STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125042	A. BUILDING _____ B. WING _____	01/14/2022

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OAHU CARE FACILITY	**1808 SOUTH BERETANIA STREET HONOLULU, HI 96826**

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) from 01/11/22 to 01/14/22. The facility was found not to be in substantial compliance with 42 CFR §483 subpart B. The highest scope and severity (S/S) = E for F679 Develop/implement Comprehensive Care Plan and F802 Sufficient Dietary support personnel. Survey dates: January 11, 2022 to January 14, 2022. Survey Census: 66. Sample size: 19.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established	F 609		2/14/22

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

Electronically Signed | 02/14/2022

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F 609	Continued From page 1 procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews, and review of facility policy, the facility failed to report Resident (R) 44's right arm bruise to the administer of the facility immediately after being identified as an injury of an unknown source. As a result of this deficient practice, R44 was put at risk for neglect or mistreatment of her injury. Findings Include: In an observation on 01/11/22 at 08:45 AM, Resident (R) 44 was observed lying in bed with her eyes closed in her room. R44's right arm was bent and laying across her chest. Surveyor observed a grayish purple bruise approximately 3 cm x 5 cm in size and located on the outer part of her right forearm. R44 smiled when surveyor asked R44 about how she received the bruise on her arm. In following observations on 01/11/22 at 12:13 PM and 01/12/22 at 08:17 AM, R44 was observed in her room using her right arm to feed herself during mealtimes. In a record review on 01/13/22 at 10:18 AM, R44 has diagnoses of dementia, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (weakness on the left side	F 609	An incident report for R44 has been completed and investigated 1/13/22. Licensed Staff and CNA's in building were in-serviced in regards to immediate reporting upon any unusual skin issues 1/13/22. All staff have been in-serviced in regards to event reporting and the importance of notification to Administrator of designee 2/11/2022. Nursing Supervisors reviewed resident charts form any abnormal documentation in weekly skin reports and documentation. Licensed Staff, Nursing Supervisors and DON, will review Point Click Care's (PCC) dashboard for any documented safety concerns, Resident or Family concerns and any behavior concerns. The Nursing Supervisor will monitor the weekly skin assessment for completeness and review for abnormal skin concerns, as well as the PCC dashboard for any documented safety concerns.	

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F 609	Continued From page 2 of her body after having a stroke), aphasia (difficulty using or understanding words) after having a stroke. "Minimum Data Set Quarterly Report" with Assessment Reference Date 11/21/21, "Section B Hearing, Speech, and Vision" indicated that R44 is nonverbal, rarely understands others, and rarely makes self-understood. On "Weekly Skin Observation Tool" dated 01/10/22, Registered Nurse (RN) 2 documented, "Bruise noted on right elbow." In an interview on 01/13/22 at 10:58 AM, surveyor asked Nursing Supervisor (NS) 3 about R44's bruise of unknown source of her right forearm. NS3 acknowledged that the administrator was not notified.	F 609	Upon report to Supervisor, DON and/or Administrator, if there are unknow or unusual skin issues, it will be reported to the Office of Healthcare Assurance promptly. Supervisors will provide the results of their audits of the weekly assessments x 4 weeks, then bi-weekly x 4, then monthly to DON. DON or designee will report the results (findings) of the audits to the Quarterly Assurance Performance Improvement Committee.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services.	F 655		2/14/22

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F 655	Continued From page 3 (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 interviews and record review, the facility was found not to follow implementation of a baseline care plan for Resident (R)4 within 48 hours of resident's admission. This deficiency has the risk to affect all residents to reach their initial goals for admission including providing effective and person-centered care of each resident that meet professional standards of quality care. Findings include: Interview done with R4 on 01/11/22 at 11:40 AM stated that he/she had a new left foot skin	F 655	Resident 4's baseline care plan was started 6/23/21 and completed on 6/29/21 by NS2. A review of all resident baseline care plans and interventions were done by NS2, NS3 and DON all have completed 2/11/2022 All members of the interdisciplinary team (IDT)have been in-serviced (2/11/22), regarding the process to complete the Baseline Care plan.	

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F 655	Continued From page 4 breakdown that happened several days ago. RR and concurrent interview with Registered Nurse (RN)1 who was queried regarding if the baseline care plan is done within 48 hours. RN1 stated that "we have two agency nurses, and one nurse is going to update but she is agency." RN1 stated "I will take care of this." RR of the care plan revealed an admission date of 06/22/22. Initialization of the care plan for skin impairment was initiated on 07/03/2021 which is 11 days after admission and greater than 48 hours for initiation of baseline care plan.	F 655	An audit will be conducted weekly X 4, then bi-weekly X 4, then monthly. The IDT members will submit data collected from auditing the baseline care plans and report their findings of the audit to the Quarterly Quality Assurance Performance Improvement Committee Meetings.	
F 656 SS=D	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). (iii) Any specialized services or specialized	F 656		2/14/22

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F 656	Continued From page 5 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 interviews, the facility failed to develop and implement a comprehensive care plan to address Resident (R) 10's injured tooth. As a result of this deficient practice, R10 was put at risk for further deterioration of R10's tooth. Findings Include: On 01/11/22 at 09:07 AM, surveyor observed Resident (R) 10 in room lying on bed with her eyes closed and with her mouth open. Her bottom teeth appeared dark yellow. One front bottom tooth appeared dark brown and shorter than the rest of the surrounding bottom teeth. In a record review on 01/13/22 at 11:14 AM, R10 is diagnosed with Alzheimer's disease and	F 656	Resident 10's care plan and interventions were completed on 1/14/2022 by NS3. A Review of all resident care plans and interventions were completed by NS2, NS3 and DON 2/13/22. MDS/RAI Nurse Coordinator, Nursing Supervisors will ensure completeness of care plans and interventions within the 14 days of admission to the facility. An audit will be done by MDS/RAI Nurse Coordinator, Nursing Supervisors, and/or designee monthly for admissions and quarterly reviews. DON, Nursing Supervisors to review	

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F 656	Continued From page 6 dysphagia (difficulty swallowing). R10's "Care Plan" stated, "Grooming-CNA (certified nursing assistant) to assist resident to wash face, arms, hands, provide oral care and comb hair with setup and verbal cues 7X/week as tolerated. Date initiated: 12/04/2020." "Dental Consult" dated on 03/29/21 stated that R10 had no missing teeth and that plaque was present. "Health Status Note" dated 11/28/21 by Registered Nurse (RN) 1 stated, "Noted missing tooth on lower jaw. Some part of the tooth still on the gum, looks decalcified. Called family to update and will call us back if they need to arrange a dental appointment. Will continue to monitor." "Long Term Care Evaluation V4" note dated 01/14/22 stated, "Nutrition: Modified consistency. Resident has obvious or likely cavity or broken natural teeth." In an interview on 01/14/22 at 09:11 AM, Certified Nursing Assistant (CNA) 1 stated, "We use a toothbrush for R10's oral care. After every meal we are supposed to do oral care. Her gums was kind of bleeding this morning after brushing so I should let the nurse know. It's not bleeding now." In an interview on 01/14/22 at 09:18 AM, RN1 stated, "I called R10's dentist about the tooth on 11/28/21. He said as long as the tooth is not bothering her there is no need to have surgery but to call him back if there are any problems. She has been eating her meals and doesn't appear in pain. I was not aware that CNA1 noticed R10's gums were bleeding this morning." In an interview on 01/14/22 at 09:20 AM, Nursing Supervisor (NS) 3 reviewed R10's care plan and confirmed that there were no interventions in the care plan to monitor R10's bottom front tooth.	F 656	audits and data collected from MDS/RAI Coordinator. DON, Nursing Supervisors and/or designee will report findings of the audit to the Quarterly Quality Assurance Performance Committee meetings.	

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F 656	Continued From page 7 NS3 stated that interventions to monitor R10's tooth should have been added to R10's care plan.	F 656		
F 679 SS=E	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, record review, and interview, the facility failed to provide and implement an ongoing program to support Residents (R) 7 and R13 in activities sponsored by the facility that meet the interests of and support the physical, mental and psychosocial well-being of the residents. As a result of this deficient practice, R7 and R13 highest level of physical, mental, and psychosocial well-being were not being met. Findings Include: 1) In observations on 01/11/22 at 09:22 AM and 11:37 AM; on 01/12/22 at 08:18 AM and 12:08 PM; on 01/13/22 at 08:24 AM, 10:50 AM, 02:02 PM, and 03:57 PM; and on 01/14/22 at 08:21 AM, Resident (R) 7 was observed lying in bed in her room. R7 was positioned on her back with pillows positioned behind each shoulder. She	F 679	Recreation Coordinator audited activity care plans for R7 and R13 on 1/20/22 in PCC, as a result R7 and R13 has an activity care plan in place initiated on 10/8/20 and 10/9/20. The activity log documentation for R7 that was provided to surveyor for the month of December 2021 was incomplete. Activity log from Point Click Care (PCC) was audited and the documentation revealed 14 days out of 31 days that R7 had in-room activities plus 4 days out of room activities. Recreation Coordinator identified residents who can benefit from in room radio, TV, or other activities supplies that can be provided to residents as needed when they are unable to join group	2/14/22

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F 679	Continued From page 8 did not respond or make eye contact when surveyor greeted her during each observation. R7's television was not on at each observation. In a record review on 01/13/22 at 04:19 PM, R7 is diagnosed with spastic quadriplegic cerebral palsy (inability to control and use body), seizures (uncontrolled convulsions of body), dysphagia (difficulty swallowing), and visual loss. "Minimum Data Set Quarterly Report" with Assessment Reference Date of 09/30/21, "Section B for Hearing, Speech and Vision" stated that R7 has moderate difficulty hearing, is unable to speak words, rarely understands others, and has severely impaired vision. "Section G for Functional Status" stated that R7 requires total dependence of staff for bed mobility, transfers, dressing, eating, and personal hygiene. "Section H Bladder and Bowel" stated that R7 is incontinent of bladder and bowel. A review of R7's "Care Plan" stated, "Invite to activities such as entertainment, current events, exercise, games, singing/music, and watching TV/movies. Offer 1:1 visits, gentle massage, talk story, short stories, radio/CDs, and TV (cartoons, children's shows/movies)." Review of document "3rd Floor-Resident's Interests 1:1" dated 12/10/21, stated that R7's activity interests were "Music, Christian music, read short stories, pet therapy." In an interview on 01/14/22 at 12:11 PM, Activities Assistant (AA) 1 stated, "R7 likes one to one visits in her room and I do sensory activities and massage. I went to R7 the other day. I'm not sure what day it was and she was sleeping so I left her alone. I'm the only activity assistant on this floor right now. My supervisor is on vacation. I log the activities that I do with R7 in the computer every time I do it."	F 679	activities. Activity staff have been in-serviced on 2/10/22 and 2/11/22 to ensure activity plan of care has been followed and reminded to continue to offer activities for all residents according to their plan of care (i.e. 1:1 or group sessions). Recreation Coordinator will monitor residents participation and report results from the monthly audits to the Quarterly Quality Assurance Performance Improvement Committee.	

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F 679	Continued From page 9	F 679		

In a record review at 12:42 PM of the facilities activity log 1:1 showed 5 days out of 31 days that R7 had in-room activities for the month of December 2021. Facility activity log 1:1 documented that the last activity done for R7 was sensory stimulation on 01/10/22.
2) Observation was made on 01/12/22 at 10:33 A M of R13 sleeping in bed, no TV or radio noted.

Record review (RR) on 01/13/22 at 10:48 AM of the facilities activity 1:1 log for the month of December showed in-room activities on December 6th and December 14, 2021, for the month of December. "Minimum Data Set Quarterly Report (MDS)" with Assessment Reference Date of 10/07/21, section G for functional status shows that R13 is totally dependent for Bed mobility, transfers, and activities.

Observation on 01/13/22 at 02:29 AM revealed R13 sleeping in bed with no TV or radio noted.

RR on 01/13/22 at 10:48 AM RR reveals a 94 y/o female with an admission date of February 2014. Care plan for physical limitations shows R13 has a deficit in activities of daily living, self-care performance related to dementia, stroke, and weakness. R13 has limited physical mobility and requires a mechanical lift for transfer. The resident needs 1:1 bedside/in-room visits and activities if unable to attend out of room events.

An interview done on 01/14/22 at 08:43 with AA2 stated that she goes to residents' rooms on her down time. Our supervisor has been on vacation since June, and I don't know when she/he is coming back. If we have 3 activity aides, one will

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F 679	Continued From page 10 fluctuate between floors and do 1:1 but we have been short staffed. Observation on 01/14/22 at 10:07 AM showed R13 sleeping, no TV or radio. On 01/14/22 at 12:01 PM interview with RN3 confirmed that R13 did not have an activity care plan. "The activity care plan coordinator is the one who does the activity care plan, and she/he has been on vacation."	F 679		
F 802 SS=E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of records, and review of policy, the facility failed to have sufficient support staff to safely carry out the	F 802	No residents were affected or identified. In-serviced dietary staff on the importance	2/14/22

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F 802	Continued From page 11 functions of the food and nutrition service as evidenced by missing documentation of temperature checks for the kitchen refrigerator and missing documentation of temperature checks for the tray line. Findings include: During an observation of the kitchen on 01/11/22 at 08:55 AM, there were three staff members working. Kitchen Staff (KS) 1 was interviewed and stated that they were short staffed "by around half the staff" because a lot was either out sick or have left with no plans to return to work. KS1 said that, although being short staffed, all the functions of the kitchen service were expected to be carried out by the three staff members that were working that day. KS1 said that they were doing their best but could only do so much with little staff. Review of the January 2022 temperature checks record for the kitchen refrigerator showed missing documentation for the following days: 01/08/22, 01/09/22, 01/10/22. During the KS1 interview, that was previously mentioned, KS1 said that the temperature checks for the kitchen refrigerator were not done because the staff person that usually did it was out sick. Review of the January 2022 temperature checks log for the tray line showed missing documentation for the following days: 01/08/22, 01/09/22. During the KS1 interview, that was previously mentioned, KS1 said that the temperature checks for the tray line were not done because the staff person that usually did it was out sick.	F 802	of logging daily refrigerator temperature checks & daily food temperature for tray line. In-service dietary staff on alerting other departments for additional support staff for kitchen help. Audit/Check refrigerator temperatures daily X 4 weeks, then weekly X 12 weeks, then monthly X 8 months. Audit/Check Daily food temperatures for tray line daily X 4 weeks, then weekly X 12 weeks, then monthly X 8 months All data collected will be submitted to the Quarterly Quality Assurance Performance Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125042	A. BUILDING _____ B. WING _____	01/14/2022

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F 802	Continued From page 12 Policy review on Storing Refrigerated and Frozen Foods read the following: Purpose, to ensure all foods are kept safe by storing foods in the refrigerator at 41 degrees and below and all frozen 0 degrees or below. Policy, to maintain quality in our foods that will be kept safe to consume by residents and staff. Procedure, 1. Staff will follow USDA fact sheet and ASSOCIATION OF NUTRITION & FOOD SERVICE PROFESSIONALS that is posted in walk in. We will keep until stated on chart if its not used before then ... Policy review on Tray Line Checklist read the following: Purpose, to ensure adequate communication about the meal service process between Dietary staff. To document both deviations from the established meal service process and corrective action taken. Policy, the tray line checklist will be completed at each meal for the resident tray line. Procedure, 1. The tray line checklist must be completed for each meal and initial by the cook and diet aide. 2. Deficiencies must be corrected immediately and corrective action documented in the action plan section. 3. The checklist must be reviewed by the Food Service Director or Lead Cook.	F 802		

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E 000	Initial Comments The facility was in compliance with the Health Section of §483.73, Requirements for Long Term Care Facility, Appendix Z, Emergency Preparedness.	E 000		

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

Electronically Signed | 02/14/2022

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

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	125042	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/18/2022**

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OAHU CARE FACILITY	**1808 SOUTH BERETANIA STREET** **HONOLULU, HI 96826**

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K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: K-291 Emergency Lighting This STANDARD is not met as evidenced by: Based on record review with staff members, the facility failed to test and maintain the emergency lighting with a 90 minute annual inspection and testing in accordance with NFPA 101, Life Safety Code, 2012 edition, sections 7.9 and 19.2.9.1 This deficiency could affect all residents, staff, and visitors during an emergency requiring evacuation from the facility. Findings include: During record review on 1/18/22 at approximately 12:15 pm revealed that the facility failed to provide documentation for the annual 90 minute emergency lighting test. These findings were verified at the exit conference with the staff members on 1/18/22 at 1:30 pm.	K 291	The facility maintenance staff performed testing and inspection of the emergency lighting on January 19, 2022 along with proper documentation. All emergency fixtures has been replaced with new fixtures on 2/11/22. Maintenance staff will conduct 90 minute annual inspection testing and will be included as part of the preventative maintenance program. Maintenance staff will conduct monthly testing of the emergency lighting and report findings/results of the testing in the Safety Committee Meetings. Environmental Director, Administrator and/or designee will report the results of the monthly emergency lighting testing at each Quarterly Quality Assurance Performance Improvement Committee Meetings.	2/14/22

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E 006 SS=C	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency	E 006		2/14/22

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E 006	Continued From page 1 Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: E-006 Emergency Prep This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to produce a complete Emergency Preparedness Plan (EPP) document in accordance with Appendix Z of the State Operations Manual (SOM) and 42 CFR 483.73 for long term care facilities. Proof of annual training and testing of the EPP with staff members was not documented. This deficiency could affect all residents, staff, and visitors during an emergency due to the lack of the required training which would provide knowledge of the	E 006	Annual Training and testing of the Emergency Preparedness Plan (EPP), with staff members was not documented in the EPP Binder. No residents were affected with the deficient practice. Staff Educator, Administrator, Director of Nursing and/or designee will review/audit training records regularly to ensure staff members receive annual training for Emergency Preparedness to be in compliance with the trainings.	

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E 006	Continued From page 2 facility EPP. Findings include: An observation on 1/18/22 at approximately 12:30 pm revealed that the facility's Emergency Preparedness Plan's Testing and Training section of the EPP was incomplete and not in accordance with Appendix Z of the SOM and 42 CFR 483.73. These findings were verified at the exit conference with the facility staff members on 1/18/22 at 1:30 pm.	E 006	No other residents were identified with the deficient practice. Staff members have been in-serviced in regards to Emergency Preparedness annual training 2/11/22. Staff Educator, Director of Nursing, Administrator and/or designee will provide on-going in-service training to staff of EPP requirements. All completed training will be documented and placed in the EPP binder. Safety Committee and/or designee will monitor the in-service records monthly for three months then quarterly for six months, then annually. The data collected from reviews with be reported to the Quality Assurance Performance Committee Meetings.	