STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125040	A. BUILDING _____ B. WING _____	10/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HILO	944 WEST KAWAILANI STREET 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
F 000	INITIAL COMMENTS A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the Hawaii Department of Health, Office of Health Care Assurance. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 10/19/21 to 10/22/21 Survey Census: 193 Sample Size: 36 Supplemental Residents: 0	F 000		
F 557 SS=C	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post the location of the results of the facility's state inspection results in an area that was readily accessible to residents, families, and the public, without having to ask staff for assistance. Findings include:	F 557	Point 1: How corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 10/22/21 the survey binder was moved from inside of the sliding glass window to the outside of the sliding glass window.	11/16/21

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

Electronically Signed | 11/05/2021

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F 557	Continued From page 1 On 10/20/21 at 10:30 AM during the group meeting with eight alert and oriented Residents (R) (R47, R72, R108, R141, R144, R147. R148, R172) in attendance. When asked if they were aware of the location of the state inspection survey results were located. All eight residents stated no. On 10/22/21 at 8:42 AM, an observation of the second-floor nurses' station revealed the state inspection survey results binder was located behind a glass window. It was visible but was not accessible without staff assistance. In an interview at 8:43 AM, the Staffing Coordinator (SC) obtained the binder from behind the glass window. When asked if the book was easily accessible without staff assistance, she stated it was not. The SC confirmed that this was the only binder available to residents, families, and visitors. In an observation and interview on 10/22/21 at 8:54 AM, Registered Nurse Care Coordinator (RNCC)1 confirmed the special care unit (SCU) on the first floor had a state survey inspection binder accessible to families and visitors, which she located behind the nurse's station in an alcove within a group of other binders. RNCC1 agreed that the binder was not readily available without staff assistance. The survey team requested, but did not receive, a policy regarding survey posting.	F 557	Point 2: How the facility will identify others resident having the potential to be affected by the same deficient practice. On 10/30/21 an audit was completed on all units for survey binder accessibility to residents, families and the public. The survey binders were posted but not readily accessible. Point 3: What measures was put into place or systemic changes made to ensure that the deficient practice will not recur. On 10/31/2021 All staff received education on posting of the survey binders in a location accessible to residents, families and the public. On 11/02/2021 survey binders were set up on units in areas accessible to residents, families and the public. Point 4: How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes. Social Services/designee will monitor weekly all units for survey binder accessibility for the next 30 days. The results of the reviews will be presented at the Quality Assurance and Performance Improvement Committee (QAPI) meeting until the QAPI committee determines that further review is no longer	

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F 557	Continued From page 2	F 557	necessary. Point 5: Date corrective action will be completed. November 16, 2021	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, observation, and resident and staff interviews, the facility failed to ensure two Residents (R) R5 and R6 of three residents who were reviewed for positioning and mobility were provided with restorative services per their plan of care. R5 and R6 did not receive assistance to apply their splints per their plans of care, creating the potential for pain, skin breakdown, or contracture development.	F 688	Point 1: How corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 10/21/2021 charge nurse assured splints for R-5 and R-6 were placed. On 10/21/2021 resident R-5 and R-6 order and care plan were reviewed and revised for nursing to don/doff splints.	11/16/21

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F 688	Continued From page 3 Findings include: 1. Review of the facility's "Restorative Nursing Policy" dated 08/07/21 revealed, "The facility is responsible for providing maintenance and restorative programs as indicated by the resident's comprehensive assessment to achieve and maintain the highest practicable outcome;" and "Restorative Nursing can be within one of the following categories: ... Splint or brace assistance." Review of R5's undated "Resident Face Sheet," located under the "Admissions" tab of the Electronic Medical Record (EMR) revealed he was admitted to the facility on 02/24/14 with diagnoses including personal history of traumatic brain injury. Review of R5's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 07/08/21 revealed R5 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 99, indicating the assessment could not be completed due to the resident's poor cognition. Further review of the assessment revealed R5 range of motion (ROM) impairment to his upper and lower extremities on one side of his body, and that a splint or brace was not in use. Review of R5's "Activities of Daily Living (ADL) Care Plan," dated 10/12/21 and found in the EMR under the Care Plan Tab, revealed the resident had ADL self-care and mobility limitations related to his history of traumatic brain injury and, "Please don B-palm guards at beginning of AM shift and doff at end of AM shift for skin integrity and contracture management. Remove all upper	F 688	On 10/21/2021 direct staff on North 2 unit were educated on application of splints by nursing staff. Point 2: How the facility will identify others resident having the potential to be affected by the same deficient practice. On 11/01/2021 an audit was completed for all residents who utilizes splints to ensure orders/care plans were accurate. On 11/01/2021 audit of skin checks were done for all residents who utilize splints. On 10/31-11/3/2021 an audit was completed for all residents who has orders/ care planned to don splints were applied as ordered/care planned. On 11/01/2021 Occupational screens were sent for all residents who utilize splints to identify any or worsening contracture development. Point 3: What measures was put into place or systemic changes made to ensure that the deficient practice will not recur. On 11/02/2021 Splint applications were added to Point of Care as a task for CNA□s daily documentation. On 11/03/2021 Licensed staff received targeted in-service education on following orders/care plans for splint application.	

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F 688	Continued From page 4 extremity splints at end of day shift;" and "Apply splinting device to affected extremity daily per protocol/physician order: remove splint daily for inspection/cleaning of skin and gentle ROM" Review of R5's "Order Listing Report", dated 10/2021 and provided by the facility, revealed an order for the resident to have a left elbow/forearm splint and a right palmer/wrist splint applied daily for five hours as tolerated. R5 was observed in his bed on 10/19/21 at 10:30 AM. The resident was observed to have bilateral contracted hands. No splinting device was observed on either of the resident's upper extremities. The resident was observed in bed in his room on 10/19/21 at 11:36 AM. The resident was not observed to be wearing any type of splinting device to his upper extremities. R5 was observed in his bed on 10/19/21 at 2:50 PM. The resident was not wearing splints on his upper extremities. The resident was observed on 10/20/21 at 8:57 AM. The resident was in his room in bed. He was not wearing splints on either of his upper extremities. R5 was observed in his bed on 10/20/21 at 1:53 PM. He was not wearing splints on either of his upper extremities. 2. Review of R6's "Resident Face Sheet" located under the "Admissions" tab of her EMR revealed she was admitted to the facility on 01/29/19 with diagnoses including history of stroke and	F 688	On 11/03/2021 Certified nurse aides received targeted in-service education on following orders/ care plans for splint application. Documenting on Point of Care tasks for splint applications. Point 4: How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes. DON/designee will audit 5 residents for splint application weekly to ensure proper application of splinting devices are applied for the next 30 days. The results of the reviews will be presented at the Quality Assurance and Performance Improvement Committee (QAPI) meeting until the QAPI committee determines that further review is no longer necessary. Point 5: Date corrective action will be completed. November 16, 2021	

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F 688	Continued From page 5	F 688		

hemiparesis/hemiplegia following the stroke.

Review of R6's quarterly MDS with an ARD of 07/08/21, revealed R6 was severely cognitively impaired with a BIMS score of 99, indicating the assessment could not be completed due to her poor cognition. The assessment indicated R6 had both short and long-term memory impairment. The MDS indicated R6 had ROM impairment to her upper and lower extremities on one side of her body, and that a splint or brace was not in use.

Review of R6's "Activities of Daily Living Care Plan", dated 10/12/21 and found in the EMR under the Care Plan Tab, indicated the resident had ADL self-care and mobility limitations related to her history of stroke and read, "Day shift nursing to don right soft palm guard splint at the beginning of shift and doff at the end of shift as tolerated;" and "Nursing to don right upper extremity splint in the morning and doff right upper extremity splint between lunch and end of day shift."

Review of R6's "Order Listing Report", dated 10/2021 and provided to the survey team, revealed an order for the resident to wear a right wrist hand orthotic and right elbow pillow splint for six to eight hours daily on the day shift.

R6 was observed on 10/19/21 at 10:01 AM while lying in her bed. The resident was observed to have contractures to her upper left extremity. No splint was in place on the resident's right upper extremity.

R6 was observed in bed on 10/19/21 at 03:04 PM. The resident was not wearing a splint on her

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F 688	Continued From page 6	F 688		

right upper extremity.

R6 was observed in bed on 10/20/21 at 9:30 AM. The resident was not wearing a splint on her right upper extremity.

The resident was observed in bed on 10/20/21 at 2:04 PM. The resident was not observed to be wearing a splint.

During an interview with Licensed Practical Nurse (LPN) 1/Unit Manager on 10/21/21 at 12:25 PM, she stated that R5 and R6 were supposed to be wearing the ordered splints during the day. She stated the splints were to be applied in the morning and removed at the end of the shift, which was at 2:00 PM. LPN1 stated that the Restorative Nursing staff was responsible for applying the splints at the beginning of the day shift. She stated, "The splints are supposed to be on."

During an interview with the Restorative Nursing Manager/Assistant Director of Nursing (ADON) on 10/21/21 at 1:36 PM, she verified the splinting orders for R5 and R6 and stated nursing staff was responsible for applying and removing the splints. She stated nursing should be applying the splints every day. She stated the facility's restorative program had been on hold temporarily due to the COVID pandemic, however nursing staff was still responsible for ensuring R5 and R6's splints were applied.

During an interview with the Director of Nursing (DON) on 10/22/21 at 9:35 AM, she stated her expectation was that splints were to be applied for residents as ordered and per their plan of care.

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F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758		11/16/21

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F 758	Continued From page 8 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure adverse reactions were consistently monitored for antipsychotic medication use for one of five residents (Resident (R) 87 reviewed for unnecessary medications. This failure created the potential for R87 to experience worsening involuntary muscle movements. Findings include: A review of R87's "Admission Record," provided on 10/21/21, revealed the resident was initially admitted to the facility on 09/09/15 and re-admitted on 07/10/20 with diagnoses that included dementia with behavioral disturbances, paranoid schizophrenia (a mental illness that has symptoms that blur the line between what is real and what isn't, making it difficult for the person to lead a typical life), and subacute dyskinesia (a condition affecting the nervous system, often caused by long-term use of some psychiatric drugs.) Review of R87's annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 08/16/21 revealed the resident was unable to participate in a Brief	F 758	Point 1: How corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 10/28/2021 resident R87 was discharged per request of her daughter. Point 2: How the facility will identify others resident having the potential to be affected by the same deficient practice. On 10/30/2021 an audit was completed for all residents on antipsychotic medications for Antipsychotic medication side effect monitoring orders. On 10/30/2021 an audit was completed for all residents who had an Abnormal involuntary movement scale (AIMS) assessment completed between January 1, 2021 - October 30, 2021 to review for worsening of symptoms. Any resident noted to have an increase in total score indicating worsening of symptoms were reported to physician for review. Point 3: What measures was put into	

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F 758	Continued From page 9 Interview of Mental Status (BIMS) cognitive assessment but was assessed by staff to have long-term and short-term memory deficits and moderately impaired decision making skills; intermittent difficulty focusing her attention; no hallucinations or delusions; wandering daily in a manner that was intrusive to others and placed the resident at risk of injury; and received antipsychotic and antidepressant medication daily. Review of a physician's progress note located in R87's EMR and dated 09/07/21, revealed R87 had a diagnosis of Tardive Dyskinesia. Review of R87's October 2021 "Physician Orders" included quetiapine (Seroquel, an antipsychotic) 100 milligrams (mg) twice daily for paranoid schizophrenia. Review of R87's "Abnormal Involuntary Movement Scale (AIMS)" assessment, provided by the facility and dated 07/11/20, revealed a score of 17. A second "AIMS" assessment dated 10/11/21 resulted in a score a 24. Both scores indicated she had severe symptoms associated with long-term use of antipsychotic medications; however, the score of 24 on the later assessment indicated the symptoms had worsened over time. Review of R89's August, September, and October 2021 "Medication Administration Record (MAR)" revealed an area for nursing staff to document, " ... Antipsychotic Medication (Quetiapine) ...Side Effects ...EXRAPYRAMIDAL REACTION (involuntary or uncontrolled movements or tremors) ... Tardive Dyskinesia ... to be monitored every shift ..." Review of the corresponding documentation showed that	F 758	place or systemic changes made to ensure that the deficient practice will not recur. On 11/03/2021 Licensed staff received targeted in-service education on documentation for monitoring of side effects for antipsychotic medication. (+) if side effects present. (-) side effects not present. Education was completed on Abnormal Involuntary Movement Scale (AIMS) assessment. Monitoring of worsening of symptoms by comparing Abnormal Involuntary Movement Scale (AIMS) scores and actions to take when noted increase in score. On 11/03/2021 Certified Nurse Aides received targeted in-service education on reporting to licensed staff abnormal eye, mouth, tongue, head, extremities, body movements. Point 4: How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes. DON/ designee will audit 5 Medication Administration Record (MAR) weekly to ensure accurate documentation for the next 30 days. DON/designee will audit 5 Abnormal Involuntary Movement Scale (AIMS) assessments weekly to ensure accurate documentation/scoring/worsening of	

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F 758	Continued From page 10 licensed nursing staff documented daily that the resident did not exhibit these symptoms despite the resident having severe side-effects from long-term use of psychotic medications and a diagnosis of Tardive Dyskinesia. Review of R87's "Monthly Medication Review" located under the "Progress Notes" tab of her EMR from 03/10/21 to present revealed no concerns or recommendations regarding the worsening AIMS results or the conflicting documentation between the MAR and AIMS results. In an interview on 10/21/21 at 8:49 AM, Licensed Practical Nurse (LPN) 2 confirmed he was familiar with AIMS assessments and completed them as one of his nursing duties. LPN2 confirmed he was a regular caregiver to R87, was familiar with her involuntary movements, and was one of the licensed nurses who had documented on the MAR that the symptoms were not present. LPN2 stated that R87's movements were always present and had gradually worsened over time, but that he would only document her symptoms on the MAR if the resident's interactions and behaviors were different than normal for her, despite the instruction to document each time they were present. An observation on 10/21/21 at 9:01 AM revealed R87 was lying in bed watching television. She had repetitive, uncontrolled tongue thrusting (constant movement of the tongue inside to outside), jaw movements, and uncontrolled arm and leg movements. In an interview on 10/21/21 at 2:21 PM, the Director of Nursing (DON) confirmed incorrect	F 758	symptoms for the next 30 days. The results of the reviews will be presented at the Quality Assurance and Performance Improvement Committee (QAPI) meeting until the QAPI committee determines that further review is no longer necessary. Point 5: Date corrective action will be completed. November 16, 2021	

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F 758	Continued From page 11 documentation on the monitoring related to R87's use of an antipsychotic medication, and it would be her expectation that the diagnosis and symptoms were monitored accurately.	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125040	A. BUILDING _____ B. WING _____	10/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HILO	**944 WEST KAWAILANI STREET 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 A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Hawaii Department of Health, Office of Health Care Assurance on 10/19/21 to 10/22/21. The facility was found to be in compliance with 42 CFR 483.73.	E 000		

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

Electronically Signed | 11/05/2021

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
	125040	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/14/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HILO	**944 WEST KAWAILANI STREET** **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 | 12/21/2021

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
	125040	A. BUILDING _____ B. WING _____	12/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HILO	**944 WEST KAWAILANI STREET 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 | 12/21/2021

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.