for new admissions, the activities staff (himself and two activities aides) try to go in and see each resident three times a day, offering books, board games, and magazines, and that every resident receives a monthly calendar of activities. AD said he does an activities assessment on each resident, and develops an activities' care plan, both of which are documented in the electronic health records (EHR). The EHR also contains the activity participation logs for each resident.

A record review (RR) of R219's activities assessment [MDS 3.0 Section F, Preferences for Customary Routine and Activities], dated 04/19/21, noted documentation that where the possible answers ranged from "no response or non-responsive" to "very important", the "Resident" had answered every question asked regarding his Daily Preferences and Activity Preferences, a total of sixteen questions in all, as "somewhat important". A review of R219's Activities Care Plan, last reviewed by Joshua on 04/13/21, revealed one of the planned interventions was to "Offer and invite me [R219] to watch the TV ...", and another, "Offer and provide me [R219] with a [sic] activity calendar in room and review programs as needed." A review of R219's activity participation log report, dated 04/29/21, revealed five activities listed since admission, three of them were "in room visit[s] ..."

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where R219 was asked how he was doing and if he needed anything, one was documentation of an observed conversation R219 had with his nurse and nurse aide upon returning from a doctor's appointment, and the last activity was "gave resident their mail."

3) R225 is a 66-year-old male admitted on 04/19/21 for cellulitis (a bacterial skin infection) of his left lower leg. R225 had been admitted to a single room on the short-term rehab wing for a 14-day quarantine per the facility's COVID-19 protocol. R225's diagnoses included chronic kidney disease with dependence on dialysis, diabetes, congestive heart failure, and muscle weakness with difficulty walking.

On 04/28/21 at 08:31 AM, R225 was observed sitting alone quietly in his room with the television (TV) off, looking out the window. During an interview in his room, when asked about activities, R225 stated that he was not aware of any activities offered in the facility. He denied having been offered the opportunity to FaceTime or Google Meet his family members, said he had never been offered any books, magazines, or newspapers, and stated he had not seen an activities calendar. R225 went on to state that he did not like being confined to his room and wanted more people to talk to. He felt there was nothing to do but watch TV, and besides watching car races occasionally, preferred to leave the TV off.

RR of R225's activities assessment [MDS 3.0 Section F, Preferences for Customary Routine and Activities], dated 04/25/21, noted documentation that where the possible answers ranged from "no response or non-responsive" to

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"very important", the "Resident" had answered every question asked regarding his Daily Preferences and Activity Preferences, a total of sixteen questions in all, as "somewhat important". A review of R225's Activities Care Plan, dated 04/20/21, revealed one of the planned interventions was to "Provide me [R225] with [an] activities calendar.", and another, "Provide me [R225] with materials for individual activities. I like the following independent activities: watching tv". A review of R225's activity participation log report, dated and timed 04/29/21 4:11:56 PM, revealed no activities documented, independent or otherwise. A second activity participation log report, dated and timed 04/29/21 4:14:49 PM, revealed one activity, an in room visit documented two minutes prior where the resident was " ...asked how he was doing and if he needed anything."

4) R224 is an 83-year-old female admitted on 04/21/21 for post-surgical care following a colostomy (an artificial opening in the abdominal wall through which the healthy end of the large intestine is attached) placement. R224 had been admitted to a single room on the short-term rehab wing for a 14-day quarantine per the facility's COVID-19 protocol. R224's diagnoses included dementia, hypertension (high blood pressure), sick sinus syndrome (irregular heart rhythms), muscle weakness, and difficulty in walking.

During an interview in her room on 04/28/21 at 11:36 AM, when asked about activities, R224 stated that she did not know if activities were offered in the facility, but that she would love to have someone to talk to. R224 said that she could not remember when she got to the facility, or why she was there. When asked if she had

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been offered any books, magazines, or newspapers, R224 paused, with a worried look on her face, and stated, "I don't have the memory." There was no monthly activities calendar observed in R224's room, either posted on the wall, or placed at the bedside.

On 04/29/21 at 08:20 AM, an interview was done with RN2 near the short-term rehab nurse's station. RN2 confirmed that R224 often forgot where she was or why she was there and had even pulled her colostomy bag off the previous night, not knowing what it was. RN2 stated that R224 required a lot of reminding and redirection and agreed that she would benefit from more one-to-one activities instead of laying idle in bed, as she did most of the time.

RR of R224's activities assessment [MDS 3.0 Section F, Preferences for Customary Routine and Activities], dated 04/27/21, noted documentation that where the possible answers ranged from "no response or non-responsive" to "very important", the "Resident" had answered every question asked regarding his Daily Preferences and Activity Preferences, a total of sixteen questions in all, as "somewhat important". A review of R224's Activities Care Plan, dated 04/21/21, revealed one of the planned interventions was to "Provide me [R224] with [an] activities calendar.", and another, "Provide me [R224] daily in-room visits and 1:1 [one-to-one] activity".

5) On 04/28/21 at 03:05 PM observed eight residents in the Na Maka Unit dining room playing BINGO. A second observation at 03:28 PM, the residents playing BINGO were seated outside of

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the dining room across the Na Maka Unit nurse's station. There were no staff present at the nurse's station or on the unit. Residents were not talking to each other, no music or radio was playing, and only one out of eight residents had reading material. At 03:35 PM while staff were coming in and out of other residents' rooms, Resident (R)64 stated out loud, "We need more activities!" R10 and R33 nodded in agreement. Two staff members were near the nurse's station and within earshot, but no staff approached or acknowledged R64's statement.

6) R10's initial admission to the facility was on 04/12/18. Diagnoses include but are not limited to unspecified hypothyroidism, essential (primary hypertension), unspecified hyperlipidemia, unspecified Vitamin D deficiency, unspecified dementia without behavioral disturbance, unspecified single episode major depressive disorder, and adjustment disorder with other symptoms.

Review of R10's quarterly Minimum Data Set (MDS) with an assessment reference date of 01/30/21, R10 scored a 10 (moderate cognitive impairment) on the Brief Interview for Mental Status. A review of the annual/comprehensive MDS with an assessment reference date of 05/06/20 for Section F. Preferences for Customary Routine and Activities, R10 was coded as somewhat important for the following activities: books, newspapers and magazines; listen to music you like; be around animals; keep up with news; do things with groups of people; do favorite activities; get fresh air; and participate in religious services or practices. There were no activities that were coded as very important.

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Interview with R10 on 04/27/21 at 10:39 AM stated she would like to see more activities, "I like to go out, I am really pissed off about it! They don't even ask us if there is anything we want to do. Nobody comes in to say hello, no visitation, don't even provide newspaper or reading materials, no nothing! They treat us like morons, I feel like we are in prison!" R10 further explained, she would like to go outside, go for a walk, sit outside in the sun, go to the store or church.

A second interview with R10 on 04/28/21 at 09:22 AM, stated she would " ...like to go out to places ...nobody talks to me here, they treat us like morons!" R10 further explained that she would like to see more people come in her room, introduce themselves, and chat with her or ask her how she is doing. R10 often referred to working in radio before and her co-workers used to come her for assistance, which made her feel important.

7) Cross Reference to F656.

Resident (R)29 was re-admitted to the facility on 11/30/21. Diagnoses include: cerebral infarction; hemiplegia, affecting left non-dominant side; unspecified cataracts; acquired absence of eye; malignant neoplasm of tongue; dysphagia; major depressive disorder; pain ; unspecified blepharitis of left eye, upper and lower lids; acquired deformity of nose; cognitive communication deficit; and displaced fracture of body of left calcaneus, subsequent encounter for fracture with routine healing.

Observation during the initial tour on 04/27/21 at 10:15 AM found R29 lying in bed. R29 was

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awake and receptive to greeting by surveyor. At 11:26 AM, R29 was observed lying in bed with right leg dangling off the bed. R29 had lunch in the room. R29 was holding a bowl of noodles and eating with fingers. R29 also had mashed potatoes with gravy, quarter of a sandwich and fruits. On 04/28/21 at 08:00 AM, R29 was lying in bed, awake while receiving nutrients via tube. R29 was lying close to the edge and when this was mentioned, R29 moved closer to the center of the bed. At 09:13 AM, R29 was lying in bed and at 10:40 AM staff member was observed conversing with the resident. On 04/29/21 at 10:15 AM and 03:05 PM, R29 was lying in bed with the television on.

Record review was done on 04/29/21 at 10:02 AM. A review of the quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 02/25/21 notes R29's vision is severely impaired (no vision or sees only light, colors or shapes, eyes do not appear to follow objects). R29 yielded a score of eight (moderately impaired cognition) upon administration of the Brief Interview for Mental Status. A review of the annual/comprehensive MDS with an ARD of 09/21/20 an interview was conducted for Section F. Preferences for Customary Routine and Activities, R29 was coded as somewhat important for the following activities: books, newspapers and magazines; listen to music you like; be around animals; keep up with news; do things with groups of people; do favorite activities; get fresh air; and participate in religious services or practices. There were no activities that were coded as very important. R29 also coded the following areas as somewhat important: choosing what clothes to wear; taking care of personal belongings or things; choosing between

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a tub bath, shower, bed bath, or sponge bath; having snacks available between meals; choosing own bedtime; having a family or close friend involved in discussions about care; using the phone in private; and having a place to lock her things to keep them safe.

The Activity Evaluation, dated 12/07/20 notes R29 receives 1:1 daily visits, loves listening to the television and music on the radio as well as talking with family on the phone. The evaluation did not include R29's preferences for television programs, radio station and how to engage the resident during one to one visits.

A review of the care plan for being at risk for decreased, little or no activity involvement related to adjustment to facility included the following interventions: participate in activities of choice by review date; ensure the activities I attend are compatible with physical and mental capabilities, known interests and preference, individual needs and abilities, adapted as needed and age appropriate; explain to me the importance of social interaction and leisure activity time; listening to my television, please turn it on as requested; enjoy nature strolling, please invite me, I may refuse at times; invite me to to scheduled activities; my family wants to face time me 2x a week Wednesday and Saturday; provide a program of activities that empowers me to make choices and encourage self-expression and responsibility; provide in-room one to one visits; provide me with activities calendar, notify of any changes to activities calendar; and remind me that I may leave activities at any time and are not required to stay for entire activity. The care plan was not person-centered to reflect R29's activity preferences for watching television, what the

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resident likes to do during one to one visits, the type of activities that empowers her to make choices and encourage self-expression and how to address needed adaptations related to her vision loss during activities.

A review of R29's activity history for March 2021 found entry on 03/10/21 that books, magazines, work search or puzzles were offered to resident. Other entries offering books or magazines was documented on 03/11/21, 03/12/21, and 03/15/21. A review of April 2021 found one face time call to a friend and refusals by resident. The 1:1 activities comprised of greeting resident, turning on the television, and asking if the resident needs anything. There is also documentation of resident being asleep when visited. The 1:1 visits have no documentation of the time spent with R29.

On 04/29/21 at 09:36 AM a brief interview was conducted with the Activities Director (AD). Inquired why are books, magazines, puzzles and word search offered to resident that is visually impaired. The AD responded, activities staff will ask resident and will read the newspaper aloud or provide audio book.

8) Cross Reference F656.

Resident (R)27 was initially admitted to the facility on 11/30/20 and readmitted on 01/21/21. Diagnoses include: cerebral infarction, unspecified; unspecified dementia without behavioral disturbance; and age-related osteoporosis without current pathological fracture.

Observation on 04/27/21 at 10:15 AM, R27's door was closed. Subsequently, observed R27 in the

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room, seated in the wheelchair. R27 was screened for interview status, R27 would not answer questions or engage in conversation. R27 was observed in the dining room for lunch seated at a table alone.

On 04/28/21 at 08:00 AM, R27 was observed up in wheelchair seated outside of the dining room in front of the nurses' station. Attempted to engage the resident in conversation, R27 kept closing her eyes. At 10:22 AM and 10:40 AM, R27 was observed sitting in her room.

Observation on 04/29/21 at 10:15 AM and 03:05 PM found the door to R27's room was closed. R27 was not observed on the unit. Inquired with Registered Nurse (RN)1 why the resident's door is closed. RN1 responded the door is closed during care. further queried why it was closed now, RN1 replied because R27's roommate has behavior and presently on 1:1.

Record review was done on 04/29/21 at 12:00 PM. A review of the admission/comprehensive Minimum Data Set (MDS) with assessment reference date (ARD) of 12/06/20 notes R27 yielded a score of four (severe cognitive impairment) on the Brief Interview for Mental Status. R27 was interviewed for activity preferences. A review of Section F. Preference for Customary Routine and Activities found all activities were coded as somewhat important: books, newspapers, and magazine; listen to music you like; be around animals such as pets; keep up with news; do things with groups of people; do your favorite activities; get fresh air when weather is good; and participate in religious services. There is no activity preference coded as very important.

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The interview for daily preferences notes all of the following as somewhat important: choosing what clothes to wear; taking care of personal belongings or things; choosing a tub bath, shower, bed bath, or sponge bath; having snacks between meals; choosing bedtime; having family or close friend involved in discussions about care; using the phone in private; and having a place to lock things to keep them safe.

A review of R27's care plan for activities, notes the resident has a preference to plan own daily activities of choice and may need support through offers of leisure materials. The interventions included: activities of current/past interest playing BINGO, doing exercise, going on nature strolls; continue to work with me/family for any new activities that can be provided; introduce me to other peers; participation barriers include acute respiratory failure with hypoxia; offer and invite me to watch the TV in the dining area; offer and provide me activity calendar and review programs as needed; offer me 1:1 visit as needed for socialization and to see if additional materials are needed for independent activities; and offer me religious programs when available.

There is no documentation of an activity assessment/evaluation which is specific to R27 to develop a person-centered care plan. The care plan does not specify which religious programs to offer; how to develop new activities; what television programs she may like to watch; and what activities to engage R27 in during 1:1 visits.

On 04/30/21 at 08:32 AM an interview was conducted with the Activities Director (AD) and Administrator. Inquired whether the facility does

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an activity assessment/evaluation. The Administrator reported the MDS is used to assess residents for activities (Section F. Preference for Customary Routine and Activities). The AD reported upon admission, residents are asked their preferences for activities, it is written down; however, there are no copies of this interview or assessment.

9) Cross Reference F656.

R28 was admitted to the facility on 08/26/20. Diagnoses include: unspecified dementia with behavioral disturbance; urinary tract infection, site not specified; primary insomnia; hallucinations, unspecified; seborrheic dermatitis, unspecified; atherosclerotic heart disease of native coronary artery without angina pectoris; malignant neoplasm of prostate; and peripheral vascular disease.

Observation during the initial tour on 04/27/21 at 10:15 AM found R28 asleep in bed. Subsequently at 11:26 AM, R28 was asleep in bed. R28 was observed in the dining room at 12:15 PM for lunch. He was asking to go "holoholo" (go out for walk or ride). On 04/28/21 at 08:00 AM, R28 was in the room seated in a wheelchair with bedside tray placed over the lap. Medical Records staff member was observed leaving the room. When asked what the staff member was doing with R28, the staff member responded, R28 was seen throwing tissues on the floor, so it was picked up and thrown out. The staff member was agreeable to find someone to assist R28 with teeth brushing. On 04/28/21 at 09:24 AM, staff member assisted R28 to face time with spouse. At 10:40 AM resident observed asleep in bed. On 04/29/21 at 10:15 AM, R28

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was up in wheelchair and preparing to face time with spouse. At 03:05 PM R28 was up in wheelchair with television on.

On 04/29/21 at 01:48 PM a record review was done. A review of the admission (comprehensive) Minimum Data Set (MDS) with assessment reference date of 09/01/20 found R28 yielded a score of one (severe cognitive impairment) upon administration of the Brief Interview for Mental Status. R28 was interviewed for daily and activity preferences. A review of Section F. Preference for Customary Routine and Activities found daily preferences were all coded as somewhat important: choose clothes to wear; take care of personal belongings; choose between a tub bath, shower, bed,bath, or sponge bath; have snacks between meals; chose bedtime; have family or close friend involved in discussions about care; se the phone in private; and have a place to lock your things to keep them safe. Preferences for activities were all coded as somewhat important: books, newspapers, and magazine; listen to music you like; be around animals such as pets; keep up with news; do things with groups of people; do your favorite activities; get fresh air when weather is good; and participate in religious services. There is no activity preference coded as very important. Further review found no documentation of an assessment to identify the resident's personal preferences (i.e. what activities are important, religious background, type of music or television program preferences, what activities to include in 1:1).

A review of R28's care plan notes R28 is at risk for decreased, little or no activity involvement. The targeted date to meet goal is 12/27/20.

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Interventions include: assess and document my prior level of activity involvement and interests by talking with me, caregivers, family and significant others; encourage on-going family involvement; ensure the activities are compatible with physical and mental capabilities, known interests and preferences, individual needs and abilities; explain the importance of social interaction and leisure activity time; need assistance to activity function; face time with family; introduce me to residents with similar background, interests and abilities; invite me to scheduled activities; take me on daily nature strolls if weather permits; provide a program of activities that empowers me to make choices and encourage self-expression and responsibility; provide me with activities calendar; provide me with daily in-room visits and 1:1 activities; provide me with materials for individual activities (watching tv); and remind me that I may leave activities at any time and not required to stay for entire activity.

Based on an activities assessment which identified R28's interest, preferences for activities, social history, R28's care plan does not reflect his personal preferences for activities, what activity to engage him in during one to one activities, what materials to provide for individual activities, and behaviors that may be triggered during activities.

A review of the activity history for April 2021 notes R28 participated in face time contact with spouse almost daily, attended group exercise twice (04/4/21 and 04/28/21), group activity (BINGO) once (04/21/21), and outside stroll once (04/27/21). There is documentation of 1:1 for 04/08/21, 04/10/21, 04/13/21/ 04/18/21, 04/19/21, 04/21/21 and 04/21/21. The 1:1 activity ranged from greeting R28 and asking resident what is

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needed, discussion of television program (building homes), listening to music, and discussion regarding flashlight. The amount of time spent with the resident for 1:1 is not always documented.

10) Confidential interview with family member was done on 04/28/21 at 02:53 PM. Family member reported the activities has been drastically reduced because of COVID but even prior to that, the activities had diminished. The family member reported having to work with the facility to increase activities for her parent. The family member also shared that on holidays the facility is a "ghost town." It was noted the number of staff members are less, like staff called out.

On 04/30/21 at 08:32 AM an interview was conducted with the Activities Director (AD) and Administrator. Inquired whether the facility does an activity assessment/evaluation. The Administrator reported the MDS is used to assess residents for activities (Section F. Preference for Customary Routine and Activities). The AD reported upon admission, residents are asked their preferences for activities, it is written down; however, there are no copies of this interview or assessment available for review in resident's electronic health record.

On 04/30/21 at 09:00 AM, a copy of the "Activity Review" with a date of 12/02/20 was provided for review. The resident's favorite activities are to watch television, listen to music and face time with family. There is no documentation of specific information regarding R28, for example, what kind of television programs he likes to watch, what kind of music he likes, what kind of assistance does he need to participate in

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activities, etc. Also, there is no documentation of addressing any behaviors resident may display while participating in activities.

11) A review of the activities policy and procedures provided by the facility notes the facility is "to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences for each resident." Activities refer to any endeavor, other than routine activities of daily living in which a resident participates intended to enhance their sense of well-being and to promote or enhance physical, cognitive, and emotional health. The compliance guidelines include each resident's interest and needs to be assessed on a routine basis. Furthermore, the assessment shall include, but not limited to: RAI Process: MDS/CAA/Care Plan; Activity assessment to include resident's interest, preferences and needed adaptations; social history and discharge information, when applicable.

Interview with the AD on 04/29/21 at 02:46 PM found the facility has a total of three activity staff, including the director. All activity staff are employed on a full-time basis and two activity staff are scheduled daily. Activity staff also facilitate visitation, on the days visits are scheduled, activity staff are split, day and evening shifts. Also, staff are scheduled for a split shift (half-day/half-day). The goal is to have two staff members available.

On 04/30/21 at 08:32 AM an interview was conducted with the Activities Director (AD) and Administrator. Inquired whether the facility does an activity assessment/evaluation. The

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F 679	Continued From page 47 Administrator reported the MDS is used to assess residents for activities (Section F. Preference for Customary Routine and Activities). The AD reported upon admission, residents are asked their preferences for activities, it is written down; however, there are no copies of this interview or assessment available in the resident's EHR. On 04/30/21 at 11:26 AM, an interview was done in the Conference Room with AD and the Administrator regarding the activities program. The Administrator acknowledged that the activities program needed "to be revamped", stating that approximately two months ago, the facility had identified on their own that activities were lacking. The Administrator explained that the most recent work being done included resident assessments that would inform, and guide performance improvement plans to create a more resident-centered program.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review (RR), interviews and observation, the facility licensed staff failed to document objective clinical data of their assessments as directed by the resident's	F 684	1. Resident 51 was re-evaluated by the physician for his/her edema. Treatment and care plan was updated as needed. DON/SDC/designee inserviced licensed	5/28/21

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F 684	Continued From page 48 person-centered comprehensive care plan (CP) for one Resident (R)51. R51's CP directed the staff to monitor her for signs and symptoms of fluid overload that included edema (swelling). As a result of this deficiency there was the potential that R51 was not consistently assessed and monitored for edema to identify early signs of worsening of her heart failure or kidney disease. There was the potential symptoms were missed, not reported to the physician and may prohibit R51 from reaching her highest practicable physical well-being. This deficient practice could affect any resident that needs specific clinical assessment and monitoring for signs and symptoms of their medical condition. Findings include: R51 is an 85-year-old female who had a fall at home that resulted in a coccyx fracture. After discharge from the hospital, she was transferred to the facility for on 02/09/21 for rehabilitation. Additional pertinent diagnoses included heart failure, acute kidney failure, and hypertension. On 04/27/21 at approximately 09:45 AM, observed R51 sitting in a chair in her room. R51 was noted to have obvious swelling (edema) of both feet and ankles. Surveyor inquired if she was aware her feet were swollen, and R51 said she was not. On 04/30/21 reviewed R51's CP dated 02/19/21 which revealed the following: Nutrition long-term goal: "Will have no s/s (signs/symptoms) of fluid overload in the next 3 months." The documented approach was "Monitor s/s of fluid overload (i.e., SOB,	F 684	nursing staff regarding reviewing care plans, documentation / notification of symptomology and fluid overload. Inservices will be ongoing as needed. 2. The alleged practice has the potential to affect residents with signs and symptoms of fluid overload. 3. The unit managers / DON / SDC /designee re-inserviced direct care staff (licensed nurses and CNAs) regarding reviewing care plans, assessing, documenting, and reporting signs and symptoms of fluid overload. Inservices will be ongoing as needed. 4. The unit managers / designee will monitor compliance through observations on daily rounds and medical record reviews 3 x weekly for a minimum of 12 weeks. Results of these audits will be brought to QAPI monthly for review and recommendations for a minimum of three months or until compliance is achieved.	

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edema/swelling, significant wt.[weight] gain, etc.) Update CN (Charge Nurse/MD for significant wt. changes, diuretic (medication to fluid retention/swelling) as ordered."
R51's had medical orders that were to help with the reduction of fluid retention that included a "no added salt" dietary restriction and a diuretic (hydrochlorothiazide 12.5 milligrams orally for hypertension once a day). Hydrochlorothiazide helps the body from absorbing too much salt, which can cause fluid retention, and reduces edema caused by conditions such as heart failure, or kidney disease.

Nursing progress note entered on 03/22/21 at 12:27 PM by Licensed Practical Nurse (LPN)1 included "+2 pitting edema (edema is evaluated on its ability to pit and is graded on a scale of +1 to +4. 2+ edema is moderate pitting) on the lower extremities, elevated 1 pillow while on bed. Pedal pulse strong and equal. Lung sounds are clear bilaterally upon auscultation, no SOB (shortness of breath) ..." There was no other documentation of assessment of R51's lower extremities or the status of the edema on the following shifts.

There were no additional entries in the nursing progress notes from 03/22/21 through 04/29/21 that documented assessment of R51's lower extremities for swelling, which included 04/27/21 when surveyor observed marked swelling of both ankles and feet.

On 04/29/21 at 04:55 PM, during an interview with the Director of Nursing (DON), reviewed R51's CP and nursing notes. The DON validated the entry on 03/22/21 noting swelling of R51's lower extremities and that there was no follow up assessment documented regarding the edema.

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F 684	Continued From page 50 The DON agreed there should have been an additional assessment and documentation to indicate the edema was being monitored as directed in the CP.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff members, the facility failed to ensure a resident (Resident 42) that eloped from the facility was assessed, monitored, and provided with care plan interventions to prevent elopement. The facility completed an elopement assessment on resident's admission (08/09/16) and no subsequent assessments were done for approximately four years, prior to actual elopement (07/08/20). The interdisciplinary team could not identify triggers to R42's elopement and it is unclear whether there is a current care plan with interventions to minimize the risk of R42 leaving a safe area without authorization and/or appropriate supervision. This deficient practice places the resident at risk for recurrence of elopement. As a result of this deficient practice, R42 is at risk for injuries related to elopement (i.e. falls with injuries). Findings include:	F 689	1. Resident 42 was re-assessed for elopement risk. Care plan was updated to reflect current interventions. DON / SDC /designee re-inserviced licensed nurses regarding wandering/elopement assessments and care plan revision. Inservices will be ongoing as needed. 2. The alleged practice has the potential to affect residents at risk for elopement. 3. Residents were re-assessed for wandering / elopement risk. Care plans were updated as needed. DON / SDC /designee re-inserviced the interdisciplinary team regarding wandering/elopement assessments and care plan revision. Inservices will be ongoing as needed. 4. The unit managers / designee will monitor compliance through medical record reviews 3 x weekly for a minimum of 12 weeks. Results of these audits will	5/28/21

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F 689	Continued From page 51 Resident (R)42 was admitted to the facility on 08/18/16. Diagnoses include: Parkinson's disease; major depressive disorder, single disorder; adjustment disorder with anxiety; sleep disorder, unspecified; mood disorder due to known physiological condition, unspecified; and schizophrenia. On 07/09/21 the facility submitted an initial "Event Report" to notify the State Agency on 07/08/20 at 09:45 PM, R42 eloped from the facility. R42's roommate, R22 pressed the call light for help. R42 was missing and code pink (missing resident) was initiated. R42 was found walking outside holding her cane and "manual call bell" in her hand. R42 reported to staff that she wanted to "shi-shi" (urinate). Upon examination, R42 had superficial abrasions to the left elbow and left knee which she acquired when climbing out of the window. The report further documents, R42 appears to have opened her window and cut the screen with her sewing scissors. Following the incident, R42 was placed on 1:1 supervision for 24 hours, resident placed on alert charting, sewing scissors and manual call bell were immediately removed from resident's possession, a psychological consult was ordered to rule out delirium vs. depression vs. dementia, pharmacy consult to review the resident's medication, room change was offered (resident declined), and window alarm installed to alert when window opens. Observation on 04/27/21 at 10:15 AM found R42 in her room sitting in a chair with forward wheel walker (FWW) next to her bed and within reach. At approximately 11:15 AM, R42 reportedly had a	F 689	be brought to QAPI monthly for review and recommendations for a minimum of three months or until compliance is achieved.	

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shower. Subsequently, R42 was observed eating lunch in her room. R42 was asked whether she would be willing to answer some questions, R42 declined stating that she would be going to sleep after lunch. On 04/28/21 at 08:00 AM, R42 was out of bed and later observed ambulating with FWW and staff in the hall. R42 reported she had a shower. At 09:12 AM, R42 was out of bed, EMMA reported R42 went for physical therapy. At 10:39 AM, R42 was observed sleeping. On the morning of 04/29/21, R42 was observed ambulating back to her room with staff after a shower. Observations found R42 did not display wandering of exit seeking behavior..

On 04/29/21 at 09:08 AM observation of the window alarm system was done with DOM. The window of R42's room has two sliding glass panes, alarms are affixed to both panes. DOM demonstrated the alarms are in working order. At 10:20 AM, the facility provided documentation of routine maintenance of the window alarms.

On 04/28/21 at 11:54 AM, R42 was sitting in her room, sewing with a scissors on her bed. R42 was interviewed regarding the incident. R42 reported that she just wanted to go out and wanted her roommate (R22) to go with her. R42 stated her roommate was too tall to go out the window. R42 further stated that she wanted to walk to the front of the building.

Record review was done on the afternoon of 04/28/21. A review of R42's comprehensive Minimum Data Set (MDS) with assessment reference date of 09/09/20 documents no wandering or mood behavior. R42 was noted to require limited assistance with one person physical assist for walking in room and corridor,

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as well as, locomotion on and off unit. Review of most recent quarterly MDS with ARD of 03/08/21 notes R42 yielded a score of nine (moderate cognitive impairment) upon administration of the Brief Interview for Mental Status. R42 also noted to require supervision with set up for locomotion on and off unit and walking in room and corridor. R42 was coded with no wandering behavior.

A review of R42's elopement evaluation was done. An admission evaluation was done on 08/19/16. R42's family/responsible party did not have concern resident would attempt to elope, did not have a history of elopement, and did not express a desire to leave the facility. R42 noted to be alert and oriented and facility will continue to monitor. Subsequent evaluation was done on 07/09/21. R42 noted to have "tried to elope" 07/08/20 through her window. The resident noted to have trouble sleeping and was prescribed temazepam 7.5 mg. at bedtime with increased forgetfulness, depression, and crying. The physician assessed R42 and discontinued the use of Temazepam on 07/06/20. There was no documentation of subsequent elopement evaluations.

A review of the facility's investigation was done. The "Incident Report" documents R42 stated she had to urinate and she appeared confused. Of note, R42's Certified Nurse Aide (CNA) reported seeing resident in her room at 09:00 PM.

A review of the care plan found two care plans for R42. The facility is currently in the process of switching electronic health records system. The care plan with targeted date of 01/03/21 includes a care plan to address wander/elopement due to confusion related to dementia. Interventions

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include: anticipate and meet all my needs; attempt to determine cause of wandering and relieve if possible, keep my daily routine intact as possible, monitor my behavior and attempt to determine pattern, frequency and intensity, monitor triggers for wandering (consider time of day, location, persons involved and situation, if I appear confused or seems tat I am hallucinating (seeing men in hallway or room) please set with me (listen to my concerns and ensure that no men are in the area), offer room changes, provide a program of activities to minimize potential for wandering, review recent changes, and walk/stroll me more frequently with purpose. A review of the second care plan has a problem start date of 03/09/21 which did not include approaches to deter elopement.

On 04/28/21 at 03:44 PM, an concurrent record review and interview was conducted with the DON. The DON provided copies of R42's care plans, explaining the facility is in the process of switching to a new electronic health record system. The DON confirmed R42 had two elopement assessments, one on admission, 08/19/16 and one following actual elopement on 07/09/20. Queried how often the facility completes elopement assessments? The DON responded with the change of EHR it may be required monthly as the template will pop up to complete it. The DON was agreeable to follow up on the required frequency for completing elopement assessments.

A second interview was conducted with the DON on 04/29/21 at 07:49 AM. Queried DON regarding R42 having two care plans, the first with a target date of January 2021 and the second one with a start date of March 2021 with a

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F 689	Continued From page 55 target date of June 2021. The DON confirmed the care plan with a start date of March 2021 did not address elopement, further explaining the switch to a new EHR and the need to ensure revision of care plans. Further queried whether the interdisciplinary team (IDT) identified R42's triggers for elopement. DON responded, the IDT was unable to identify triggers for elopement. The facility assessed R42's medications and obtained a psychological consult; however, did not identify triggers for elopement.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and	F 690		5/28/21

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F 690	Continued From page 56 (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's 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 record review and interview with staff member and resident representative, the facility failed to ensure 2 of 2 residents (Residents 27 and 21) in the sample were provided with interventions to prevent the reoccurrence of urinary tract infection. As a result of this deficient practice, the residents are place at risk for rehospitalization and repeated use of antibiotics. Findings include: 1) Resident (R)27 was admitted to the facility on 11/30/20 and readmitted 01/22/21. Diagnoses include: cerebral infarction, unspecified; age-related osteoporosis without current pathological fracture; and unspecified dementia without behavioral disturbance. On 04/28/21 at 09:00 AM an interview was done with R27's representative. The resident's representative reported R27 was readmitted after hospitalization for urinary tract infection (UTI). R27 reportedly was hospitalized for approximately three days and treated with antibiotics.	F 690	1. Residents 21 and 27 were reassessed by the physician. Care plans were updated to reflect treatments. DON/SDC/designee re-inserviced licensed nurses regarding UTIs, treatments, incontinence care, hydration and revising care plans. 2. The alleged practice has the potential to affect facility residents. 3. SDC/Unit managers/designee re-inserviced licensed nurses and cnas in incontinence care. Inservices will be ongoing as needed. 4. The unit managers / designee will monitor compliance through observations on daily rounds and medical record reviews 3 x weekly for a minimum of 12 weeks. Results of these audits will be brought to QAPI monthly for review and recommendations for a minimum of three months or until compliance is achieved.	

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Record review done on 04/28/21 at 09:07 AM notes R27 was hospitalized for sepsis related to a UTI. A review of the history and physical dated 01/22/21 notes R27 was transferred to the emergency department on 01/17/21 for further evaluation related to fever and chills, oxygen saturation of 85%, and crackles to bilateral bases of the lungs. R27 was admitted with diagnosis of UTI (e. coli), staph epi bacteremia, hypoxia (resolved) and dementia.

A review of R27's admission Minimum Data Set with an assessment reference date of 12/06/20 notes R27 requires extensive assist with one-person physical assist for toilet use. R27 was coded as frequently incontinent of bladder and continent of bowel. Also, R27 was not coded for UTI. A quarterly MDS with ARD of 01/24/21 (following hospitalization) notes R27 with UTI and septicemia. R27 continues to require extensive assist with one-person physical assist for toilet use. And remains frequently incontinent of bladder and continent of bowel. R27's care plan did not include interventions for UTI prevention.

On 04/30/21 at 08:30 AM an interview was conducted with MDS Coordinator (MDSC)1. MDSC1 confirmed R27 was hospitalized on 01/17/21 for sepsis due to UTI (e. coli). And noted resident may have had possible micro aspiration pneumonia. Inquired whether a care plan was developed for UTI prevention. MDSC1 reviewed the electronic health record and commented that the facility switched to new software in January. MDSC1 confirmed that at the present time there is no care plan to address R27's history of UTI with preventative interventions. Further queried whether R27's physician made new orders for UTI prevention.

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MDSC1 was unable to find new orders related to UTI.

2) R21's initial admission to the facility was on 06/04/19. Diagnoses include but are not limited to pain in right knee, unspecified chronic obstructive pulmonary disease, state 3 chronic kidney disease (moderate), essential (primary) hypertension, unspecified site osteoarthritis, unspecified heart failure, unspecified atrial flutter, not elsewhere classified stiffness of right knee, pain in right leg, age-related osteoporosis without current pathological fracture, pain in left shoulder, unspecified rheumatoid arthritis, pain in right shoulder, other reduced mobility, and muscle weakness (generalized).

Review of R21's quarterly Minimum Data Set (MDS) with an assessment reference date of 02/22/21, in Section G. Functional Status, under Toilet use (how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet, cleanses self after elimination; changes pad, manages ostomy and catheter; and adjusts clothes), R21 requires total assistance-full staff performance every time with two or more-person physical assist. Under Section H. Bladder and Bowel H.0300. Urinary Continence and H.0400 Bowel Continence R21 is always incontinent of bladder and bowel.

Review of the facility's Notice of Resident Discharge/Transfer form dated 02/24/21, R21 was admitted to the hospital on 02/10/21. Review of R21's hospital discharge summary indicates R21 was admitted to the hospital on 02/11/21 and returned to the facility on 02/16/21. The final diagnosis included congestive heart failure, atrial

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F 690	Continued From page 59 flutter, and UTI. Review of R21's hospital notes and physician's documentation dated 02/10/21 a Sepsis Assessment was completed due to "Concern for sepsis, patient [R21] does have a UTI." Further documentation from the hospital notes on 02/15/21 R21 was being treated for Sepsis secondary to UTI with positive Escherichia coli (E. coli) bacterium. Interview with Director of Nursing (DON) on 04/20/21 at 08:28 AM, DON stated R21 is incontinent but can tell you when she needs incontinence care. Concurrent review with DON of R21's care plan in the facility's previous electronic health record (EHR) and present EHR found R21 " ...requires extensive ...total assist ...for toileting." and does not address interventions to prevent UTI.	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;	F 692		5/28/21

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F 692	Continued From page 60 §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 prevent significant weight loss or to identify the need for dietary evaluation and intervention for one resident (R)219, as evidenced by an unrecognized weight loss of 6.1% in fourteen days. As a result of this deficient practice, the facility placed this resident at risk for avoidable declines and injuries. This deficient practice had the potential to affect all residents at the facility. Findings include: On 04/27/21 at 12:01 PM, an interview was done with R219 in his room on the new admission hall of the facility. R219 complained about the taste of the food and the small portions he received since his admission on 04/13/21. R219 stated that he had been weighed twice a week since his admission and knew that he had lost at least five pounds. A review of R219's documented weights since his admission confirmed he was admitted at 140.4 pounds, and his last weight taken on 4/27/21 was 131.8 pounds, reflecting a loss of 8.6 pounds or 6.1%. Further review of R219's electronic medical record (EMR) revealed no progress notes, no referrals, and no interventions planned to address his weight loss, despite the EMR system red flagging his two most recent weights	F 692	1. Resident 219 was re-evaluated by the RD. Resident is on weekly weights. Care plan was updated as needed. VP of Clinical re-inserviced DON / SDC and RD regarding weight program, notification of team members and interventions / care planning. Inservices will be ongoing as needed. 2. The alleged practice has the potential to affect facility residents. 3. SDC/Unit managers/designee re-inserviced licensed nurses and cnas on the weight program and interventions/care planning. Inservices will be ongoing as needed. 4. The DON / designee will monitor compliance through medical record reviews weekly for a minimum of 12 weeks. Results of these audits will be brought to QAPI monthly for review and recommendations for a minimum of three months or until compliance is achieved.	

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F 692	Continued From page 61 for follow-up. On 04/30/21 at 10:22 AM, an interview was done with the Director of Nursing (DON) in her office. Upon discussion of R219's weight loss, the DON admitted she could not find any progress notes or interventions planned either. She went on to state that weekly interdisciplinary meetings were conducted for residents identified as at risk, with the last meeting held on 04/23/21. Although the Registered Dietician (RD) was present at that meeting, and despite R219 having lost 7.4 pounds by then, R219 was not identified or discussed as at risk. The DON then called the RD for a phone interview. The RD stated she did not recall and could find no documentation of being notified of R219's significant weight loss. Both the DON and the RD acknowledged that a dietary referral should have been made, and that something should have been done sooner to address the weight loss.	F 692		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		5/28/21

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F 755	Continued From page 62 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review (RR) and interviews, the facility failed to ensure staff followed nursing standards for safe medication administration. Safe medication administration includes timeliness of administration as well as accurate and complete documentation to ensure adherence to the prescribed frequency and the time which promotes safety. Medication Administration Records (MAR) for Resident (R)35 revealed multiple entries that did not document the actual time the medications were administered. Investigation further revealed the facility changed electronic medical records and the technology change resulted in staff workarounds and inconsistencies for documenting administration of medications. This deficiency leaves a margin for error that may result in negative consequences for the resident and could affect any resident in the facility.	F 755	1. Resident 35 is receiving his/her medication timely. Licensed nurses were re-inserviced regarding documentation of medications at time of administration by DON/SDC/designee. Inservices will be ongoing as needed. 2. The alleged practice has the potential to affect facility residents receiving medications. 3. DON, SDC, Unit managers and Licensed nurses were re-inserviced regarding documentation of medications using the facility's new software program in the medical record by the Director of Informatics. Inservices will be ongoing as needed. 4. The unit managers / designee will monitor compliance through medical record reviews weekly for a minimum of 12 weeks. Results of these audits will be	

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F 755	Continued From page 63 Findings include: R35 is a male resident admitted to the facility on 01/15/21 who had chronic pain related to cervical stenosis and a laminectomy, a surgical operation to remove one or more vertebrae of the back. R35 was on multiple medications for his chronic pain. Review of R35's MAR on 04/29/21 revealed several entries with comments of "Late Administration: Charted late." The February 2021 MAR for administering R35's Duragesic (fentanyl) patch for pain revealed there were 10 times the patch was applied, with five of the ten entries documented as "Late Administration: Charted late." The April 2021 MAR (through day shift 04/29/21) revealed there were 10 times the patch was applied with two of the ten entries documented as "Late Administration: Charted late," with the comment "Administered on time." The April 2021 MAR (through day shift 04/29/21) for administering R35's Oxycontin (opioid for pain) revealed there were 59 times the medication was administered, with 11 entries documented as "Charted Late" with some having added comments of "Administered on time, " or "on time." The April 2021 (through day shift 04/29/21) for administering R35's Neurontin (Gabapentin) for pain revealed there were 88 times the medication was administered, with 19 entries documented as "Charted Late" with several having added comments of "Administered on time." On 04/30/21 reviewed the facility policy titled "Administering Medications" dated 04/01/21. The	F 755	brought to QAPI monthly for review and recommendations for a minimum of three months or until compliance is achieved.	

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F 755	Continued From page 64 policy included the following statements: "Medications shall be administered in a safe and timely manner, and as prescribed." "Medications must be administered in accordance with the orders, including any required time frame." "Medications must be administered in accordance with the orders, including required time frame." "As required or indicated for a medication, the individual administering the medication will record in the resident's medical record: a. The date and time the medication was administered ..."	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff member, the facility failed to ensure residents are free of significant medication errors. Resident (R)33 is prescribed medication to control high blood pressure with parameters to hold the medication when the blood pressure is below 110. The facility did not assure the medication was held when the resident's blood pressure was less than 110 on two separate occasions, placing the resident at risk of low blood pressure. Findings include: Resident (R)33 was admitted to the facility on 07/03/19. Diagnoses include Type 2 diabetes mellitus with unspecified complications, morbid obesity, hypertension, and unspecified atrial fibrillation.	F 760	1. Resident 33 was reassessed by physician and treatment updated as needed. Licensed nurses involved wither/his medication administration outside of parameters were re-inserviced by the DON regarding medication administration. Inservices will be ongoing as needed. 2. The alleged practice has the potential to affect facility residents receiving blood pressure medications with parameters. 3. Facility Licensed nurses were re-inserviced regarding medication administration by DON/SDC/unit managers. Inservices will be ongoing as needed. 4. The unit managers / designee will monitor compliance through medical	5/28/21

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F 760	Continued From page 65 On 04/29/21 at 08:30 AM record review revealed a physician order for losartan, 25 mg once daily, hold if SBP (systolic blood pressure) is less than 110. Losartan is helps relax the blood vessels to lower high blood pressure. A review of the Medication Administration Record (MAR) for April 2021 found documentation that losartan was administered two times when R33's blood pressure was below 110 and the medication was contraindicated. R33's blood pressure on 04/11/21 was 106/69 and on 04/18/21 it was 106/70. Interview and concurrent record review done with MDS Coordinator (MDSC)2 on 04/30/21 at 09:01 AM. MDSC2 reviewed R33's MAR and confirmed the losartan was administered. MDSC2 also confirmed losartan should have been held as R33's blood pressure was below 110.	F 760	record reviews weekly for a minimum of 12 weeks. Results of these audits will be brought to QAPI monthly for review and recommendations for a minimum of three months or until compliance is achieved.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		5/28/21

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F 812	Continued From page 66 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, review of the facility's policy and procedures, and interview with staff members, the facility failed to ensure stored and served dry goods were kept in a tight and sealed container and the facility also failed to ensure the temperature of all cooked food textures (regular, mechanical, and pureed) on the tray line were held at an appropriate temperature before serving. As a result of this deficiency, residents are at risk of a food-borne illness and have the potential for more than minimal harm. Findings Include: 1) During the initial kitchen tour observation on 04/27/21 at 09:55 AM in the dry good storage room, observed a bag of powdered instant food thickener in bulk inside a box. The bag containing the powdered instant food thickener was left opened and not tightly sealed. Concurrent observation with Cook1 stated the bag of thickener must have been opened this morning. According to Cook, the thickener is not kept in a sealed container when opened but kept in the original box and the bag holding the thickener is sealed shut with a tie. Cook further stated the thickener should be sealed to prevent moisture from getting into the bag. Review of the facility's policy and procedure dated 04/12/21 provided by Dietary Supervisor (DS) and confirmed by Administrator states "Containers with tight fitting covers should be used for storing	F 812	1. Cook 1 and Cook 2 were re-inserviced on storage of dry goods and food temperatures by the Director of Nutritional Services. Inservices will be ongoing as needed. The thickener was re-stored appropriately. 2. The alleged practice has the potential to affect facility residents. 3. The dietary staff were re-inserviced regarding appropriate storage of food items and food temperature procedures and recording by the Director of Nutritional Services/designee. Inservices will be ongoing a needed. Dry storage items were reviewed to ensure compliance. 4. The Director of Nutritional Services / RD / designee will monitor compliance through observation and audit of storage areas and temperature logs and temping procedures 3 x weekly for a minimum of 12 weeks. Results of these audits will be brought to QAPI monthly for review and recommendations for a minimum of three months or until compliance is achieved.	

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F 812	Continued From page 67 ...dry goods." 2) On 04/29/21 at 11:05 AM observed Cook2 checking holding temperatures of food to be served on the tray line. Observed Cook2 take the temperature of the cooked regular texture chicken at 168 degrees Fahrenheit (F) and log the temperature on the "Food Temperature Record" form. Observed Cook2 take and log the temperature of the regular hot vegetable at 176 degrees F, then drew a line down for the mechanical soft and pureed sections of the hot vegetable and meat/entrée (chicken), indicating the temperatures are all the same for the various food consistencies. On the form, surveyor observed the mechanical soft texture and puree texture sections for "Meat/Entrée," "Hot Vegetable," "Starch" and "Salad" had lines drawn through them with no temperature indicated on previous dates. Inquired whether Cook2 took the temperature for the mechanical soft and pureed chicken. Cook2 pointed to the temperature for the regular chicken. Further inquired if temperatures were taken separately for the mechanical soft and pureed chicken. DS assisted Cook2 and confirmed temperatures of the regular, mechanical soft and pureed textured food items should all be taken separately and logged in the Food Temperature Record. Review of the Food Temperature Record from dates 04/25/21 to 04/29/21 for breakfast, lunch and dinner meat/entrée, lunch and dinner hot vegetable, lunch and dinner starch and lunch and dinner salad for the mechanical soft, puree, brown rice, and mashed potatoes have entries where temperatures were not logged but had lines drawn through them.	F 812		

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E 000	Initial Comments A recertification survey was conducted by the Office of Health Care Assurance on May 10, 2021. The facility was found not to be in substantial compliance with §483.71, Long Term Care facilities, Emergency Preparedness and Disaster Planning.	E 000		
E 036 SS=E	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this	E 036		5/28/21

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

Electronically Signed | 05/28/2021

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

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E 036	Continued From page 1 section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop an emergency preparedness training and testing program to adequately prepare for a COVID-19 outbreak, as evidenced	E 036	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an	

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E 036	Continued From page 2 by the facility failing to ensure that each staff member had been medically evaluated and cleared for N95 respirator use. As a result of this deficient practice, the facility placed the staff at risk of being unable to safely wear a respirator if required for their protection. This deficient practice had the potential to affect all healthcare personnel at the facility. Findings include: During a review of the facility's documentation of staff fit testing for N95 respirators, it was noted that although staff had completed medical questionnaires prior to fit testing, there was no documentation that the questionnaires had been reviewed by a medical professional. On 04/30/21 at 07:35 AM, an interview was done in the conference room with the Activities Director, who was responsible for completing most of the fit testing done at the facility. The Activities Director stated he was unaware that a medical professional was supposed to clear staff for respirator use, he thought the questionnaire was good enough. On 04/30/21 at 11:35 AM, an interview was done with the Administrator in the conference room. The Administrator stated he too was unaware that medical evaluations and clearances were required prior to fit testing. The Administrator explained that the Hawaii National Guard had trained the Activities Director how to conduct the fit testing and had not informed them that a review of the medical questionnaires, and clearance of each staff member by a medical professional was necessary.	E 036	admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. 1. Current staff questionnaires were reviewed for any answers that would lead to further assessment by a physician prior to fit testing by the Infection Preventionist RN . None were found needing further examination.. Questionnaires / answers were appropriate for fit-testing those staff members. Environmental Service Director was re-inserviced regarding having questionnaires reviewed by the DON / Medical director and/or healthcare professional designee prior to fit-testing staff. 2. The alleged practice has the potential to affect facility residents and staff. 3. The Corporate Infection Preventionist inserviced the medical director, DON, IFP RN, administrator and EVSD regarding fit-testing and healthcare professional oversight. Inservices will be ongoing as needed. Fit-testing Health Questionnaires will be reviewed by the DON, IFP and medical director prior to actual testing to ensure compliance. 4. Fit-testing program will be monitored for compliance monthly for a minimum of three months to ensure compliance by the IFP / designee. Results of these audits will be brought to QAPI monthly for review and recommendations for a minimum of three months or until compliance is achieved.	

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E 036	Continued From page 3 A review of the Centers for Disease Control (CDC) guidance from the Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, last updated 02/23/21, noted the following: "Respirator use must be in the context of a complete respiratory protection program in accordance with OSHA [Occupational Health and Safety Administration] Respiratory Protection standard (29 CFR 1910.134) ...HCP [healthcare personnel] should be medically cleared and fit tested if using respirators with tight-fitting facepieces (e.g., a NIOSH-approved N95 respirator) ...".	E 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125065	A. BUILDING **01 - REGENCY HILO REHABILITATION & NURSING CENTER** B. WING _____	**10/19/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HILO REHABILITATION & NURSING CENTER	**563 KAUMANA DRIVE** **HILO, HI 96720**

(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
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 | 11/07/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125065	A. BUILDING _____ B. WING _____	10/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HILO REHABILITATION & NURSING CENTER	**563 KAUMANA DRIVE HILO, HI 96720**

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

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

Electronically Signed | 11/07/2021

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