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	125015	A. BUILDING _____ B. WING _____	11/23/2021

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WAHIAWA GENERAL HOSPITAL	128 LEHUA STREET WAHIAWA, HI 96786

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 11/16/2021 - 11/23/2021. The facility was found not to be in substantial compliance with 42 CFR 483, Subpart B. Four facility-reported incidents (FRI)s were investigated during this survey (ACTS #8775, #8911, #7977, and #7931). ACTS #8775 was unsubstantiated, while ACTS #8911, #7977, and #7931 were all substantiated at F689 and E006, with the highest scope/severity level of K. An Immediate Jeopardy (IJ) was identified on 11/19/21 in Quality of Care at F689. The Administrator was informed of the IJ on 11/19/21 at 11:49 AM. The State Agency (SA) Medicare Certification Officer was also notified of the IJ on 11/19/21. The facility's IJ Removal Plan was reviewed and approved by the survey team on 11/22/21 at 01:42 PM, and the IJ was determined to be removed on 11/23/21 at 08:14 AM. Survey Dates: 11/16/21 - 11/19/21 and 11/22/21 - 11/23/21 Survey Census: 86	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.	F 550		2/4/22

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

Electronically Signed | 01/09/2022

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F 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility 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 interview, and policy review, the facility failed to ensure the residents' right to a dignified existence for 2 of 18 residents in the sample (Resident (R)78 and R89), by ensuring the residents were treated with respect and dignity.	F 550	E1: R78& 89 were both assessed by the social worker for depression or anxiety r/t to the allegation. E2: Residents have the potential to be at risk	

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F 550	Continued From page 2 Specifically, the facility failed to ensure that English was consistently spoken in all resident care areas, exposing both residents to frustrating situations where the resident(s) feel like staff may be talking badly or making fun of the them. R89 also reported that he asked staff for water and staff responded by pointing to the bathroom sink and told the resident there is water in the bathroom sink if the resident is thirsty. This deficient practice has the potential to affect all residents in the facility. Findings include: 1) On 11/16/21 at 12:06 PM, an interview was done with Resident (R)78 in her room on the first floor. R78 complained that staff speak in Filipino, which she does not understand, and she finds it frustrating. R78 stated she is afraid to ask staff not to speak Filipino in front of her because she is concerned that they will not be as nice to her. R78 explained that what frustrates her the most is when a certified nurse aide (CNA) is assisting her in her room and another staff member will speak to her/him from the doorway, and the CNA helping her will leave the room without explaining what is going on, or when she/he will be back, leaving her unfinished. R78 stated sometimes the staff member does not return. On 11/23/21 at 09:54 AM, an interview was done with Long-Term Care Coordinator (LTCC)1 at the first-floor nurses' station. When questioned about staff speaking languages other than English in resident care areas, LTCC1 confirmed that she has heard about residents complaining, on all shifts, about staff speaking Filipino. LTCC1 explained that despite a policy requiring English to be spoken in all care areas unless the resident	F 550	E3: Staff will be in-serviced on our English in the workplace, Customer Service & Rights and Responsibility Policy & Procedure. E4: The director of social services will conduct random audits to 35% of the residents weekly to ensure staff are not speaking Filipino & treated with dignity x4 weeks. Then Audit 20% of resident□s weekly x 2 weeks. Issues will be addressed immediately with the appropriate department head. Auditing will be conducted until substantial compliance has been met. Results of the audits will be discussed monthly with the QAA committee until such time it is determined that substantial compliance is maintained. E5: The administrator is ultimately responsible for compliance Corrective action completion date: 2/4/22	

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F 550	Continued From page 3	F 550		

themselves do not understand or speak it, this has been an ongoing problem for a while.

On 11/23/21 at 12:40 PM a review was done of the facility policy: English in the Workplace, issued on 12/03/2012. The policy states "All employees ...must communicate in English in areas where patient care is delivered and in areas where patient's family, friends, and visitors of patients are present or within hearing range."

2) R89 is a 71-year-old female who was admitted to the facility with diagnoses that include a stroke involving altered motor speech abilities, congestive heart failure, seizure disorder, and right sided weakness. Review of a Brief Interview for Mental Status (BIMS), created and revised on 11/15/21 at 01:51 PM, documented R89 is cognitively intact.

On 11/16/21 at 1:57 PM, during an interview with R89, the resident reported incidents during which R89 did not feel as if the staff treated her with respect and dignity. R89 stated there were several occasions during which the staff's actions made the resident feel self-conscious and that staff were speaking negatively about her. R89 reported staff would speak to each other in Filipino when providing care for the resident. R89 stated, "I don't understand Filipino, they could be and were probably talking about me. It made me feel self-conscious because they could be talking badly or making fun of me, and I wouldn't even know it." R89 reported on one occasion, she was thirsty and asked staff for some water. Staff pointed to the bathroom sink and told R89 there is water in the bathroom sink to drink if she was thirsty. R89 stated "I'm here because I need help and they're telling me to drink from the sink, I

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F 550	Continued From page 4 cannot get up by myself, I need help and I don't want to drink from the sink, that's where they wash their hands."	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		2/4/22

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F 584	Continued From page 5 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the residents' right to a safe, clean, comfortable and/or homelike environment for 3 of 18 residents sampled (Resident (R)89, R18, and R20). Observed a portable fan used for R89 (receiving 2 liters of oxygen continuously, for difficulty breathing) to be covered in a layer of built-up dust with dust threads (approximately 1-3 inches in length) hanging from the fan's front cover. R18 is a resident who is easily susceptible to loss of body heat and possible illness, if ambient temperatures are less than 71 degrees Fahrenheit. Temperatures were measured to be 67 to 69 degrees Fahrenheit in her room, and in the unit. In addition, the facility failed to provide maintenance of Resident R20's broken window blinds located in R20's room. Findings include: 1) During the initial observation and interview of Resident (R)89 on 11/16/21 at 12:15 PM, the resident was seated on the bed writing on the bedside table with a portable standing fan approximately 2 feet away from the resident. The fan was on high and blowing directly onto the resident. R89 also had a nasal cannula and was receiving 2 liters of oxygen. Inquired with R89 about the fan, and the resident stated he/she gets hot, and the fan helps the resident to cool down.	F 584	E1: Resident 89 fan was removed and cleaned upon notification of the deficiency. The resident vitaRls were reviewed and the resident was given an albuterol neb treatment. R20 was assessed on 12/31/21 for S&S of Hypothermia. The resident temperature is The Maintenance director checked the HVAC system and found it to be in need of repair. The resident room temp was a work order that had been placed to have the room’s thermostat fixed. The resident was offered a room change and. The resident was giving additional blankets. The resident stated that the blankets made them feel comfortable. R20 blinds were replaced upon notification E2: Residents with a fan have the potential to be affected. The fans within the facility were cleaned on 12/31/21. Residents on the first floor have the potential to be affected. The HVAC system was serviced and the temperature is 74. Residents with windows blinds have the potential to be affected all rooms will be assessed to ensure the blinds were in working order E3: The Safe and home like Environment	

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F 584	Continued From page 6 At 1:22 PM, R89's visitor alerted Team Lead (TL)5 that R89 was having difficulty breathing and had received Albuterol Sulfate (2.5 milligrams per 3 milliliter) nebulization solution. During an interview with R89 on 11/18/21 at 10:35 AM, this surveyor noticed the portable standing fan was not on, which enabled the dust on the fan to be seen. The entire front fan cover was covered in built-up dust with long threads of dust that hung throughout the entirety of the front cover. The dust threads were approximately 1-3 inches in length. At 10:45 AM, conducted an observation of the portable fan with TL5. TL5 confirmed the portable fan was extremely dusty and was not maintained in a manner that was acceptable for resident use. TL5 stated R89 has difficulty breathing and the dust on the fan could contribute and/or exacerbate the resident's difficulty with breathing. 2) On 11/16/21 at 08:58 AM, an initial observation of R18 was done of her in her room. She laid quietly in bed with a thick, white blanket covering her. Surveyor also noted that it felt cold in her room. The environment outside in the unit also felt cold. Several observations from 11/18/21 through 11/21/21 at various times of the day, revealed R18 lying still in bed in her room with a thick, white blanket covering her. On 11/22/21 at 09:30 AM, R18 was asked if the ambient temperature felt cold to her in her room and she stated, "Yes." She further stated that she does not want to get out of bed if she feels cold. She was lying still in bed covered up to her neck with a thick, white blanket.	F 584	policy was updated and reviewed and deemed appropriate by management. The maintenance director was in-serviced on the policy. The Housekeeping department was educated on the Safe and home like Environment policy. The facility has added cleaning of fans to the daily cleaning list E4: The maintenance director will audit the facility temperature 5 times a week for 5 weeks then audit the facility temperature weekly during their preventive maintenance rounds thereafter. The housekeeping supervisor will audit the facility resident fans & blinds once a week for 8 weeks to ensure compliance with the facility Safe and home like environment policy. Audit results will be reviewed by the Risk Management/Quality Assurance Committee monthly x 3 months until a lesser frequency is deemed appropriate E5: The administrator is ultimately responsible for compliance Corrective action completion date: 2/04/22	

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On 11/22/21 at 2:24 PM, surveyor observed the thermostat in R18's room to be set at 80 degrees Fahrenheit. R18 asked surveyor what the thermostat was set at, and she was informed it was set at 80 degrees Fahrenheit. She stated, "It doesn't feel like 80 (degrees), it's cold in here." She lay in bed covered by a thick, white blanket.

On 11/23/21 at 09:21 AM, the Director of Facilities (DOF) initially checked the thermostats in both hallways of the unit and verified that they were set at 70 degrees Fahrenheit. The DOF checked the ambient temperatures in both hallways and confirmed that it registered at 68 to 69 degrees Fahrenheit. The surveyor and DOF verified that the thermostat in R18's room was set at 80 degrees Fahrenheit. He then checked the ambient temperature in R18's room and it registered 67 to 68 degrees Fahrenheit. R18 stated, "It's cold!"

3) On 11/16/21 at 12:00 PM in R20's room, surveyor observed R20 lying down in bed on his back with no t-shirt on. R20's chest and stomach were exposed, as well as his legs (from his thighs to his feet).

Two rectangular windows were located on the left side of R20's bed. Both windows had horizontal plastic blinds. The right-side window had blinds that were drawn halfway down with a blanket hanging from the blinds to cover the rest of the window underneath. Surveyor observed the right window with a blanket hanging on following observations to R20's room on 11/17/21 through 11/19/21.

In an interview on 11/16/21 at 12:00 PM in R20's room, R20 stated staff are unable to lower the

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F 584	Continued From page 8 blinds, so a bedsheet was put up to cover the window. In an interview with Long-Term Care Coordinator (LTCC)1 on 11/19/21 at 09:29 AM, LTCC1 was unaware that the blinds in R20's room were broken and stated she would call maintenance to fix the window blinds. On 11/19/21 at 01:42 PM in R20's room, LTCC1 confirmed that the window blinds were broken and needed to be fixed.	F 584		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is	F 604		2/4/22

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F 604	Continued From page 9 indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to ensure the resident's right to be free from any physical restraint imposed for purpose of convenience, and not required to treat the resident's medical symptoms as evidenced by a pad (lap buddy) placed across Resident (R)83's lap which was secured at both ends to the resident's wheelchair by Velcro, restricting R83 from freely standing. R83 was admitted to the facility with a diagnosis including Alzheimer's and a fractured right arm. The resident's arm was wrapped in a splint and a placed in a sling, which immobilized the resident's dominant right arm and hand. Staff did not evaluate or assess R83's cognitive ability to understand the purpose of implementing the lap buddy and recall how to unsecure the lap buddy safely at a future time, or R83's physical ability to safely unsecure the lap buddy from the wheelchair with one hand. As a result of this deficiency, the resident is at risk of the potential for more than minimal physical and/or psychological harm. Findings include: R83 was admitted to the facility on 11/09/21 after falling at home and sustaining a right arm fracture. The resident's admitting diagnoses include a fractured right arm, hypertension, Alzheimer's disease, epilepsy, depression, and insomnia. R83 has a history of falls. The resident's admission Minimum Data Set (MDS)	F 604	E1: R83 is no longer a resident here at WNRC E2: There are no other residents who have a lap buddy at the time of survey. Residents who have dementia and impulsivity and use a wheelchair have the potential to be affected. E3: The Restraint free environment policy was updated and reviewed and deemed appropriate by management. Staff will be educated policy and procedure E4: The director of nursing or designee will audit resident’s residents who have dementia and impulsivity and use a wheelchair. Audit results will be reviewed by the Risk Management/Quality Assurance Committee monthly x 3 months until a lesser frequency is deemed appropriate E5: The administrator is ultimately responsible for compliance Corrective action completion date: 2/04/22	

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was in progress and had not yet been submitted.

On 11/16/21 at 1:08 PM, while standing in the hallway directly outside the resident's room, observed R83, inside the room, seated in a wheelchair. The resident's right arm was in a sling (fastened across the resident's body and around R83's neck). R83 began attempting to stand but was unable to due to a pad which was on top and spanned across the resident's lap. R83 attempted to stand twice but was unsuccessful. R83 then grabbed at the pad with his/her left hand and attempted to pull the lap buddy off in an upward motion. While grabbing at the lap buddy, R83 appeared to become increasingly frustrated and irritable. R83 was unable to fully remove the lap buddy, but did manage to partially stand, leaving R83 in a compromised position between the lap buddy and the wheelchair. R83 was visibly unsteadily on his/her feet and at risk of falling. Staff then assisted R83 back into the wheekchair and placed the lap buddy across the resident's lap and secured it to the wheelchair.

On 11/16/21 at 3:05 PM, conducted a record review of R83's Electronic Health Record (EHR). A progress note written on 11/12/21 at 1:01 PM documented R83 had a fall from his/her wheelchair to the floor at 12:25 PM. The resident was unable to verbalize what the resident was attempting to do. Prior to the fall R83 appeared to be restless and staff redirected R83 to remain seated in the wheelchair. In a progress note written on 11/15/21 at 11:39 AM, Physical Therapy (PT)8 assessed R83 for changes in the resident's range of motion, strength, and functional mobility after falling on 11/12/21. PT8 concluded R83's fall on 11/12/21 was due to the

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resident's poor cognition and safety awareness. PT8 educated R83 on using the call light and not attempting to stand or do out of bed activities without assistance from staff. PT8 implemented the lap buddy to remind R83 to not get up without assistance.

On 11/19/21 at 10:10 AM, conducted an interview and concurrent record review of R83's EHR with Long Term Care Coordinator (LTCC)2. LTCC2 navigated R83's EHR and confirmed R83 did not have a physician's order for use of the lap buddy, no assessment was completed to evaluate and ensure the lap buddy was not a restraint, no assessment was completed to evaluate the resident's cognitive ability recall (at a later date) of how to remove the lap buddy from the chair due to the resident's diagnosis of Alzheimer's disease, or that R83 could physically reach and remove the lap buddy appropriately. LTCC2 confirmed R83's care plan was not updated to include the use and/or parameters of using the lap buddy.

On 11/22/21 at 11:19 AM, conducted an interview and concurrent record review of R83's EHR with PT8. PT8 navigated R83's EHR during the interview and reviewed the progress note PT8 wrote on 11/15/21 at 11:39 AM. PT8 confirmed writing the progress note and stated R83 is impulsive, has poor safety awareness and cognition. PT8 confirmed R83's physical and cognitive functioning was not assessed or evaluated to ensure the lap buddy would not be a restraint when implemented, and the care plan was not updated to include the use of the lap buddy. Requested for PT8 to explain how the lap buddy is used and the reasoning for its use. PT8 explained the lap buddy is a soft foam pad that

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F 604	Continued From page 12 goes over the resident's lap and attaches to the resident's wheelchair with Velcro straps and is used for residents who are spontaneous/impulsive by preventing the resident to stand on impulse and remind residents to use their call lights. PT8 confirmed the resident is impulsive/spontaneous and continuously attempts to stand throughout the day. PT8 confirmed R83 can independently stand from a wheelchair. PT8 stated that although R83 was educated and shown how to remove the Velcro straps from the wheelchair, the resident was not asked to do a return demonstration ensuring the lap buddy would not be an accident hazard or restraint. PT8 confirmed R83 does not have the cognitive capability to recognize the lap buddy as a prompt to call for staff assistance, and the lap buddy did function as a restraint.	F 604		
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	F 609		2/4/22

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F 609	Continued From page 13 for jurisdiction in long-term care facilities) in accordance with State law through established 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 record review and interview, the facility failed to report to appropriate agencies - the Department of Health Office of Health Care Assurance (OHCA), Adult Protective Services (APS) and Department of Human Services (DHS) an altercation that occurred between R54 and his roommate. The deficient practice is a failure of the facility to protect the rights of the resident who allegedly was abused by R54 and has the potential to affect all residents. Finding includes: On 11/19/21 at 3:30 PM the facility's "Incident Reports July 2021" log was reviewed. It was noted that on 07/24/21 at 11:20 AM, R54 had "Behavior Conflicts: Assaultive, patient with (sic)." Under the "OHCA (Office of Health Care Assurance); APS (Adult Protective Services); DHS (Department of Human Services) REPORTED" column, there was no documentation. On 11/22/21 at 08:49 AM, R54's EMR was reviewed. R54 is a 49-year-old male with the following diagnoses: hemiplegia (paralysis of the	F 609	E1: The resident roommate has been discharged. E2: All residents have the potential to be abused. Residents will be audited to ensure there are no current allegations of abuse E3: The Abuse policy was updated and reviewed and deemed appropriate by management. Staff will be educated on Abuse policy and procedure E4: The Director of Nursing Services, or designee, will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks. These residents will be assessed and interviewed to ensure that any allegations of abuse are identified, properly investigated and reported to the appropriate people. Audit results will be reviewed by the Risk Management/Quality Assurance Committee monthly x 3 months until a lesser frequency is deemed appropriate E5: The administrator is ultimately responsible for compliance Corrective action completion date: 2/04/22	

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body) following cerebral infarction (stroke) affecting right dominant side, unspecified symptoms and signs involving cognitive functions following cerebral infarction, dependence of wheelchair, and epilepsy (seizure disorder).

Progress notes revealed documentation on 07/24/21 at "14:41" (2:41 PM) by a licensed nurse about the incident. The note stated that after breakfast, R54 had a verbal altercation with his roommate which turned physical. R54 was difficult to re-direct and assaulted nursing staff. The facility's security and eventually the police were called to assist.

On 11/23/21 at 8:30 AM, the DON was queried about the lack of documentation in the "OHCA; APS; DHS REPORTED" column for the incident involving R54 on 07/24/21 on the "INCIDENT REPORTS July 2021" log. She verified that there was no documentation in that column and was unsure if the alleged abuse was reported to these agencies. She was then asked to provide an investigation of this incident.

On 11/23/21 at 1:00 PM, the DON provided documentation that was not an investigative report of the alleged abuse incident of R54's roommate inflicted by R54 on 07/24/21.

On 11/23/21 at 1:15 PM, reviewed the facility's "Abuse Prohibition and Investigation Procedure" last revised on 09/2021. "C. Immediate Action to an Abuse or Suspected Abuse 1. Whenever an act, event, or omission that is not consistent with the routine of the facility occurs, that occurrence will be immediately investigated as a possible abuse concern...report the occurrence to his/her supervisor as well as the appropriate regulatory

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F 609	Continued From page 15 agencies."	F 609		
F 623 SS=E	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; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;	F 623		2/4/22

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(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 agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy

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F 623	Continued From page 17 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 interview and record review, the facility failed to provide proper notification of discharge/transfer to three residents in the sample. Residents 9, 77, and 53 were discharged without receiving written notification of their discharge, their right to appeal the discharge, or contact information for the Office of the State LTC [long-term care] Ombudsman (LTCO). In addition, the facility failed to send notification of their discharge/transfer(s) to the LTCO. This deficient practice has the potential to affect all residents at the facility who are discharged or transferred. Findings include: 1) Resident (R)9 is a 61-year-old female admitted to the facility on 07/28/21. During a review of her	F 623	E1: A certified letter will be mailed to resident 9 detailing the residents rights to appeal their discharge by the administrator. Resident____53 __ will be provided the reason for transfer/discharge in by the social worker. Resident 77 has expired. The State Long-Term Care Ombudsman was notified on _____1/19/22_____. E2: Residents who are transferred or discharged have the potential to be affected. E3: The Notice of Resident Discharge & Transfer Policy was updated and reviewed and deemed appropriate by management. Registered & licensed nurse, Social workers, and unit clarks will be educated on the transfer and discharge policy and	

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F 623	Continued From page 18 electronic health records (EHR) on 11/22/21 at 09:00 AM, it was noted that R9 was transferred to the acute care hospital on 10/20/21. There was no discharge/transfer notification or LTCO notification found in the EHR for this transfer. On 11/23/21 at 09:11 AM, during an interview in her office, the Director of Nursing (DON) confirmed that although the facility does have a Notice of Resident Discharge/Transfer, it was not completed for R9's 10/20/21 transfer. 2) In a record review (RR) on 11/18/21, it was noted that Resident (R)77 was admitted to the facility on 10/13/18. On 08/17/21, R77 fell and was then transferred to the hospital for an acute fracture of the right femur (right thigh bone). In an interview on 11/22/21 at 01:39 PM with the Director of Nursing (DON), the DON stated that there was no written notice given to R77's family including the reason for his transfer to the hospital, the date of his transfer, the location to which R77 was transferred, a statement of R77's appeal rights, whom to contact for assistance in completing and submitting the appeal hearing request, and the contact information of the Office of the State Long-Term Care Ombudsman (LTCO). In addition, the LTCO was not notified of R77's transfer. 3) During a RR on 11/18/21 at 10:09 AM, it was noted that Resident (R)53 was admitted to the facility on 03/11/21 from an acute hospital with diagnoses including stroke, hypertension, and uncontrolled diabetes. On 03/21/21, R53 was transferred to an acute hospital due to a change in cognition, altered mental status.	F 623	procedure. E4: Social Services Director or designee will audit transfers and discharges for compliance 3 times a week for x 4 weeks, then audit transferred or discharged residents once a week for 4 weeks. Audit results will be reviewed by the Risk Management/Quality Assurance Committee monthly x 3 months until a lesser frequency is deemed appropriate. E5: The administrator is ultimately responsible for compliance Corrective action completion date: 2/04/22	

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F 623	Continued From page 19 On 11/22/21 at 12:06 PM, during an interview with Social Worker (SW)3, SW3 confirmed a written Notice of Resident Discharge/Transfer was not completed for the resident, the resident's representative, or Ombudsman for R53's 03/21/21 transfer.	F 623		
F 625 SS=E	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 specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced	F 625		2/4/22

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F 625	Continued From page 20 by: Based on interview, record review, and policy review, the facility failed to provide written notice of the facility's bed hold policy that address holding a resident's bed during periods of absence such as during hospitalization, to three residents (or their representatives) in the sample. As a result of this deficient practice, the residents (or their representatives) were not made aware of their rights regarding a bed hold. Findings include: 1) Resident (R)9 is a 61-year-old female admitted to the facility on 07/28/21. During a review of her electronic health records (EHR) on 11/22/21 at 09:00 AM, it was noted that R9 was transferred to the acute care hospital on 10/20/21. There was no documentation found in the EHR that R9 had been provided information regarding the facility's bed hold policy prior to, upon, or after this transfer. On 11/23/21 at 09:11 AM, during an interview in her office, the Director of Nursing (DON) confirmed that although the facility does have a Bed Hold Policy and a Bed Hold Agreement Form, this form was not completed for R9's 10/20/21 transfer. On 11/23/21 at 04:00 PM, during a review of the facility's Bed Hold Policy, last revised on 08/2020, the following was noted: "Upon transfer of a resident to the Acute Care Hospital ...[the facility] will issue a "Bed Hold Agreement Form" ..." In a record review (RR) on 11/18/21, Resident (R)77 was admitted to the facility on 10/30/18. On 08/17/21, R77 fell and was transferred to the	F 625	E1: Residents R9 & R53 have been discharged from the facility. Resident R77 will be notified of our bed Bed hold policy E2: Residents who are transferred out of to another facility have the potential of being affected. E3: The Bedhold Agreement policy was updated and reviewed and deemed appropriate. Registered & licensed nurse, Social workers, and unit clerks will be educated on the bed hold policy and procedure E4: Social Services Director or designee will audit for utilization of the Bedhold Agreement form 3 times a week for x 4 weeks, then audit transferred residents once a week for 4 weeks. Audit results will be reviewed by the Risk Management/Quality Assurance Committee monthly x 3 months until a lesser frequency is deemed appropriate. E5: The administrator is ultimately responsible for compliance Corrective action completion date: 2/4/22	

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F 625	Continued From page 21 hospital for an acute fracture of the right femur (right thigh bone). R77 received hip surgery and returned to the facility on 08/25/21. A nursing progress note dated on 08/17/21 stated that the physician had left a message on R77's sister's phone informing her about R77's injury. Nursing progress note on 08/18/21 stated that R77's sister was called by the facility regarding a bed hold for R77. In an interview on 11/22/21 at 01:39 PM with the Director of Nursing (DON), the DON stated that there was no written notice given to R77's family about the facility's policy on bedholds. 3) On 11/18/21 at 10:09 AM, conducted a RR of Resident (R)53's EHR which documented Resident (R)53 was admitted to the facility on 03/11/21 with diagnoses including stroke, hypertension, and uncontrolled diabetes. On 03/21/21, R53 was transferred to an acute hospital due to a change in cognition, altered mental status. On 11/22/21 at 12:06 PM, during an interview with Social Worker (SW)3, SW3 confirmed a a Bed Hold Policy and a Bed Hold Agreement Form was not completed for R53's 03/21/21 transfer to the acute hospital.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		2/4/22

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F 641	Continued From page 22 Based on record review and interview, the facility failed to accurately reflect Resident (R) 24's status in his Quarterly Minimum Data Set (MDS) report. As a result of this deficient practice, R24's antipsychotic medications were not accurately assessed which resulted in a failure to promote or maintain the R24's highest practicable mental, physical, and psychosocial well-being. Findings include: In a record review (RR) of R24 on 11/18/21 at 01:26 PM, it was noted that R24 was admitted to the facility on 04/02/20 for diagnoses of major depressive disorder, vascular dementia with behavioral disturbance, anxiety disorder, and insomnia. Physician orders showed that R24 was prescribed ziprasidone hydrochloride 20 mg, one capsule by mouth two times a day for vascular dementia with behavioral disturbance and sertraline hydrochloride tablet 100 mg, one tablet by mouth once a day for major depressive disorder. The Quarterly Minimum Data Set (MDS) report with Assessment Reference Date (ARD) of 08/20/21 indicated that in "Section N0410. Medications Received" that R24 received an antipsychotic and antidepressant for the last 7 days. In "Section N0450. Antipsychotic Medication Review: A. Did the resident receive antipsychotic medications since admission/entry or reentry prior OBRA Assessment, whichever is more recent," R24 was coded as "No antipsychotic were received." As a result of this answer of "No" in Section N0450, the next question, "B. Has a gradual dose (GDR) been attempted?" was skipped. In an interview with Long-Term Care Coordinator (LTCC) 1 on 11/19/21 at 12:59 PM, LTCC1	F 641	E1: Affected resident (R24) coding error (Section N0450 a,b,c,d,e) was modified in MDS to reflect that the resident had received Antipsychotic medication on a routine basis. Modification was completed/transmitted/accepted on: 12/1/21. The coding error was an isolated incident and likely caused by data entry error. E2: Residents receiving Antipsychotic medications have the potential to be affected. E3: The MDS 3.0 Completion policy was reviewed and deemed appropriate. An In-Service education program was conducted by the Nurse Consultant with an interdisciplinary team and MDS Staff addressing the importance of identifying the use of antipsychotic medications and the effect on the resident. All disciplines shall follow the guidelines in Chapter 3 of the current RAI Manual for coding each assessment. E4: MDS Lead will audit MDS weekly for 4 weeks for: Section N0450 for 50% of completed weekly MDS assessments, then audit 25% x 4 weeks. Audit results will be reviewed by the Risk Management/Quality Assurance Committee monthly x 3 months until a lesser frequency is deemed appropriate. E5: The administrator is ultimately responsible for compliance Corrective action completion date: 2/4/22	

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F 641	Continued From page 23 confirmed that R24's medications of ziprasidone and sertraline were both started on 04/03/20 with dosages staying the same for both medications until present. In an interview with Minimum Data Set Coordinator (MDSC) 2 on 11/19/21 at 01:45 PM, MDSC2 confirmed that the Quarterly MDS report with ARD of 08/20/21 under "Section N0450", the response of "No" was an error and that the correct answer should have been "1. Yes-Antipsychotics were received on a routine basis only."	F 641		
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 rehabilitative services the nursing facility will	F 656		2/4/22

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F 656	Continued From page 24 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 observations, interviews, and record reviews, the facility failed to ensure that the care plans for three residents (R) of the sample, R51, R48 and R59, were person-centered to meet their individual goals. R51 lacked specific direction for appropriate vital sign (VS) monitoring after receiving her hemodialysis (HD) treatments. R48 did not have a care plan to address his homelessness and his desire to be discharged from the facility and as a result developed behaviors, and for R59, a care plan was not developed for insomnia resulting in inadequate monitoring. This deficient practice fails to define a comprehensive plan for the staff to follow that helps to attain R51's, R48's and R59's individual medical and psychosocial needs, and as a result these residents were placed at risk for a decline in their quality of life. This deficient practice has the potential to affect all the residents at the	F 656	E1: R59 – medication was dc'd on 11/24/21. Care plans of residents R51 and R48 were reviewed and updated as indicated. E2: The facility has determined that residents receiving Hemodialysis and those residents with behaviors have the potential to be affected. E3: The interdisciplinary care plan team members responsible for writing care plans will be re-educated on the facilities Comprehensive Plan of Care Policy for developing / revising Comprehensive Care Plans. The facility nursing staff will be educated on following the plan of care for taking vital signs for all Hemodialysis residents pre and post dialysis. The policy was reviewed and deemed appropriate by management. Registered and Licensed	

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F 656	Continued From page 25 facility. Findings include: 1) On 11/18/21 at 09:59 AM, team leader (TL)6 was queried about the care process for hemodialysis (HD) residents. She stated that vital signs (VS) which includes blood pressure, pulse, and temperature, are taken before and after their HD treatments. On 11/18/21 at 10:35 AM, R51's electronic health record (EHR) was reviewed. R51's care plan for "Hemodialysis" revealed that VS are checked "per routine." Continued review of R51's EHR included R51's "Weights and Vitals Summary" and the "*Nursing Progress Note (Narrative)." There was no evidence of VS being taken from R51 when she returned to the facility after her HD treatments on 10/18/21, 10/27/21, and 11/01/21. On 11/18/21 at 03:38 PM, the facility's policy "Care of the Pre and Post Hemodialysis Resident", revised on 10/2020, was reviewed. It stated, "16. Check vital signs upon return to the unit. Assure resident is hemodynamically (blood circulation) stable." (Refer to F740 Behavioral Health Service) 2) On 11/16/21 at 12:38 PM, an initial observation was made of R48 sitting upright in bed with his lunch tray in front of him. R48 looked distressed and stated, "They're taking my money!" R48 did not want to further converse with the surveyor. At 1:37 PM, R48 laid quietly in bed, looking out the window. At 2:35 PM the surveyor observed R48 yelling out, "Get outta here!" to CNA16 when he walked into his room. CNA16 immediately	F 656	Nursing Staff will be educated on policy and procedure E4: MDS Lead or designee will audit 50% of care plans for those residents requiring a new: Admission, Annual, Qtrly, Sig Change, MDS during the past 7 days for x 4 weeks, then audit 25% of residents x 4 weeks. Audit results will be reviewed by the Risk Management/Quality Assurance Committee monthly x 3 months until a lesser frequency is deemed appropriate. E5: The administrator is ultimately responsible for compliance Corrective action completion date: 2/04/22	

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walked out of R48's room without engaging with R48.

On 11/17/21 at 08:17 AM, observed R48 sitting upright in bed with his untouched breakfast tray in front of him. Licensed practical nurse (LPN)1 was preparing medications at her medication cart in the hallway and stated that he received his breakfast about five minutes ago.

At 08:26 AM, R48 was observed to be yelling out angrily, "Stay away!" out the door to staff passing by his room. R48 was now dangling at the edge of his bed with his bedside table pushed to the side and was throwing items from his breakfast tray out the door. R48 was occasionally mumbling to himself. R48 became verbally abusive and threw more items out of room into the hallway. Long term care coordinator (LTCC)2 picked up items from the floor and discarded them into the trash. She did not engage with R48. R48 then threw his breakfast plate out the door, the plate loudly crashing onto the floor. Several staff tried to engage with R48, but he angrily yelled, "Get the fuck out!"

At 09:18 AM, R48 was in sitting in his bed in his room quietly communicating with a staff member using a whiteboard.

On 11/18/21 at 2:42 PM, R48's EMR was reviewed. His diagnoses included: sepsis (blood infection) stemming from cellulitis (serious bacterial skin infection) of both legs, Wernicke's encephalopathy (problems with memory and disorientation arising from thiamine (vitamin B1) deficiency), urinary tract infection, homelessness, and liver disease. He was admitted to the facility on 04/08/21.

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A progress note for R48 documented by social worker (SW)1 on 04/20/21 at 09:18 AM, revealed that he was homeless with no known support, and he desired to return to homelessness. He had no known history of any mood or behavioral issues. Another progress note by SW1 on 10/21/21 at "14:53" (2:53 PM) stated that R48 refused to cost share his Medicaid and stated that he rather be homeless.

R48's admission Minimum Data Assessment (MDS) of 04/14/21 under Section D for Mood, showed that his Resident Mood Interview (PHQ-9©, depression screening) score was two (minimal depression). Under Section E for Behavior, R48 did not exhibit any physical or verbal behavioral symptoms towards others.

R48's MDS quarterly assessment of 09/24/21 under Section D for Mood revealed his PHQ-9© score was twelve (moderate depression). Section E for Behavior, R48 had physical and verbal behavioral symptoms towards others (one to three days of the seven day look back period).

A progress note documented by social worker (SW)1 on 11/17/21 at 09:42 AM stated that R48 was upset about not being able to be discharged to a foster home.

R48's care plan was not individualized to provide appropriate behavioral care for his history of homelessness and his desire to be discharged from the facility. His care plan also did not provide individualized interventions on how to manage his refusals of care, verbally abusive behavior and desire to be isolated.

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An interview was done with SW1 on 11/22/21 at 09:46 AM in the sitting area on the second floor. She stated that being homeless can be a traumatizing event and should be care planned. She also stated that the activities department is very important in managing behaviors.

An interview was done with the activities director (AD) on 11/22/21 at 10:11 AM in the sitting area on the second floor. He stated that R48 liked his outing to the bank in May, where the bank worker recognized him. He also stated that R48 did not like "new people." These individual interventions were not inputted into R48's care plan.

2) Resident (R)59 is a 97-year-old female admitted to the facility on 07/07/21 for skilled nursing care with admitting diagnoses that include dementia, a history of falling, and difficulty walking. Beginning on 07/18/21, R59 was ordered Trazodone [an antidepressant] "for insomnia."

On 11/18/21 at 10:28 AM, a review of R59's electronic health record (EHR) noted that R59 had been diagnosed with neither depression nor insomnia. A review of her progress notes revealed the first documentation of sleeplessness was found in a Nursing Progress Note from 07/18/21 09:29 PM, which documented "Note Text: Dr ...updated re: 97 y/o female, at baseline with restlessness and confusion, sustained multiple falls. CNAs [certified nurse aides] reported that resident has not slept for the past two nights. Per Dr ..., new order entered for Trazodone HCl Tablet 50 MG Give 0.5 tablet by mouth at bedtime for insomnia." A review of R59's comprehensive care plan noted no care plan for insomnia, and further review of the EHR

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F 656	Continued From page 29 noted no non-pharmacological interventions attempted for insomnia prior to the trazodone being ordered. On 11/23/21 at 04:00 PM, a request to Administration confirmed there was no documentation found regarding a care plan for insomnia despite the resident being prescribed medication for the condition since July.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the 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	F 657		2/4/22

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F 657	Continued From page 30 assessments. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review (RR) the facility failed to ensure the good clinical practice of timely revisions to Resident (R) care plans (CP) when relevant clinical changes were identified or needs changed. Specifically, R81, R231, and R63 exhibited behaviors of risk for elopement and their CP's were not revised until after they eloped, R52 had no revisions to their behavioral care plan despite signs of inadequacy, and R83's care plan did not include interventions implemented after a fall. Timeliness of care plan revisions have the potential to affect all residents. As a result of this deficient practice there is the potential residents may have negative outcomes and not reach their highest practicable physical, psychological or social well-being. Findings include: 1) R81 is an 82-year-old female admitted to the facility on 05/27/21 for short term rehabilitation and skilled nursing services after she had a fall at home with a closed head injury. Her admission MDS (Minimum Data Set-assessment of clinical and functional status) dated 06/02/21 documented a BIMS (Brief Interview of Mental Status) of 13, reflecting intact cognitive response. Her functional status documented she was unsteady walking and normally used a walker or wheelchair. R81 eloped on 06/01/21 at approximately 08:43 PM without a device (walker or wheelchair). She was found on the sidewalk about .2 miles away. R81 was at risk of being struck by a vehicle, falling, and other potential hazards.	F 657	E1: Residents discharged from the facility prior to POC completion: R81, R83, R231 and R281. Care Plan for resident R52 and R63 were reviewed and updated as indicated. E2: Residents with behaviors, at risk for elopement and at risk for falls have the potential of being affected. E3: The interdisciplinary care plan team members responsible for writing / revising resident care plans will be re-educated on the facilities Comprehensive Plan of Care policy and procedure related to timeliness for updating of care plans. staff will be in-serviced on caring for residents with behaviors, elopement, and falls risk. The facility care plan policy and procedure were updated and/or reviewed and deemed appropriate by management. E4: DON or designee will audit resident care plans once a week during the weekly at risk meetings. During this meeting residents with identified behaviors and those at risk for elopement and falls care plan will be updated as needed. Audit results will be reviewed by the Risk Management/Quality Assurance Committee monthly x 3 months until a lesser frequency is deemed appropriate E5: The administrator is ultimately responsible for compliance Corrective action completion date: 2/04/22	

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Reviewed R81's progress notes and CP on 11/18/21 which revealed R81 began to exhibit behaviors she was a risk for elopement starting 05/28/21. Prior to her elopement on 06/01/21, R81 called a taxi, verbalized wanting to call the police, being held hostage, being incarcerated, held against her will and wanting to go home. In addition, on the afternoon of 06/01/21 she was found halfway down a stairwell from the second floor approximately six hours before she successfully eloped.

R81's CP was not revised in a timely manner after she exhibited behaviors of needing additional supervision and measures to reduce the risk of elopement as much as possible. The interventions for risk of elopement were added on 06/02/21.

2) R231 was admitted to the facility on 10/01/19 for short term rehabilitation (rehab). He is a 66-year-old male with degeneration of the nervous system due to alcohol, severe protein-calorie deficiency, history of falling, Type 2 Diabetes, tremors, muscle weakness, anxiety, and homelessness. R231 can ambulate with a front wheel walker (FWW).

On 12/13/19, R231's BIMS was documented to be 7 (seven), reflecting significant cognitive impairment. On 12/06/19 at approximately 08:06 AM, R231 was found outside. On 12/22/19 at approximately 11:30 AM, R231 eloped for a second time and was found down the street by the Library.

On 11/18/21, reviewed R231's progress notes, CP and physician notes which revealed the following:

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11/21/19 10:35 PM Nursing note: "...At around 20:29, this writer saw resident came out from room 270 and was walking on [sic] the hallway, towards the elevator. ..."

11/26/19 03:52 PM Nursing note: "Resident with very poor safety awareness. ...Resident was wheeling self on [sic] the hallway. ..."

11/30/19 03:29 PM Nursing note: "Resident with episode of trying to elope from the facility. Resident was found front of entrance door and convinced to come back inside the facility...Resident persistent of going home."

12/02/19 R231's CP was revised to add he was at risk for elopement. The CP documented "6am, resident seen getting out of the elevator on first floor." This incident was not documented in the nursing progress notes. CP interventions included:
"Attempt to determine reason for resident's wandering, such as boredom, hunger, pain, loneliness, or missing family."
"Monitor resident where abouts every shift."
The reason for R231's behavior became very targeted to leave the facility rather random unfocused wandering.

12/06/19 08:06 AM Nursing note: "During endorsement to day shift, one of the day shift CNAs (Certified Nursing Assistant) notified this RN (Registered Nurse) and day shift RN that pt. is outside walking in the parking lot. ..."
12/06/19 11:14 AM Nursing note: "07:07 AM: As this writer walked down the hallway of activities and rehab rooms, I noticed an empty wheelchair with an active sounding chair alarm. As I turned off the alarm, resident...states, "The tall...man

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from upstairs walked out. ..."
12/06/19 CP revision included the intervention "If resident wants to take a stroll outside or off site, contact Activities staff, Nursing, SS(Social Services) to accompany him."

12/09/19 07:55 AM Nursing note: "Refused wander-guard device"

12/11/19 11:35 PM Nursing note: "...Resident wanted to leave facility, but it is unsafe for patient to leave facility..."

12/13/19 MDS assessment significant change: "able to propel self in and out of the facility. ..."

12/14/19 07:49 AM Nursing note: "Throughout NOC shift, pt. would frequently get up from bed yet able to re-direct. However, at 07:00 pt. started to get up from bed again and became irritable yelling at staff when trying to re-direct back to his room. ...Security called and able to transfer pt. back to room."

12/21/19 03:55 PM Nursing note: "Throughout shift, pt. continues to get OOB to walk to bathroom or transfer self to w/c without calling for assistance. Pt unsteady when ambulating. ..."

12/22/19 05:25 PM Nursing note: "Resident walked out of facility @ approximately @11:30 towards library. Resident stated, "I want to go to Salvation army to get new shoes." Staff able to bring back resident back to facility with no difficulty. Continue to monitor."

12/23/19 09:44 AM Nursing note: "Resident eloped out of facility on 12/22/19 approximately @11:30 am...Obtained order from MD1 for 1:1

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sitter."
Revisions made to the "Focus" area of R231's CP included:
"12/23/19: 1:1 sitter"
"01/14/20: @1433, insisting to leave facility while downstairs with 1:1 sitter: walked out of facility onto Lilani Ave. sidewalk past the Emergency Room sign, combative with staff, HPD called @1438, two officer arrived and escorted resident back to unit."
The last revision to the CP interventions for risk of elopement was 12/06/19. In addition, there is no reference in the CP regarding a wander guard.

On 11/23/21 at approximately 12:30 PM, during an interview and RR with the Director of Nursing (DON) and Quality Coordinator, they confirmed R81 and R231's CP's should have been revised when they first exhibited the behaviors they were at risk for elopement.

3) Cross reference to F689 Free of Accident Hazards/Supervision
The facility did not provide adequate supervision and implement measures to reduce the risk of elopement as much as possible when two of the residents (R81 and R231) exhibited behaviors prior to the elopement. The elopements put both residents in unsafe environments which put them at risk of potential harm or death.
4) On 11/16/21 at 08:58 AM surveyor initially observed R63's entrance to her room obstructed with a wheelchair. R63 was lying on her side sleeping, her breakfast tray on the bedside table untouched.

On the same day at 12:25 PM, certified nurse aide (CNA)6 was observed to be entering her room. The wheelchair was still obstructing the

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entrance to her room. R63 was still sleeping in bed. CNA6 stated, "If we don't wake her up for lunch, she will skip lunch too."

On 11/18/21 at 09:30 AM, it was identified by the survey team that R63 resided across of stairwell (STW)3 and that R63 had a history of elopement.

On 11/19/21 at 11:00 AM an immediate jeopardy (IJ) situation was found for resident elopement from the facility for three residents, R81, R231, and R281. R63 was identified as being high risk for elopement and was added to the resident sample for investigation. (Refer to F689 Free of Accident Hazards/supervision/devices)

On 11/22/21 at 08:19 AM, R63's electronic health record (EHR) was reviewed. Her Quarterly MDS of assessment review date (ARD) 10/08/21 revealed that her BIMS was "03," indicating severe cognitive impairment. R63's CP revealed: "At risk for wandering and elopement due to cognitive imparment secondary to dementia." An intervention listed with this "Focus" is "Apply wander guard to walker. Date Initiated: 05/04/2018" The wander guard bracelet is to be applied to the resident and it triggers sensors located at exits when the resident wanders away. There also were no interventions to address the fact the R63 resided across STW3 that did not have a wander guard alarm sensor.

(Refer to F744 Treatment/service for Dementia)
5) On 11/16/21 at 12:53 PM, surveyor saw R52 eating her lunch and R52 stated that her lunch was good.

On 11/18/21 at 09:30 AM, surveyor observed R52 watching television and was able to engage in a

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conversation with R52 about the television program she was watching.

On 11/19/21 at 2:03 PM, surveyor observed the door to R52's room was closed and that R52 was yelling constantly, sounding distressed. Team Leader (TL)2 was standing in the hallway outside her door.

On 11/19/21 at 3:30 PM, the facility's "Dementia Care" policy was reviewed. The date of implementation was 11/19/21. Specifics include the following: "3. The care plan interventions will be related to each resident's individual symptomology ..." "4. Care and services will be person-centered ..." "5. Individualized, non-pharmacological approaches to care will be utilized, to include meaningful activities aimed at enhancing the resident's well-being."

On 11/21/21 at 8:07 PM, R52's EHR was reviewed. R52's diagnoses included: other sequelae of cerebral infarction (altered sensation after stroke), moderate protein-calorie malnutrition, unspecified dementia (persistent loss of intellectual functioning) with behavioral disturbance and paraplegia (paralysis of the lower extremities). Progress notes were reviewed, and it revealed that R52's family refused for her to be on medication to manage her behaviors because it made her sleepy. A progress note written by Social Worker (SW)2 on 07/14/21 at 16:42 (4:42 PM), stated that "Resident will respond positively in casual discussion, topics of her interest, likes to talk about her own interests, past jobs, activities that she participated in during her youth, water sports, beach." R52's care plan did not have these individualized interventions on how to care for R52. The only intervention listed if she

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becomes physically abusive was "SW to counsel resident when guidance is needed." For activities, R52's care plan stated, "offer to (sic) opportunity to go outside for fresh air and sunshine as tolerated."

On 11/22/21 at 09:35 AM, R52 was lying in a 45-degree angle in bed, her television and music player were off, and a cell phone was noted on her bedside table close to her. She had a music player that was off on her bedside table and a note on her wall stated, "Keep radio on Christian station per family's (Son) request." This intervention was not documented on R52's care plan. She asked surveyor to look for her blue shoes.

On 11/22/21 at 09:46 AM, SW1 was interviewed in the sitting room on the second floor. She stated that if the family is called when she has behaviors, it seems to help. Also visits will help, if someone is there to talk to her, she'll calm down. She likes to talk to someone. These individualized interventions should be in her care plan. She also stated that the activities department is very important in managing behaviors.

On 11/22/21 at 10:11 AM, the Activities Director (AD) was interviewed in the sitting room on the second floor. He stated that R52 is good with one-to-one visits and likes to "talk story" and she watches some television. She looks at magazines sometimes and "she didn't like it when we got her up to go to the patio."

On 11/22/21 at 10:40 AM, CNA3 was interviewed in the hallway a couple of doors down from R52's room. She stated that R52 asks for things when

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she is uncomfortable, so we try to make her comfortable and she is okay.

6) R83 was admitted to the facility on 11/09/21 after falling at home and sustaining a right arm fracture. The resident's admitting diagnoses include a fractured right arm, hypertension, Alzheimer's disease, epilepsy, depression, and insomnia. R83 has a history of falls and benign brain tumors. The resident's admission Minimum Data Set (MDS) was in progress and had not yet been submitted.

On 11/17/21 at 08:59 AM, this surveyor was seated at the nursing station an heard a resident continuously yelling "I'm sore, help, I need my medication, I'm in pain, hurry up!" Staff entered R83's room in an attempt to calm the resident down. R83 continued to yell out in pain despite staff telling the resident Team Leader (TL)5 was getting his/her pain medication.

On 11/17/22 at 4:22 PM, conducted a RR of R83's Electronic Health Record (EHR). Review of R83's physician's orders documented an order for Acetaminophen 650 milligrams (mg) every 4 hours as needed for mild pain 1-3/10 (one to three out of scale of ten). Review of the resident's November Medication Administration Record documented R83 was administered at least one dose of Acetaminophen 650 mg for pain. Review of R83's care plan documented an alteration in comfort related to a right humerus fracture, general discomfort, possible need for oxygen, however, non-pharmacological strategies were not included in the interventions to reduce the level of R83's pain.

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F 657	Continued From page 39 On 11/19/21 at 10:10 AM, conducted a concurrent interview and review of R83's Electronic Health Record (EHR) with Long Term Care Coordinator (LTCC)2. LTCC2 navigated R83's EHR during the interview. LTCC2 confirmed R83's care plan did not include non-pharmacological interventions. LTCC2 also confirmed that due to the resident's diagnoses of Alzheimer's, history of falls, impulsitivity, non-pharmacological interventions should be offered before and in conjunction with the resident's pharmacological interventions.	F 657		
F 684 SS=G	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 observations, interviews and record reviews, the facility failed to provide needed care or services for two residents (Resident (R)20 and R53). R53's blood glucose levels were not managed appropriately, resulting in altered mental status for the resident and being transferred to an acute hospital for treatment. In addition, R20's bowel regime was not managed appropriately resulting in failure to improve and/or attain his highest practicable physical, mental, and/or psychosocial well-being. As a result of this deficient practice, R20 was put at risk for	F 684	E1: R53 has been discharged from the facility. R20 currently resides in the facility. The MD & RD was notified regarding the loose stools. At the time of notification the resident no longer displayed S&S of diarrhea E2: Residents with loose stools have the potential to be affected. Residents who are diabetic are at risk for this deficient practice. E3: The Quality care, Incontinence, Blood Glucose Monitoring policy & vital sign	2/4/22

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F 684	Continued From page 40 dehydration and skin breakdown. Findings include: 1) R53 is a 68-year-old male admitted to the facility from an acute hospital on 03/11/21 with diagnoses including Diabetes Mellitus type II, hypertension, schizophrenia, dysphasia following a cerebral infarction (stroke), and coronary artery disease. On 11/23/21 at 10:18 AM, conducted an interview and concurrent record review with Long Term Care Coordinator (LTCC)3 for R53. Review of the acute hospital's Transfer Summary written on 03/11/21 at 10:36 AM revealed that before R53 was admitted to the acute setting (while he was at home), R53 received Lantus 100 Units/1 Milligram (ml), 20 Units (U) subcutaneous (subq) at bedtime and Novolog 100U/1ml, 15U subq twice a day at home. When R53 was transferred from the acute setting to the facility (on 03/11/21), R53 was receiving 10 Units of Lantus subq. Review of R53's Order Review Report documented a standing order: Titrate Lantus by 2 units every other day until his fasting sugar is less than 180, one time every other day; ordered on 03/12/21; start date: 03/13/21; end date: 03/12/21 Titrate Lantus by 2 units every other day until his fasting sugar is less than 180, one time every other day; ordered on 03/12/21; start date: 03/13/21; end date: 03/14/21 Titrate Lantus by 2 units every other day until his fasting sugar is less than 180, one time every other day; ordered on 03/15/21; start date: 03/15/21; end date: 04/12/21	F 684	policy was updated and reviewed and deemed appropriate by management. The Physician will be educated on the quality care policy. The nursing staff will be educated on the incontinent, blood glucose monitoring, Blood glucose standing order, vital signs and quality of care policy and procedure. Staff education on notifying MD, identifying change in condition, accepting/clarifying ambiguous or unsafe orders E4: The director of nursing or designee will audit 50% of diabetic residents once a week for x 4 weeks, then audit 25% of residents x 4 weeks to ensure compliance with the quality of care policy. Auditors will check to ensure the physician orders are being followed, and diabetic monitoring is in place.The director of nursing or designee will audit newly identified with loose / water stools weekly x8 weeks for appropriate Incontinence interventions. Audit results will be reviewed by the Risk Management/Quality Assurance Committee monthly x 3 months until a lesser frequency is deemed appropriate. E5: The administrator is ultimately responsible for compliance Corrective action completion date: 2/04/22	

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Titrate Lantus by 2 units every other day until his fasting sugar is less than 180, one time every other day; ordered on 03/14/21; start date: 03/14/21; end date: 03/15/21

R53's physician orders summary documented:

03/11/21: Lantus 10 units, subq one time a day, hold if fasting BS<100
03/14/21: Lantus 12 units, subq one time a day, hold if fasting BS<100
03/17/21: Lantus 14 units, subq one time a day, hold if fasting BS<100
03/19/21: Lantus 16 units, subq one time a day, hold if fasting BS<100
03/21/21: Lantus 18 units, subq one time a day, hold if fasting BS<100

Review of R53's Blood Glucose (BG) Summary documented:

03/12/21 at 06:29 AM- 270.0 mg/dl
03/13/21 at 06:30 AM- 278.0 mg/dl
03/14/21 at 05:19 AM- 259.0 mg/dl
03/15/21 at 05:59 AM- 273.0 mg/dl
03/16/21 at 06:08 AM- 323.0 mg/dl
03/17/21 at 06:39 AM- 418.0 mg/dl
03/18/21 at 06:54 AM- 395.0 mg/dl
03/19/21 at 06:59 AM- 391.0 mg/dl
03/19/21 at 08:53 PM- 389.0 mg/dl
03/20/21 at 05:53 AM- 373.0 mg/dl
03/20/21 at 10:45 AM- 373.0 mg/dl
03/21/21 at 06:27 AM- 481.0 mg/dl

After reviewing R53's physician orders for Lantus and the Blood Glucose Summary with LTCC3, LTCC3 confirmed R53's BG was not adequately managed with 10 Units of Lantus alone and should have had a sliding scale of Novolog to

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address the resident's BG which was rising consistently daily. LTCC3 stated normally if the resident's BG is not within normal limits (WNL) with oral and/or a long-acting medication, the physician should have ordered a sliding scale of Novolog. LTCC3 also stated that the physician's order to increase Lantus by 2 Units every two days was not an order that licensed staff normally see for residents. Reviewed a Nursing Progress Note written on 03/21/21 at 01:43 PM which documented at the beginning of the shift R53 was alert, non-verbal, and did not follow commands. The Lantus was increased from 16 units to 18 units due to the resident's fasting blood sugar level of 481.0 mg/dl. The resident refused breakfast. At around 12:00 PM, the resident was lethargic and somnolent, responding to tactile stimuli only, and was transferred to an acute hospital due to altered mental status. Inquired if R53's transfer to the acute setting was due to the resident's unmanaged BG. LTTC3 confirmed a BG level of 481.0 mg/dl and R53 presenting as lethargic and somnolent is evident that the resident's BG level was high enough to put the resident in a diabetic coma and affected the resident adversely.

On 11/23/21 at 10:18 AM, conducted an interview and concurrent review of R53's Electronic Health Record (EHR) with the Long Term Care Coordinator (LTCC)3. LTCC3 navigated R53's EHR during the interview. Reviewed R53's Order Summary Report, Physician Order Summary, and the resident's Blood Glucose Summary. LTCC3 confirmed Lantus alone was not effective in managing R53's blood glucose levels and no other medications were added as an adjuvant therapy. LTCC3 also confirmed that R53's blood glucose was extremely elevated at 481.0 mg/dl

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(normal range is 65 to 99 mg/dl) and the resident's blood glucose was on an upward trend towards a diabetic coma and/or a potentially fatal outcome.

On 11/23/21 at 10:33 AM, conducted a telephone interview with Medical Doctor (MD)3. MD3 stated he was covering for MD2 due to MD2 being on vacation. MD3 had access to R53's EHR and navigated the records throughout the interview. Inquired with MD3 if the Lantus should have been given at bedtime instead of the morning. MD3 stated that it did not matter if the medication was administered at bedtime or in the morning. Reviewed the Lantus insert instructions which documented Lantus is most effective when administered at bedtime as opposed to the morning. After reviewing R53's chart, the Order Summary Report, Physician Order Summary, and the resident's blood glucose result, MD3 confirmed the resident's blood glucose levels were not properly managed and required an order for a sliding scale of Novolog to maintain appropriate blood glucose levels. MD3 confirmed the orders to titrate Lantus by 2 units every other day sets the titration to a day as opposed to the resident's blood glucose levels and delegates the responsibility of managing the resident's blood glucose levels to the nursing staff, which is not in accordance with professional standards of practice.

2) On 11/16/21 at 12:00 PM, surveyor observed R20 lying down in bed on his back without a T-shirt on. R20 appeared well nourished. A suprapubic catheter was seen draining from his abdomen to a urinary bag hanging off the bed below his waist. His skin on his legs and feet appeared flaky.

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In an interview with surveyor on 11/16/21 at 12:00 PM, R20 stated he has "Plenty diarrhea," and he was "Not sure," what staff was doing for his diarrhea. R20 stated he was in a motorcycle accident and as a result, had limited use of his legs, and had leg pain from muscle spasms. He also stated that his skin is itchy and that staff apply lotion to his skin daily.

On 11/17/21 at 11:00 AM in a record review (RR) of R20's EHR, it was noted that R20 was diagnosed with incomplete paraplegia (partial paralysis of body), Diabetes Type II (impairment in the way the body regulates and uses sugar (glucose) as fuel), diarrhea (loose bowel movements), neuromuscular dysfunction of bladder (lack of bladder control due to nerve condition), chronic pain, and rash. R20 has a regular diet. Quarterly Minimum Data Set (MDS) report with Assessment Reference Date (ARD) of 08/12/21, indicated that R20 has a Brief Interview Mental Status score of 14, meaning he is cognitively intact. In MDS report with ARD of 08/21/21, in "Section G0110 Activities of Daily Living Assistance", he requires one-person physical assist to move in bed, dressing, toileting and has total dependence for bathing. In "Section G0400 B" he has impairment of both sides of the lower extremities (hip, knee, ankle, foot). In "Section H Bladder and Bowel" he has an indwelling catheter and is always incontinent of bowel movements. "Weekly Skin Assessment" dated 11/15/21 indicated that R20 has the following risk factors for developing problems with skin integrity: incontinence, immobility, impaired circulation, moisture, pressure, trauma, dry skin, suprapubic catheter in place, paraplegia, and back skin discoloration. "Task Flowsheet for

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F 684	Continued From page 45 Bowel Movement and Toilet Use" documented loose/diarrhea bowel movements daily from 10/24/21 thru 11/20/21. In an interview with Long-Term Care Coordinator (LTCC)1 on 11/19/21 at 10:16 AM, LTCC1 was not aware of R20 having daily episodes of diarrhea. LTCC1 reviewed R20's record and confirmed that R20 was having daily episodes of diarrhea. LTCC1 also confirmed that R20 was not on any medications to treat diarrhea. LTCC1 stated that she would notify the dietician and physician of diarrhea episodes. In a following interview with LTCC1 on 11/19/21 at 01:36 PM, LTCC1 confirmed that diarrhea is not a normal occurrence for R20 and that the certified nurse assistant should have reported the episodes of diarrhea to the nurse.	F 684		
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review (RR), the facility failed to provide adequate supervision to four residents (R) for elopement. Since the last recertification survey on 10/02/19, three residents (R81, R231 and R281) eloped. Most recently, on 06/02/21, R81, an 82-year-old female was found approximately 0.2 miles away	F 689	E1: Residents R81,R281, R83 & R231 are no longer residents here at WNRC. Once the IJ was received the following was done for resident R63, the resident was moved closer to the nursing desk, a new wandering assessment was performed, the Care plan was updated to	2/4/22

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F 689	Continued From page 46 from the facility. In addition, R63, who was a high-risk of elopement resided in Room (RM) 268, which was next to an unmonitored stairwell and double doors. Investigation revealed the facility did not have an effective system in place to proactively identify residents at risk for elopement, did not have a written policy for missing persons, did not provide adequate supervision and implement timely measures to reduce the risk of elopement as much as possible for R81 and R231. The facility did not demonstrate a commitment to safety and did not thoroughly investigate and analyze the elopements to identify targeted interventions for system improvement. As a result of these deficiencies, there was the potential that another elopement could occur which could result in resident harm or death, and an immediate jeopardy (IJ) was identified. The State Agency (SA) identified Immediate Jeopardy (IJ) on 11/19/21 at 11:00 AM. On 11/19/21 at 11:49 AM, the Administrator and Assistant Administrator (AADM) were notified of the IJ at 483.25 (F689) and provided with the IJ template. The Administrator signed the template to attest receipt of the notice. On 11/22/21 at 01:42 PM, the facility provided a removal plan approved by the SA. The removal plan consisted of development of an elopement risk assessment tool which was used to assess all residents in the facility, implementation of a safety monitoring system to ensure safety of all residents, development of an Elopement and Wandering Policy and Procedure, and staff training regarding all of the above. On 11/23/21 at 08:14 AM, the SA finalized onsite verification that the IJ Removal Plan had been implemented	F 689	reflect the resident at risk for elopement. A wander guard was also applied; the resident was added to the elopement book. E2: All residents have the potential to be affected. Upon notification of the Ij, all residents were assessed to determine if they were at risk for wandering or elopement. Residents who were deeded at risk for wandering were moved closer to the nursing desk until their care plan could be updated and reviewed. The exit doors were checked and alarmed. A wonder guard was placed on the residents who are at risk for elopement. An order was obtained to check the wander guard daily. A QAPI meeting was held to review the IJ . A Binder was developed and placed at each nursing desk and at the front hospital entrance that has a list of residents who are at risk for elopement. Elopement training and locating a missing resident was added to all new hire orientation. Residents who require seizure pads are at risk deficient practice. Residents who receive a shower are at risk for this deficient practice. E3: The Elopement policy, Missing Persons Policy, wandering , Communicating with Persons with Limited English Proficiency Policy, Preventive Maintenance Policy, Shower Policy, Seizure Precaution Policy was updated and reviewed and deemed appropriate by management. All Staff will be educated on: Elopement, missing persons,	

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F 689	Continued From page 47 and confirmed IJ Removal, however a pattern of deficient practices at F689 remain. Based on observation, interview, and record review, the facility failed to ensure two other residents in the sample were free from accident hazards. Resident (R)78 was left unsupervised in the shower, resulting in the resident falling from the shower chair to the floor, and R83 had large seizure precaution pads placed improperly on his bedrails, creating a risk for entrapment. This deficient practice has the potential to affect all the residents at the facility. Findings include: 1) The Office of Healthcare Assurance (OHCA) received a facility incident report (FRI) ACTs # 7931 regarding the elopement of R281 on 12/05/19. R281 was found in the parking lot at 03:15 PM by a visitor. "Per resident she wants to go home. Resident was assisted via wheelchair back to facility. ...Wander guard placed on wheelchair. ...Resident had pneumonia and new onset of confusion." RR of R281's progress notes and physician history and physical revealed the following: R281 was a 82 year old female with history of Alzheimer's dementia, and a stroke with residual right-sided weakness admitted to the facility 08/31/18. Her Brief Interview of Mental Status (BIMS) score on 11/01/19 prior to the elopement was 3 (three), severe cognitive impairment. 12/06/19 01:30 PM Social Service note: "Informed by nursing that resident was found in the parking lot yesterday afternoon. Told nursing she wanted to go home. ...Resident stated in	F 689	wandering, Communicating with Persons with Limited English Proficiency, preventive maintenance and Shower, Seizure precautions policy and procedure . licensed nurses and registered nurses were educated on the wandering assessment. The maintenance team will be in-serviced on notifying the admin of deficiencies observed during PM rounds that could affect the safety of residents. The nursing staff will be educated on how to properly place the seizure pads on the bed E4: The Director of nursing or designee will audit all new admits, readmits and for residents who have had a change of status weekly for 8 weeks to ensure compliance with the elopement policy & procedure. The Director of nursing or designee will audit residents who have seizure pads once twice a week for 8 weeks to ensure proper placement of the pads The Director of nursing or designee will audit the random showers weekly to ensure the shower policy and procedure is being followed. The audit will be performed for 8 weeks. Audit results will be reviewed by the Risk Management/Quality Assurance Committee monthly x 3 months until a lesser frequency is deemed appropriate E5: The administrator is ultimately responsible for compliance Corrective action completion date: 2/04/22	

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Japanese that she wanted to see her family and go home, she had concerns about her husband. ..."

A request was made for an interpreter policy and investigation notes related to this event. The facility did not provide a policy and there were no investigation notes to document the incident was thoroughly investigated to prevent future elopements for residents at the facility.

2) The OHCA office received a FRI (ACTs #7977) regarding R231's elopement that occurred on 12/22/19 at approximately 11:30 AM. The report included "Staff member had been in residents' room and resident appeared to be sleeping. ...Upon staffs return to the unit a brief time later, staff noticed resident was not in his bed. ...Staff looked out the window and saw resident ambulating through the parking lot. 2 staff members approached him calmly asking where he was going. He stated he was going to the Salvation Army to get different shoes. ...Resident was placed on a 1:1 sitter. Resident continues to refuse to wear wander guard. It was placed on his wheelchair, but resident is ambulatory at this time. Care Plan (CP) updated. ...Resident still has confusion."

On 11/18/21 reviewed R231's progress notes, CP and physician notes which revealed the following: R231 was admitted to the facility on 10/01/19 for short term rehabilitation (rehab). He is a 66 year old male with degeneration of nervous system due to alcohol, severe protein-calorie deficiency, history of falling, Type 2 Diabetes, tremors, muscle weakness, anxiety, and homelessness. R231 can ambulate with a front wheel walker (FWW). On 12/13/19 R231's BIMS was

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documented to be 7 (seven), significant cognitive impairment.

11/21/19 10:35 PM Nursing note: "...At around 20:29, this writer saw resident came out from room 270 and was walking on [sic] the hallway, towards the elevator. ..."
11/26/19 03:52 PM Nursing note: "Resident with very poor safety awareness. ...Resident was wheeling self on [sic] the hallway. ..."
11/30/19 03:29 PM Nursing note: "Resident with episode of trying to elope from the facility. Resident was found front of entrance door and convinced to come back inside the facility...Resident persistent of going home."
12/02/19 CP documented "6am, resident seen getting out of the elevator on first floor." This incident was not documented in nursing progress notes.
12/06/19 08:06 AM Nursing note: "During endorsement to day shift, one of the day shift CNAs [Certified Nursing Aide] notified this RN [Registered Nurse] and day shift RN that pt. [patient] is outside walking in the parking lot. ...received a call from SW [Social Worker] at nurses' station that SW intern attempted to re-direct pt. to return to facility. However, SW reports pt. attempted to hit her, pt. fell backwards and hit head on grass. Pt. transferred back to facility via wheelchair."
12/06/19 11:14 AM Nursing note: "07:07 AM: As this writer walked down the hallway of activities and rehab rooms, I noticed an empty wheelchair with an active sounding chair alarm. As I turned off the alarm, resident...states, "The tall...man from upstairs walked out." ...As for this writer, I proceeded to walk to the parking lot. It was then I saw intern social worker, standing next to resident as he was sitting on the grass. Both

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where [sic] near the Thrift Shop on the side of Kilani Avenue, still within the grounds of hospital property. ...He attempted to step down onto the sidewalk of Kilani Avenue [he would have had to step 2 feet off ledge onto the sidewalk] but then CNA showed up with assistance and resident wheelchair..."
12/06/19 03:09 PM Nursing note: "Resident with poor safety [sic] Resident gets combative and angry when gets stop [sic] leaving the facility. ..."
12/09/21 07:55 AM Nursing note: "Refused wander-guard device"
12/11/19 11:35 PM Nursing note: "...Resident wanted to leave facility, but it is unsafe for patient to leave facility..."
12/13/19 MDS assessment (Minimum Data Set-assessment of clinical and functional status) significant change: "able to propel self in and out of the facility. ...Change of Condition wandering 1. Behavior of this type occurred 1-3 days. Does the wandering place the resident at significant risk of getting to a potentially dangerous place? (e.g., stairs, outside of the facility?) NO."
This behavior and elopement on 12/06/21 did in fact put R231 in a dangerous place. The parking lot has traffic with vehicles pulling in and out, and the ledge by the sidewalk was noted to be a two feet drop.
12/14/19 "Throughout NOC (night) shift, pt. would frequently get up from bed yet able to re-direct. However, at 07:00 pt. started to get up from bed again and became irritable yelling at staff when trying to re-direct back to his room. ...Security called and able to transfer pt. back to room."
12/21/19 03:55 PM Nursing note: "Throughout shift, pt. continues to get OOB [out of bed] to walk to bathroom or transfer self to w/c [wheelchair] without calling for assistance. Pt unsteady when ambulating. ..."

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12/22/19 05:25 PM Nursing note: "Resident walked out of facility @ approximately @11:30 towards library. Resident stated, "I want to go to Salvation army to get new shoes." Staff able to bring back resident back to facility with no difficulty. Continue to monitor."
12/23/19 09:44 AM Nursing note: "...Obtained order from MD1 for 1:1 [one-to-one] sitter."

RR of R231's CP revealed it was revised on 12/02/19 to include he was at risk for elopement. R231 first began displaying behaviors of risk for elopement starting on 11/30/19. He eloped 12/07/19, and a second time on 12/22/19.

Request made to the Administrator for all documentation related to R231's elopement. on 12/22/19. The facility provided the internal incident report and a handwritten statement by the CNA who identified R231 missing. The statement included "...When I was done, I went back to check on [R231]..., but he was gone. When I looked out the window he was walking and already exiting the visitor parking lot. ...took a wheelchair...ran to retrieve pt. [R231] that was on the corner of Lehua + Center St." There was no additional documentation to indicate a thorough investigation had been completed.

3) The OHCA office received a FRI (ACTs #8911) regarding R81's elopement on 06/01/21. The report included: R81 was admitted to the facility on 05/27/21 for short term rehabilitation (rehab) and skilled nursing services after she had a fall at home with a closed head injury. She is alert and oriented to name, place, and time. R81 was ambulatory and had a steady gait. "Per resident's latest PCP (primary care physician) notes, resident with history of confusion and behaviorally

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difficult sometimes at home. At approximately 20:00 [08:00 PM], assigned CNA checked on resident in her room. She was sitting at the edge of her bed. Approximately 30 minutes later, assigned CNA went back to her room and resident was yelling but still in her room. ...At approximately 20:43, assigned RN went to check on resident in her room and she was not there. Resident was found on the sidewalk along Lehua Street, next to the...Public Library building approximately 20:48. She was very difficult to redirect and refused to come back to the facility, yelling she wanted to go home. Staff brought a wheelchair and asked her to sit in it for safety reasons...staff were able to bring resident back."

Reviewed R81's progress notes, MDS assessments and Physician notes on 11/18/21 which revealed the following:
05/21/21 R81 was admitted to the second floor admission unit (Room 213). R81 is 82 years old. Her admission MDS dated 6/02/21 indicated she had a BIMS of 13, intact cognitive response. Her functional status documented she was unsteady walking and normally used a walker or wheelchair.
05/28/21 10:57 PM Nursing note: "At this time, patient (R81) was sundowning (refers to a state of confusion occurring in the late afternoon and spanning into the night and can cause a variety of behaviors such as confusion, anxiety, aggression or ignoring directions.)...Later, the patient called a taxi service to bring her home. Patient got out of bed and ambulated in hallway to go home. ...got OOB (out of bed) independently without staff x4 (four times)." The taxi was canceled by staff.
05/29/21 11:38 PM Nursing note: "saying that she (R81) wants to go home and attempted to call police. Difficult to redirect. Resident kept saying

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that we're keeping her hostage. Ambulatory with/without device."
05/30/21 05:10 AM Nursing note: "...Attempted to leave facility but staff able to redirect and assisted back to her room..."
05/31/21 07:11 AM Rehab note: "ST (speech therapist) administered the Saint Louis University Mental Status Examination (SLUMS). Pt obtained 9/30 placing her in the "Dementia" range."
05/31/21 02:12 PM Nursing note: "... Ambulated 120 ft with FWW (front wheel walker)."
06/01/21 02:41 PM Nursing note: "transferred from [Room 213]...Resident (R81) continuously yelling at staff members claiming that she is being held against her will. Resident stated, "You are keeping me incarcerated which is illegal!" Resident is very difficult to redirect when yelling at staff members. Resident began wandering around unit this morning. ...Resident later found walking halfway down the stairwell (located close to main entrance/exit) by PT (Physical Therapy). ...."
06/01/21 09:44 PM Nursing note: "Resident left facility at 20:45 with no device (wheelchair or walker) and was found along Lehua Street sidewalk next to the library building. Staff had to have resident sit in wheelchair to be able to bring her back to the facility.
The Public Library is located on California Avenue, a busy main street, which is approximately .2 miles or 5 minute walk for average adult per Google map. R81 would have crossed one street that has a stop sign.
06/01/21 10:36 PM Nursing note: "New order from MD2 (Physician) resident on PO (oral) Donepezil 5 mg (milligrams) HS (at bedtime) for dementia with behaviors and may send resident to ER (Emergency Room) for psychiatric emergency."

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06/02/21 04:38 PM Social Services note: "SW (Social Worker) with resident to f/u on her elopement from the facility last night. "Resident states she was hitchhiking to go home." SW talked to resident about the potential for harm and/or injury with leaving the facility unattended." On 06/02/21 after R81 eloped, her CP was revised to add she was an elopement risk. R81 began exhibiting behaviors starting 05/28/21.

Requested the Administrator to provide all facility investigation notes related to R81's elopement. The facility provided the report sent to the OHCA office and one written statement signed and dated 06/01/21 by the CNA on duty at the time of the elopement. The statement read; "After my dinner break at 20:00 I check [R81] in her room. She was sitting on side of her bed. After 30 minutes I went to her room, she was yelling "I want to get out of here, call the police." I told her tomorrow you can talk to them about going home. ...I want to go home tonight. ..." The facility did not do a thorough investigation, and did not analyze the elopement to identify opportunities or develop targeted interventions to reduce the potential for further elopements. There was no documented follow-up with the CNA who heard R81 verbalize she was going home that night before she eloped.

The facility did not have a process in place to proactively identify residents at risk for elopement. Review of the facility policy dated 09/2020 titled "Admission Procedure to...[facility]" directed nursing to complete the facility Admissions Checklist within 24 hours of admission. The checklist did not include any assessment for risk of elopement.

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The Assistant Administrator (AADM) and Director of Nursing (DON) could not verbalize the process staff use to identify a resident at risk for elopement. During an interview with the DON, she said they did not have a tool and acknowledged there was not a standardized method for assessment for risk of elopement. If a resident had a known history of wandering identified when the MDS admission assessment was completed, the problem would get care planned. This would not be considered standard of care.

4) On 11/16/21 at 01:16 PM, Surveyor (S)1 performed a tour of the first-floor unit. S1 observed a back door fire exit that leads out to the street across from the post office. S1 along with the AADM and Long Term Care Coordinator (LTCC)1, tested the alarm on the back door, and no alarm went off. It was observed that the door exited out onto a narrow cement pathway that declined steeply to the sidewalk approximately 20 feet below. LTCC1 stated that the red light indicator on the alarm was lit, so it should be working. Both the AADM and LTCC1 validated that the alarm should be on at all times. LTCC1 stated she would alert Maintenance, and the AADM stated they would "take care of it."

On 11/16/21 at 02:11 PM, an interview was done with LTCC1 at the first-floor nurses' station. LTCC1 reported that there were four residents on the first-floor unit who could self-propel in their wheelchairs, and none of the residents could ambulate independently. A review of the facility's fire exit logs indicated the door alarm was initially documented as not working on 11/15/21.

On 11/16/21 at 03:39 PM, the AADM entered the

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conference room to state that the door alarm had been fixed and was operational.

On 11/18/21 at 09:30 AM, S2 toured the facility to identity exits and security systems in place. The facility is a two floor building (Building A and Building B). There is one set of elevators in Building B located at the main entrance/exit. There are three stairwells (STW) accessible in this area. STW1 is located next to the elevators and main entrance that do not have alarms. STW2 (no alarms) Building B is located outside Room (Rm) 268, and STW3 (Fire alarm exit with alarm) Building A exits to a steep walk to the sidewalk located by Lehua Street. There are two sets of double doors, one (unmonitored /no alarm) located across from Rm. 268 which has access to STW3, and another with door alarm on the first floor by the activities room that exits the long term care (LTC) area and enters another section of the facility that includes the cafeteria, hospital departments and several other rooms. The LTC main entrance door had an alarm and is locked for entry, but anyone can exit. The door alarm system should activate an audible alarm if a resident is wearing a transmitter (wander guard/bracelet) that has been applied correctly. There is no direct visualization of the main entrance by facility staff.

On 11/19/21 at 01:45 PM, when asked the Administrator if she had the elopement policy requested the previous day, she said, "We don't have one and are working on one now." The Administrator acknowledged she was aware they needed a policy because the Emergency Management Committee had identified it was a required element for the LTC Emergency Preparedness Program.

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F 689	Continued From page 57 On 11/19/21, a request was made to the AADM for the content of staff orientation on elopement. The facility did not provide this information during the survey. On 11/23/21 reviewed the installation manual of the Secure Care 135DE system, the door alarm system. The system consists of mounted hardware on doorways or near the exits and transmitters (bracelets) that are recommended to be placed on the residents' leg because of where the alarms are mounted. When the resident passes through the door, an alarm will sound to alert staff. The installation manual "Section 11 Testing" provides instructions how and when to test the system to ensure it is functioning. The recommendation for testing the doors and transmitters is to use a handheld tester. On 11/22/21 at 10:00 AM, conducted an interview with the Chief Operating Officer, Lead Engineer, and Director of Facilities who said they do not perform any preventive maintenance on the door alarm system. They went on to say they didn't know if the facility had a hand held tester because Nursing tests the transmitters and only sends a work order if something is not working. On 11/22/21 at 10:30 AM, during an interview with the DON, she said they do not have a hand held tester and the staff test the transmitter bracelets by taking the residents to the door to see if it activates. The facility does not document testing or daily checks to ensure resident wander guard bracelets are on.	F 689		

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On 11/22/21 at 11:15 AM interviewed the Unit Clerk (UC)2 who said they usually keep a couple of the wander guard bracelets on the first and second floor, but they were currently out. She later informed surveyor they had been ordered last Friday (11/19/21) but had not yet arrived. One bracelet was later located on the first floor.

Reviewed the Facility Assessment dated 10/19/21 which identified the diagnoses and conditions residents in the facility had when the assessment was completed. The facility had six residents with care plans (CP)s for behavioral health needs, 15 residents who had Dementia/Impaired cognition, one with schizophrenia, five with depression, nine with anxiety disorder, one with psychosis and one with bipolar disorder. These conditions and combinations of conditions would be considered common types of residents/conditions the facility may accept as admissions, or that residents may develop and that the facility assessed themselves to have the necessary resources needed to care for them.

5) On 11/16/21 at 08:58 AM surveyor initially observed R63's entrance to her room obstructed with a wheelchair. R63 was lying on her side sleeping, her breakfast tray on the bedside table untouched.

On the same day at 12:25 PM, CNA6 was observed to be entering her room. The wheelchair was still obstructing the entrance to her room. R63 was still sleeping in bed. CNA6 stated, "If we don't wake her up for lunch, she will skip lunch too."

On 11/18/21 at 09:30 AM, it was identified by the survey team that R63 resided across of STW3 and that R63 had a history of elopement.

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On 11/19/21 at 11:00 AM an immediate jeopardy (IJ) situation was found for elopement at the facility of three residents (R81, R231, and R281). R63 was identified as being high risk for elopement and was added to the resident sample for investigation.

On 11/22/21 at 08:19 AM, R63's Electronic Health Record (EHR) was reviewed. Her Quarterly MDS of assessment review date (ARD) 10/08/21 revealed that her BIMS was "03," indicating severe cognitive impairment. R63's CP revealed: "Resident at risk for Elopement related to Dementia Related Diagnosis, Episodes of Wandering, Poor Safety Awareness..."

On 11/22/21 at 02:20 PM, R63 was observed to be sleeping in bed. She still resided in the room across of STW3. The left door of the double doors at the end of the hallway where she resided was propped open to block the door to STW3.

On 11/22/21 at 02:30 PM, LTCC2 was queried about R63. She stated that R63 prefers to sleep during the day and is awake during the evening time where she likes to come out of her room utilizing her walker and stays in the hallway. She is able to be redirected if she goes into any other resident's room. There is only one CNA in the evening assigned for the hallway that R63 resides on.

On 11/23/21 at 09:00 AM, surveyor verified that R63 was still in her same room across from STW3. LTCC2 stated that R63 needed to be moved to another room.

On 11/23/21 at 11:45 AM, surveyor followed up

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with LTCC2 and AADM to see if a plan was in place to transfer R63 to another room. According to AADM, there had been no plan formulated and AADM stated that R63 will be transferred to another room.

6) Resident (R)78 is a 59-year-old female admitted to the facility for short-term rehabilitation on 07/21/21, following a stroke that resulted in left-sided paralysis and weakness. Other admitting diagnoses include heart failure, hyperlipidemia, depression, and anxiety. On 11/16/21 at 12:08 PM, during an interview with R78 in her room on the first floor, R78 shared that she had experienced an unattended fall in the shower room "about a month ago." R78 stated that it happened when she was still on the second floor, while the certified nurse aide (CNA) began to shower her, R78 dropped the washcloth on the floor. The CNA then left her alone, seated in the shower chair, while she went to grab a clean washcloth. R78 bent down to pick up the washcloth still sitting on the floor, lost her balance and fell off the shower chair. R78 stated she sustained a "black eye and some scrapes on my face."

On 11/18/21 at 11:11 AM, a review was done of R78's electronic health record (EHR). A Nursing Progress Note was found briefly detailing R78's unattended fall on 08/19/21 at 01:40 PM. A review of the Fall Scene Investigation Report from 08/19/21 confirmed that R78 was left alone in the shower room and fell, sustaining an abrasion on her forehead and with resulting complaints of pain to her left shoulder and left knee. A review of R78's comprehensive care plan noted that R78 had been identified as a falls risk upon admission, and her falls care plan

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included the intervention: "Provide a safe environment at all times."

On 11/23/21 at 09:11 AM, during an interview with the Director of Nursing (DON) in her office, the DON validated that the CNA should not have left R78 in the shower unattended and had received training not to do so.

7) Resident (R)83 was admitted to the facility on 11/09/21 after falling at home and sustaining a right arm fracture. The resident's admitting diagnoses include a fractured right arm, hypertension, Alzheimer's disease, epilepsy, depression, and insomnia. R83 has a history of falls. The resident's admission Minimum Data Set (MDS) was in progress and had not yet been submitted.

On 11/19/21 at 12:46 PM, conducted an interview with Long Term Care Coordinator (LTCC)2, while LTCC2 reviewed R83's Electronic Health Record (EHR). Reviewed an admission assessment for the use of side rail/device which was effective on 11/09/21 at 04:12 PM. The admission assessment documented the bed side rails were to assist the resident with bed positioning and mobility, transferring in and out of bed, daily care (holding of SR (side rail)), and padded Halo Bars for seizure precautions. After reviewing R83's EHR, observed R83 with LTCC2. R83 was lying in bed and attempted to reach for the bed rails for assistance. When R83 reached for the halo side rail bar, the bed rail padding obstructed the resident from being able to grab the halo side rail bar. As R83 continued to reach for the halo side bar, the padding spun around the halo side bar causing the resident to slip between the bed and side rail padding and the resident's body fell

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F 689	Continued From page 62 toward the bed rail. Inquired with LTCC2 if the bed rail padding was safely installed to ensure it was not an accident hazard for the resident. LTCC2 inspected the halo side rail bar and the bed rail padding and confirmed the bed was not equipped with the correct bedrails to support the proper use of the bedrail padding and the current set-up was an accident hazard to the resident.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one resident sampled was offered/received sufficient fluids to maintain proper hydration and health.	F 692	E1:Resident R234 has been discharged E2: Residents have the potential to be affected. All residents were audited to ensure they had the appropriate hydration	2/4/22

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F 692	Continued From page 63 Findings include: Resident (R)234 was admitted to the facility on 11/11/21 with diagnoses including a urinary tract infection related to E.Coli, aortic aneurysm without rupture, and a right shoulder rotator cuff tear. The resident's admission Minimum Data Set (MDS) was in progress and had not been completed. On 11/17/21 at 09:30 AM, conducted an interview with R234. Observed R234 with dry lips that were peeling. Inquired with the resident if the he/she was offered a plastic pitcher of water or any type of container that could hold fluids, so the resident was able to drink as needed. The resident stated he/she was not offered any container to have water at the bedside when he/she wanted. R234 confirmed often feeling thirsty and received fluids only with meals and when taking medication. On 11/17/21 at 09:45 AM inquired with Team Leader (TL)5 if R234 was given a pitcher of water to ensure the resident had access to hydration as needed. TL5 confirmed R234 did not have a pitcher for water and had not had one since admission. On 11/18/21 at 12:30 PM, conducted an interview with Long Term Care Coordinator (LTCC)3, while LTCC3 reviewed R234's Electronic Health Record (EHR). Review of R234's Physician Orders documented the resident was ordered thin liquid consistency on his/her diet order. LTCC3 confirmed the resident was not at risk for aspiration. R234's Care Plan (CP) documented nutritional risk was related to the resident's	F 692	cup on 1/7/21 E3: The Hydration policy was updated and reviewed and deemed appropriate by management . Staff will be educated on hydration policy and procedure. E4: The DON or designee will audit residents 50% of residents weekly x8, for the appropriate hydration cup and any signs and symptoms of fluid balance deficit. Audit results will be reviewed by the Risk Management/Quality Assurance Committee monthly x 3 months until a lesser frequency is deemed appropriate. E5: The administrator is ultimately responsible for compliance Corrective action completion date: 2/04/22	

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F 692	Continued From page 64 suboptimal fluid intake (initiated on 11/11/21, revised on 11/18/21) with interventions to monitor R234's daily fluid requirements to meet goal range and no fluid restriction (initiated on 11/1/21 and revised on 11/18/21). LTCC3 stated the resident is offered fluids during the "social hour". LTCC3 navigated the chart and could not find documentation confirming R234 had received fluids during social hour. Review of a progress note written by the Registered Dietician (RD) documented R234 is dependent on staff for provision of fluids and drinking less than 1000 milliliters per day.	F 692		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure one resident sampled received treatment and care in accordance with professional standards of practice for pain management. The facility did not include non-pharmacological interventions, and did not include pharmacological interventions to treat moderate or severe pain for Resident(R)83, who was admitted with a fractured right arm. As a result of this deficiency, the resident is at risk of physical and psychological harm related to unmanaged pain. Findings include:	F 697	E1: R 83 has been discharged E2: All Residents have the potential to be affected. Nursing will conduct a pain assessment on residents to identify any unmet pain needs or changes in pain. Residents who have unmet pain needs will have their care plan updated and there medications reviewed by the physician E3: The Pain management policy was updated and reviewed and deemed appropriate by management. Registered nurses and Licensed practical nurses will	2/4/22

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F 697	Continued From page 65 R83 was admitted to the facility on 11/09/21 after falling at home and sustaining a right arm fracture. The resident's admitting diagnoses include a fractured right arm, hypertension, Alzheimer's disease, epilepsy, depression, and insomnia. R83 has a history of falls and benign brain tumors. The resident's admission Minimum Data Set (MDS) was in progress and had not yet been submitted. On 11/17/21 at 08:59 AM, this surveyor was seated at the nursing station an heard a resident continuously yelling "I'm sore, help, I need my medication, I'm in pain, hurry up!" Staff entered R83's room to calm the resident down. R83 continued to yell out in pain despite staff telling the resident Team Leader (TL)5 was getting his/her pain medication. On 11/17/22 at 4:22 PM, conducted a RR of R83's Electronic Health Record (EHR). Review of the resident's care plan documented non-pharmacological interventions were not included as part of R83's pain management interventions. Review of R83's physician's orders documented an order for Acetaminophen 650 milligrams (mg) every 4 hours as needed for mild pain 1-3/10 (on a scale of 1-10 where 10 is severe pain) as the only pharmacological treatment option. Review of the resident's November 2021 Medication Administration Record (MAR) documented R83 was administered Acetaminophen 650 mg for pain a total of 11 times; 7 of 11 administrations, R83 reported pain levels higher than 3/10. 11/10/21 at 9:30 AM, 4/10; 11/11/21 at 09:34 AM, 4/10	F 697	be educated on the pain management policy and procedure. E4: The DON or designee will audit 50% of residents once a week for x 4 weeks, then audit 25% of residents x 4 weeks to ensure residents pain needs are met & that the appropriate pain assessments are performed. Audit results will be reviewed by the Risk Management/Quality Assurance Committee monthly x 3 months until a lesser frequency is deemed appropriate. E5: The administrator is ultimately responsible for compliance Corrective action completion date: 2/04/22	

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F 697	Continued From page 66 11/13/21 at 00:40 AM, 5/10 and at 3:11 PM, 4/10; 11/15/21 at 10:01 AM, 5/10; 11/16/21 at 5:46 PM; and 11/17/21 at 9:15 AM. On 11/19/21 at 10:10 AM, conducted a concurrent interview and review of R83's Electronic Health Record (EHR) with Long Term Care Coordinator (LTCC)2. LTCC2 navigated R83's EHR during the interview. The LTCC2 confirmed R83's care plan did not include non-pharmacological interventions. Review of the resident's November 2021 Medication Administration Record (MAR) confirmed staff erroneously administered Acetaminophen 650 mg (for mild pain;1-3/10) despite R83 reporting a high level of pain. LTCC2 confirmed the professional standard practice for pain management includes the implementation of both non-pharmacological and pharmacological interventions. Non-pharmacological interventions should be offered first and in conjunction with pharmacological interventions and R83 should have had pharmacological interventions to address moderate and/or severe pain. Inquired if staff should have contacted the medical doctor to obtain an order for a pain medication that would alleviate R83's pain more effectively. LTCC2 reviewed a secure message system used by staff as a form of communication. The secure messaging system documented staff informed Medical Doctor (MD)3 that R83 was still complaining of pain, rated above 3. As of 11/19/21 at 1:05 PM, no order addressing R83's reported pain higher than 3 had been obtained.	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l)	F 698		2/4/22

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F 698	Continued From page 67 §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide for the appropriate nursing care of one resident, R51, who receives hemodialysis (HD) treatments. This deficient practice is a neglect of the facility to ensure that the resident is safe from potential complications after receiving a medical treatment. Findings include: On 11/17/21 at 08:40 AM, R51 was asked if her dialysis access implanted into her right arm was checked by the nurse before and after her HD treatments, she nodded yes. When further queried, R51 stated, "You talk to my daughter" conveying that she had minimal understanding of English. On 11/18/21 at 09:59 AM, TL6 was queried about the care for HD residents surrounding their HD treatments. She stated that vital signs (VS) are taken before and after their HD treatments. There is also an HD communication book for the resident to bring to the HD facility that is used as a tool for continuity of care. On 11/18/21 at 10:35 AM, R51's EHR was reviewed. R51's care plan for "Hemodialysis" revealed that she receives HD on Monday, Wednesdays, and Fridays and is out of the facility from 10:30 AM to 5:30 PM. VS are to be checked	F 698	E1: The Resident Care plan and orders will be reviewed and updated as needed. E2: Residents who receive dialysis have the potential to be affected. E3: The Hemodialysis policy was updated and reviewed and deemed appropriate. Registered nurses and Licensed practical nurses will be educated on policy and procedure by management. Registered nurses and Licensed nurses will be educated on obtaining and recording post dialysis vital signs. E4: The DON or designee will audit all Dialysis residents post dialysis vitals signs once a week for x 8 weeks, Audit results will be reviewed by the Risk Management/Quality Assurance Committee monthly x 3 months until a lesser frequency is deemed appropriate. E5: The administrator is ultimately responsible for compliance Corrective action completion date: 2/4/22	

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F 698	Continued From page 68 "per routine." Reviewed R51's "Weights and Vitals Summary" and there were no VS documented in the afternoon of 10/18/21, 10/27/21, and 11/01/21. The "*Nursing Progress Note (Narrative)" were reviewed for the same days and no VS were documented. On 11/18/21 at 03:38 PM, the facility's "Care of the Pre and Post Hemodialysis Resident" revised on 10/2020, was reviewed. It stated, "16. Check vital signs upon return to the unit. Assure resident is hemodynamically stable." (Refer F656 Develop/implement Comprehensive Care Plan)	F 698		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to provide a supportive physical, mental, and psychosocial environment that provided for the behavioral health for one resident ((R)48) in the sample. The facility failed to provide an accurate behavioral picture of the resident, did not recognize that his history of homelessness and his desire to be discharged could potentially be a trigger for his	F 740	E1: The IDT team will hold a behavioral health meeting for resident 48. Based on the results of the meeting, the resident 48 care plan will be updated to reflect his current psychosocial needs. E2: Residents have the potential to be affected. E3: The Comprehensive care plan & behavioral Health Services policy was	2/4/22

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F 740	Continued From page 69 behaviors and did not have an appropriate policy for residents with behavioral issues. This deficient practice is the facility's failure to maintain R48's highest possible level of functioning and well-being and could potentially affect all residents. Findings include: On 11/16/21 at 12:38 PM, an initial observation was made of R48 sitting upright in bed with his lunch tray in front of him. R48 looked distressed and stated, "They're taking my money!" R48 did not want to further converse with the surveyor. At 1:37 PM, R48 laid quietly in bed, looking out the window. At 2:35 PM the surveyor observed R48 yelling out, "Get outta here!" to certified nurse aide (CNA)16 when he walked into his room. CNA16 immediately walked out of R48's room without engaging with R48. On 11/17/21 at 08:17 AM, observed R48 sitting upright in bed with his untouched breakfast tray in front of him. Licensed practical nurse (LPN)1 was preparing medications at her medication cart in the hallway and stated that he received his breakfast about five minutes ago. At 08:26 AM, R48 was observed to be yelling out angrily, "Stay away!" out the door to staff passing by his room. R48 was now dangling at the edge of his bed with his bedside table pushed to the side and was throwing items from his breakfast tray out the door. R48 was occasionally mumbling to himself. R48 became verbally abusive and threw more items out of his room into the hallway. Long term care coordinator (LTCC)2 picked up items from the floor and	F 740	updated, reviewed, and deemed appropriate. The IDT will be educated on The Behavioral Health Services & The Comprehensive care plan policy and procedure. Daily clinical review for newly admitted/re-admitted residents and residents with clinical changes will be reviewed for potential revisions or updates to the care plan interventions. The facility care plan policy and procedure were updated and/or reviewed and deemed appropriate. E4: The Director of Nursing Services (DNS), or designee, will complete “10” random weekly audits of care plans for eight (8) consecutive weeks. Random audits will be completed to ensure that comprehensive care plans are developed for residents. Care plans will be reviewed weekly in accordance with the care plan review schedule by the Social services department. All care plans will be updated as indicated. The Social social director will maintain a list of residents for review during the monthly psychotropics meeting. Audit results will be reviewed by the Risk Management/Quality Assurance Committee monthly x 3 months until a lesser frequency is deemed appropriate. E5: The administrator is ultimately responsible for compliance Corrective action completion date: 2/4/22	

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discarded them into the trash. She did not engage with R48. R48 then threw his breakfast plate out the door, the plate loudly crashing onto the floor. Several staff tried to engage with R48, but he angrily yelled, "Get the fuck out!"

At 09:18 AM, R48 was in sitting in his bed in his room quietly communicating with a staff member using a whiteboard.

On 11/18/21 at 2:42 PM, R48's electronic health record (EHR) was reviewed. His diagnoses included: sepsis (blood infection) stemming from cellulitis (serious bacterial skin infection) of both legs, Wernicke's encephalopathy (problems with memory and disorientation arising from thiamine (vitamin B1) deficiency), urinary tract infection, homelessness, and liver disease. He was admitted to the facility on 04/08/21.

A progress note for R48 documented by social worker (SW)1 on 04/20/21 at 09:18 AM, revealed that he was homeless with no known support, and he desired to return to homelessness. He had no known history of any mood or behavioral issues. Another progress note by SW1 on 10/21/21 at "14:53" (2:53 PM) stated that R48 refused to cost share his Medicaid and stated that he rather be homeless.

R48's admission Minimum Data Assessment (MDS) of 04/14/21 under Section D for Mood, showed that his Resident Mood Interview (PHQ-9©, depression screening) score was two (minimal depression). Under Section E for Behavior, R48 did not exhibit any physical or verbal behavioral symptoms towards others.

R48's MDS quarterly assessment of 09/24/21

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under Section D for Mood revealed his PHQ-9© score was twelve (moderate depression). Section E for Behavior, R48 had physical and verbal behavioral symptoms towards others (one to three days of the seven day look back period).

On 11/18/21 at 3:40 PM, the facility's "Mood and Behavior Monitoring Program" policy was reviewed. Noted the policy was last reviewed on 10/2021, had a "DRAFT" watermark and was not signed by the Director of Nursing (DON) and Administrator. The policy only referred to the care of residents on psychotropic (affecting the mental state) drugs.

On 11/21/21 at 3:13 PM, R48's "Behavior Monitoring" flowsheet was reviewed from 10/23/21 to 11/21/21. Behaviors of "Rejection of Care" occurred eight of the 20 days in November, no behaviors were documented for the latter part of October. "Yelling/Screaming" occurred only two of the 20 days in November, none in October. There were no behaviors documented for those observed by the surveyor on 11/17/21.

R48's progress notes were reviewed. In a note documented by team leader (TL)2 on 10/28/21 at "22:03" (10:03 PM), R48 refused care, yelled at the certified nursing assistant (CNA) and "swear at her." Another note documented on 11/17/21 at "03:01" by TL3 stated, "Trying to throw stuff and curse to the CNA." R48's "Behavior Monitoring" flowsheet did not have documentation for "Rejection of Care," "Yelling/Screaming," and "Abusive Language" on 10/28/21. "Abusive Language," and "Threatening Behavior" also were not marked for 11/17/21. (Refer to F842 Resident Records - Identifiable Information)

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F 740	Continued From page 72 A progress note documented by social worker (SW)1 on 11/17/21 at 09:42 AM stated that R48 was upset about not being able to be discharged to a foster home. R48's care plan was not individualized to provide appropriate behavioral care for his history of homelessness and his desire to be discharged from the facility. His care plan also did not provide individualized interventions on how to manage his refusals of care, verbally abusive behavior and desire to be isolated. An interview was done with SW1 on 11/22/21 at 09:46 AM in the sitting area on the second floor. She stated that being homeless can be a traumatizing event and should be care planned. She also stated that the activities department is very important in managing behaviors. An interview was done with the activities director (AD) on 11/22/21 at 10:11 AM in the sitting area on the second floor. He stated that R48 liked his outing to the bank in May, where the bank worker recognized him. He also stated that R48 did not like "new people." These individual interventions were not inputted into R48's care plan.	F 740		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and	F 744	1: The IDT team will hold a behavioral	2/4/22

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F 744	Continued From page 73 interviews, the facility failed to provide appropriate care of Resident (R)52's behaviors related to her dementia. Staff did not provide interventions for R52 as she was yelling in her room behind a closed door, individualized interventions were not outlined in her care plan, and a Dementia Care policy had not been implemented at the facility. This deficient practice is a failure of the facility to recognize R52's distress and provide appropriate care for her, and has the potential to affect all residents with dementia. Findings include: On 11/16/21 at 12:53 PM, surveyor saw R52 eating her lunch and R52 stated that her lunch was good. On 11/18/21 at 09:30 AM, surveyor observed R52 watching television and was able to engage in a conversation with R52 about the television program she was watching. On 11/19/21 at 2:03 PM, surveyor observed the door to R52's room was closed and that R52 was yelling constantly, sounding distressed. Team leader (TL)2 was standing in the hallway outside her door. On 11/19/21 at 3:30 PM, the facility's "Dementia Care" policy was reviewed. The date of implementation was 11/19/21. Specifics include the following: "3. The care plan interventions will be related to each resident's individual symptomology ..." "4. Care and services will be person-centered ..." "5. Individualized, non-pharmacological approaches to care will be utilized, to include meaningful activities aimed at enhancing the resident's well-being."	F 744	health meeting for resident R52. Based on the results of the meeting, resident R52 care plan will be updated to reflect his current psychosocial needs E2: Residents with a diagnosis of dementia have the potential to be affected. A care conference will be held for residents with a current diagnosis of dementia. Their Care plan will be updated and reviewed to reflect their current psychosocial needs. E3: The Comprehensive care plan & Dementia policy was updated, reviewed, and deemed appropriate. Staff will be educated on the dementia policy and procedure. E4: Care plans will be reviewed weekly in accordance with the care plan review schedule by the MDS Coordinator(s). All care plans will be updated as indicated. The Director of Nursing Services (DNS), or designee, will complete 10-random weekly audits of care plans for eight (8) consecutive weeks. Random audits will be completed to ensure that appropriate dementia interventions are developed & care planned for residents. Audit results will be reviewed by the Risk Management/Quality Assurance Committee monthly x 3 months until a lesser frequency is deemed appropriate. E5: The administrator is ultimately responsible for compliance Corrective action completion date: 2/4/22	

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On 11/21/21 at 8:07 PM, R52's electronic health record (EHR) was reviewed. R52's diagnoses included: other sequelae of cerebral infarction (altered sensation after stroke), moderate protein-calorie malnutrition, unspecified dementia (persistent loss of intellectual functioning) with behavioral disturbance and paraplegia (paralysis of the lower extremities). Progress notes were reviewed, and it revealed that R52's family refused for her to be on medication to manage her behaviors because it made her sleepy. Numerous progress notes were documented for injuries inflicted by R52 to herself, and injuries inflicted by R52 to staff. A progress note written by Social Worker (SW)2 on 07/14/21 at 16:42 (4:42 PM), stated that "Resident will respond positively in casual discussion, topics of her interest, likes to talk about her own interests, past jobs, activities that she participated in during her youth, water sports, beach." R52's care plan did not have these individualized interventions on how to care for R52. The only intervention listed if she becomes physically abusive was "SW to counsel resident when guidance is needed." For activities, R52's care plan stated, "offer to (sic) opportunity to go outside for fresh air and sunshine as tolerated." There was no progress note documenting R52's persistent yelling observed by the surveyor on 11/19/21 at 2:03 PM and if any interventions were provided by staff to relieve R52 of her distress.

On 11/22/21 at 09:35 AM, R52 was lying in a 45-degree angle in bed, her television was off, and a cell phone was noted on her bedside table close to her. She had a music player that was off on her bedside table and a note on her wall stated, "Keep radio on Christian station per

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F 744	Continued From page 75 family's (Son) request." This intervention was not documented on R52's care plan. She asked surveyor to look for her blue shoes. On 11/22/21 at 09:46 AM, SW1 was interviewed in the sitting room on the second floor. She stated that if the family is called when she has behaviors, it seems to help. Also visits will help, if someone is there to talk to her, she'll calm down. She likes to talk to someone. These individualized interventions should be in her care plan. She also stated that the activities department is very important in managing behaviors. On 11/22/21 at 10:11 AM, the Activities Director (AD) was interviewed in the sitting room on the second floor. He stated that R52 is good with one-to-one visits and likes to "talk story" and she watches some television. She looks at magazines sometimes and she didn't like it when we got her up to go to the patio. On 11/22/21 at 10:40 AM, CNA3 was interviewed in the hallway a couple of doors down from R52's room. She stated that R52 asks for things when she is uncomfortable, so we try to make her comfortable and she is okay.	F 744		
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;	F 758		2/4/22

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F 758	Continued From page 76 (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 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	F 758		

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F 758	Continued From page 77 the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, interviews observation and review of policy and procedures, the facility failed to ensure potentially unnecessary psychotropic medications for two residents in the sample. Specifically, the facility failed to ensure a PRN (as needed) psychotropic medication order was limited to 14 days for Resident (R)59, and when the order was extended beyond 14 days, the facility failed to ensure the PRN order had an order duration indicated, failed to accurately monitor R24's targeted or associated behaviors to determine the efficacy of R24's psychotropic medications, and failed to attempt a gradual dose reduction (GDR) of those medications. As a result of this deficient practice, the residents were placed at risk of having unnecessary psychotropic medication(s) which have the potential to lead to negative outcomes for the residents. This deficient practice has the potential to affect all residents with psychotropic medication orders. Findings include: 1) Resident (R)59 is a 97-year-old female admitted to the facility on 07/07/21 for skilled nursing care with admitting diagnoses that include dementia, a history of falling, and difficulty walking. Beginning on 07/18/21, R59 was ordered Trazodone [a psychotropic medication approved to treat depression] "for insomnia." On 11/18/21 at 10:28 AM, a review of R59's electronic health record (EHR) noted that R9 had been diagnosed with neither depression nor insomnia. A review of her progress notes revealed the first documentation of sleeplessness	F 758	E1: A medication review will be conducted for resident R24 & R59 by the physician. The psychotropic medication prescribed for prn sleep was discontinued for resident R24. For resident R59 A GDR, will be done by the pharmacist in conjunction with the ordering physician for both residents. E2: Residents who are on psychotropic medications have the potential to be affected. A medication review will be conducted to ensure all prn psychotropic medications have the appropriate indications for use and appropriate orders. A review of residents who are prescribed psychotropic will be conducted by the pharmacist in conjunction with the ordering physician and appropriate GDR will be done per policy. E3: The Gradual dose reduction of psychotropic drug, Use of psychotropic medication & Psychotropic committee policy was updated and reviewed and deemed appropriate by management. Long term care coordinators, Director of Quality, Physician & Social worker will be educated on the Gradual dose reduction of psychotropic drug & Psychotropic committee policy and procedure E4: The Social worker or designee will complete random weekly audits for Eight (8) consecutive weeks of new prn medication orders to ensure that appropriate indications for use & stop date of any prn psychotropic medication are clearly documented in the medical record.	

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F 758	Continued From page 78 was found in a Nursing Progress Note from 07/18/21 at 09:29 PM, which documented "Note Text: Dr ...updated re: 97 y/o female, at baseline with restlessness and confusion, sustained multiple falls. CNAs [certified nurse aides] reported that resident has not slept for the past two nights. Per Dr ..., new order entered for Trazodone HCl Tablet 50 MG Give 0.5 tablet by mouth at bedtime for insomnia." On 07/20/21, R59's Trazodone order was increased to a full tablet (50mg) daily. A review of R59's comprehensive care plan noted no care plan for insomnia, and further review of the EHR noted no non-pharmacological interventions attempted for insomnia prior to the trazodone being ordered. On 10/03/21, R59's Trazodone order changed from 50mg daily to "Trazodone 50mg Give 1 tablet by mouth every 24 hours as needed for Insomnia (sic)." On the same day, R59 was started on melatonin (a dietary supplement that studies have shown may help with certain conditions, such as jet lag, delayed sleep-wake phase disorder, some sleep disorders in children, and anxiety before and after surgery) 6mg at every bedtime "for insomnia." On 11/18/21 at 12:11 PM, during an interview with Long-Term Care Coordinator (LTCC)1 at the first-floor nurses' station, LTCC1 could not locate any documentation regarding the PRN psychotropic medication being used for more than 14 days, nor could she explain the lack of documentation. LTCC1 stated there should be internal psychotropic team review notes documented in the EHR monthly for all residents on psychotropic medications. On 11/23/21 at 12:51 PM, additional review of R59's EHR found no medication regimen review	F 758	The pharmacist or designee will conduct random weekly audits for eight (8) weeks to ensure residents on psychotropic medications have had a GDR per policy. Audit results will be reviewed by the Risk Management/Quality Assurance Committee monthly x 3 months until a lesser frequency is deemed appropriate E5: The administrator is ultimately responsible for compliance Corrective action completion date: 2/4/22	

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(MRR) to address the Trazodone PRN [as needed] order exceeding 14 days, and no physician notes justifying the PRN order exceeding 14 days.

2) In a record review (RR) on 11/18/21 at 01:26 PM, it was noted that R24 was admitted to the facility on 04/02/20 for diagnoses of major depressive disorder and vascular dementia with behavioral disturbance. Quarterly Minimum Data Set (MDS) report with Assessment Reference Date (ARD) of 08/20/21 showed a Brief Interview for Mental Status (BIMS) score of 03, meaning R24 is not cognitively intact. In "Section E. for Behavioral Symptoms", R24 was not coded for indicators of psychosis or behavioral symptoms such as hitting or yelling. Prior MDS admission report with ARD of 04/08/21 noted that in "Section E for Behavioral Symptoms" also documented R24 with no indicators for psychosis or behavioral symptoms. Physician orders showed that R24 was prescribed ziprasidone hydrochloride capsule 20 mg, one capsule by mouth two times a day for vascular dementia with behavioral disturbance and sertraline hydrochloride tablet 100 mg, one tablet by mouth once a day for major depressive disorder.

In an interview with Long-Term Care Coordinator (LTCC) 1 on 11/19/21 at 12:59 PM, LTCC1 stated that ziprasidone hydrochloride was initially started on 04/03/20 and sertraline hydrochloride started on 04/03/20 with dosage staying the same for R24 until present. LTCC1 confirmed that a gradual dose reduction (GDR) was not attempted for sertraline hydrochloride since R24's admission. LTCC1 said that the facility's Psychotropic Committee consisting of the pharmacist, long-term care coordinator, social

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worker, facility administrator, and director of nursing meets monthly to discuss R24's monthly medication regimen review and decides if there are any changes in medication. LTCC1 said that R24's primary physician is mainly responsible for deciding if GDR should be attempted. LTCC1 confirmed that in "Medication Regimen Review-Notifications of Irregularities Identified" notes for 07/14/20, 08/14/20, 12/09/20, and 01/18/21, the "Physician Review" section was signed by a long-term care coordinator and not R24's physician.

LTCC1 also stated that the Psychotropic Committee reviews the "Task: Behavior Monitoring flowsheet" during their meetings to determine if changes in medication are needed. LTCC1 said that the certified nurse assistant (CNA) is responsible for documenting behaviors in the "Task: Behavior Monitoring" flowsheet and informing the nurse of the behavior. The nurse then documents the behavior in a progress note. When LTCC1 was asked what behaviors of R24 were being monitored, LTCC1 responded that R24 was being monitored for "Cooperativeness with care, yelling, and outbursts." LTCC1 confirmed after reviewing R24's "Task: Behavior Monitoring" flowsheet, that there is no area provided for CNAs to document behaviors identified by LTCC1 (cooperativeness with care, yelling, and outbursts).

On 11/22/21 at 09:30 AM, surveyor heard R24 yelling, "I'm hungry," repeatedly from his room. Director of Nursing (DON) went to R24's room and the yelling stopped. On 11/22/21 at 09:35 AM, surveyor heard R24 yelling, "I'm hungry," again. DON then went to R24's room and the yelling stopped. Surveyor walked to R24's room

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F 758	Continued From page 81 and observed R24 being given water and yogurt by nursing staff. On 11/23/21 at 10:30 AM in an interview with DON, DON stated that the certified nurse aide is responsible for charting any observed behaviors for R24 in the "Task: Behavior Monitoring" flowsheet and reports it to the nurse. The nurse then writes a progress note for the behavior. DON confirmed R24's behavior (yelling) on 11/22/21 at 09:30 AM was not documented in the CNA's "Task: Behavior Monitoring" flowsheet or in the nursing progress notes. On 11/23/21 at 11:30 AM, a review of the facility's policy for Psychotropic Committee revised on 09/21 stated, "the Facility shall attempt to taper and/or gradually reduce dose of Psychotropic Medications. Gradual dose reduction will be attempted twice within the first year in (2) separate quarters with at least (1) month between attempts and annually thereafter unless proven to be clinically contraindicated."	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure medication error rates are not 5 percent or greater. The facility had a 7.41 % medication error rate, 2 medication errors were observed out of 27	F 759	E1: resident R238 is no longer a resident here. E2: All residents have the potential to be affected.	2/4/22

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F 759	Continued From page 82 opportunities for errors. Findings include: 1) On 11/18/21 at 09:28 AM, observed Team Leader (TL)5 administer medications to Resident (R)238. TL5 administered folic acid 1 mg (1 tablet), lisinopril 5 mg (1 tablet), magnesium oxide 400 mg (1 tablet), multivitamin (1 tab), potassium chloride 20 milliequivalent (1 tablet), vitamin D 25 mcg (2 tablets), heparin 5000/ml (1 milliliter), and acetaminophen 325 mg (2 tablets) to the resident. On 11/18/21 at 12:08 PM, conducted a record review and comparison of R238's medication orders and medications that were administered by TL5 to R238 at 09:28 AM. Review of the resident's medication orders documented an order for Thiamine HCl 100 mg tablet which was not administered during this surveyor's observation. On 11/18/21 at 12:34 PM, conducted an interview and concurrent review of R238's medications and Medication Administration Record (MAR) with TL5. TL5 confirmed R238 was ordered Thiamine HCl 100 mg on 11/17/21 at 09:00 AM and should have received the first dose on 11/18/21 at 09:00 AM. TL5 confirmed R238 should have received Thiamine HCl 100 mg as order but did not as evidence by all the Thiamine HCl 100 mg tablets were still in the blister pack (sent from the pharmacy) and R238 was not administered the medication as ordered. TL5 stated he/she had a question about the medication and forgot to go back and administer the medication as ordered. 2) On 11/18/21 at 09:28 AM, observed TL5	F 759	E3: The Medication Administration policy was updated and reviewed and deemed appropriate. The licensed and registered nurses will be educated on medication administration policy and procedure E4: DON or designee will conduct Random medication administration audits will be conducted for three (5) nurses weekly for (8) weeks, then one nurse monthly on-going to ensure compliance with facility guidelines. Audit results will be reviewed by the Risk Management/Quality Assurance Committee monthly x 3 months until a lesser frequency is deemed appropriate E5: The administrator is ultimately responsible for compliance Corrective action completion date: 2/4/22	

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F 759	Continued From page 83 administer two tablets of Acetaminophen 325 mg to R238 for complaint of pain to the resident's left leg. At 12:34 PM, conducted a concurrent interview and review of R238's electronic health record with TL5. TL5 confirmed administration of Acetaminophen 650 mg was not documented on the MAR as administered and no follow-up for effectiveness was assessed.	F 759		
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 interview and record review (RR), the facility failed to ensure its residents were free from significant medication errors. Specifically, an elderly resident (R) with a history of frequent falls was administered a PRN [as needed] psychotropic medication (with daytime sleepiness as a common side effect) more than two hours early despite the behavior it was prescribed for (insomnia) was neither monitored nor observed. Safe and appropriate medication administration practices are essential for the health and well-being of the residents. As a result of this deficient practice, R59 was placed at increased risk of daytime somnolence (sleepiness) with the potential for injury. This deficient practice has the potential to affect all residents in the facility being given medications with somnolent effects. Findings include: Resident (R)59 is a 97-year-old female admitted to the facility on 07/07/21 for skilled nursing care	F 760	E1: resident R238 is no longer a resident here. E2: All residents have the potential to be affected. E3: The Medication Administration policy was updated and reviewed and deemed appropriate. The licensed and registered nurses will be educated on medication administration policy and procedure E4: DON or designee will conduct Random medication administration audits will be conducted for three (5) nurses weekly for (8) weeks, then one nurse monthly on-going to ensure compliance with facility guidelines. Audit results will be reviewed by the Risk Management/Quality Assurance Committee monthly x 3 months until a lesser frequency is deemed appropriate	2/4/22

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F 760	Continued From page 84 with admitting diagnoses that include dementia, a history of falling, and difficulty walking. Beginning on 07/18/21, R59 was ordered Trazodone [a psychotropic medication approved to treat depression] "for insomnia." On 11/18/21 at 10:28 AM, a review of R59's comprehensive care plan noted no care plan for insomnia, and further review of the electronic health record (EHR) noted no non-pharmacological interventions attempted for insomnia prior to the Trazodone being ordered. Additional review of R59's EHR noted that on 10/03/21, R59's Trazodone order changed from 50mg daily to "Trazodone 50mg Give 1 tablet by mouth every 24 hours as needed for Insomnia (sic)." A review of R59's medication administration record (MAR) for November noted that on 11/14/21, R59 had been given a dose of Trazodone 50mg twice in a 24-hour period, first at 12:25 AM by licensed practical nurse (LPN)5, then again at 09:52 PM by Team Leader (TL)11, a registered nurse. On 11/18/21 at 12:11 PM, an interview was done with Long-Term Care Coordinator (LTCC)1 at the first-floor nurses' station. While reviewing the November MAR with her, LTCC1 acknowledged the Trazodone had been given twice on 11/14/21 and stated that it should not have happened. LTCC1 explained that "the system [electronic MAR program]" should have stopped the nurse from giving the medication early. On 11/18/21 at 04:00 PM, an interview was done with TL11 outside room 166. TL11 confirmed that he gave the Trazodone 50mg early on 11/14/21. TL11 stated that the system did alert him that he was about to administer the medication early, but	F 760	E5: The administrator is ultimately responsible for compliance Corrective action completion date: 2/4/22	

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F 760	Continued From page 85 he bypassed the warning thinking "it was okay [for him] to give it a little early because she [R59] was restless." When questioned further, TL11 acknowledged that the Trazodone was prescribed for insomnia and that restlessness and insomnia are not the same thing but confirmed that he did give it for restlessness.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record	F 761	E1: Resident R38 could not be identify	2/5/22

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F 761	Continued From page 86 reviews, and review of policy and procedures, the facility failed to ensure that medication for Resident (R) 38 was labeled in accordance with professional standards and stored in a locked compartment. As a result of this deficient practice, R38 was put at risk for adverse clinical consequences. Findings Include: On 11/18/21 at 08:42 AM, surveyor observed four pills in a medicine cup stored inside the top drawer of medicine Cart B. The medicine cup had the letter "V" written on it. Licensed Practical Nurse (LPN) 3 stated that she was storing R38's medication in a cup because the resident didn't want to take all of her morning medication at once and would take it later. LPN 3 said that the medications in the medicine cup were aspirin, fenofibrate, amlodipine, and sertraline. LPN3 took out the blister packs to identify the medication in the cup by matching it with the labeled medication. LPN3 said that R38's carvedilol medication cannot be given because R38's pulse was 54 and needed to be 60 or above to be given. Surveyor reviewed R38's electronic medical administration record with LPN3 and medications due for 09:00 AM were not signed off. LPN3 then took the medicine cup with the four pills to R38's room. Surveyor observed R38 sitting in bed eating breakfast. Surveyor observed a medicine cup with three dark colored pills next to her breakfast meal. LPN3 said to R38 that "You need to take your pills. The surveyor is here". LPN3 said to surveyor that the four pills in the medicine cup at the bedside were Gabapentin, Multivitamin, Senna, and Keppra. Surveyor observed three dark colored pills in the cup and did not see a fourth pill. LPN3 watched	F 761	E2: All residents have the potential to be affected. E3: The storage of medications, Medication Administration general guidelines , Medication self-administration of medication & medication error policy was updated and reviewed and deemed appropriate by management. The licensed and registered nurses will be educated on medication administration policy and procedure E4: DON or designee will conduct Random medication administration audits will be conducted for three (3) nurses weekly for (8) weeks, then one nurse monthly on-going to ensure compliance with facility guidelines. Audits will be conducted to ensure the five rights of medication administration are followed and that there are no medications left at the bedside or in the med cart. Audit results will be reviewed by the Risk Management/Quality Assurance Committee monthly x 3 months until a lesser frequency is deemed appropriate E5: The administrator is ultimately responsible for compliance Corrective action completion date: 2/4/22	

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F 761	Continued From page 87	F 761		

resident ingest the three pills in the medicine cup at the bedside. LPN3 then watched R38 ingest the four pills that had been stored in the medicine cup in the storage cart. LPN then left the room and signed off on the medications given.

In an interview on 11/18/21 at 10:50 AM with Long-Term Care Coordinator (LTCC) 1, LTCC1 stated that R38 usually takes her medicine after breakfast and that R38 should take all of her scheduled medication at one time. LTCC1 stated, "You shouldn't leave pills at the beside. You don't know if she (R38) will spill the meds somewhere. If you pop it (the medication), you are supposed to give it right after. She cannot self-administer medication. You must be there to watch her take medications. If resident refuses medication, you should take the pills away from them and toss them out. You can document that the resident refused medication. If refusal is consistent, you can call the doctor. If not, just document that medication was refused." Surveyor inquired whether R38 was assessed to self-administer medication, LTCC1 confirmed that R38 is unable to self-administer medication.

In an interview on 11/18/21 at 11:29 AM, LPN3 stated, "R38 takes medication herself." When surveyor asked if R38 was assessed to have the ability to self-administer medication, LPN3 stated, "Yes, she is alert to take medications by herself as far as I know of."

In a record review at 11/18/21 at 9:30 AM, R38 was diagnosed with hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness of one side of the body) following a cerebrovascular accident (CVA or stroke). R38's diagnoses include depression, chronic kidney

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F 761	Continued From page 88 disease (kidneys unable to filter waste from blood), hypertension (high blood pressure), and epilepsy (seizures). R38's electronic medication administration record showed that eight medications were administered by LPN3 at 09:00 AM that morning: one tablet of aspirin tablet delayed release 81 mg for cerebrovascular accident, one tablet of fenofibrate tablet 160 mg for hyperlipidemia, one tablet of amlodipine tablet 5 mg for hypertension, one tablet of sertraline hydrochloride tablet 25 mg for depression, one tablet of gabapentin capsule 300 mg for neuropathic pain, one tablet of levetiracetam tablet 500mg for epilepsy, one tablet of senna-s tablet (Docusate Sod + Senna 50 mg - 8.6 mg) for constipation, and one Multivitamin Tablet as a supplement. There was no physician order in R38's electronic health record for R38 to self-administer medication. In a review on 11/18/21 at 01:00 PM of the facility's "Storage of Medications" policy and procedure revised on 08/20, stated that under "II Procedure. C. All medications dispensed by the pharmacy are stored in the box, bag, blister card, bottle or other container with the pharmacy label." Review of the facility's policy for "Medication Administration General Guidelines" revised on 12/20 stated that under "B. Administration 15. The resident is always observed after administration to ensure that the dose was completely ingested." Review of the facility's policy for "Self-Administration of Medication by Inpatients" revised on 01/20 stated under "II Procedure: Specific orders for self-administration of medication by the patient must be written by the physician."	F 761		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed	F 803		2/4/22

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F 803	Continued From page 89 CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to identify and provide food that accommodates resident (R) personal dietary choices and cultural needs as evidenced by two residents (R78 and R6) stating they are not aware of what is on the menu and are not offered a substitution when they are given foods that do not appeal to them. Often one of the last individual pleasures a person has, eating food they enjoy	F 803	E1: Resident R78 & R6 will both be given a copy of the menu and the alternatives available Each resident likes and dislikes were updated on their tray card. E2: Residents have the potential to be affected. Residents will be giving a copy of the current menu and the alternative	

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F 803	Continued From page 90 can be critical to helping a resident attain, maintain, or restore their highest practicable well-being. This deficient practice has the potential to impact all residents at the facility. Findings include: 1) Resident (R)78 is a 59-year-old female admitted to the facility for short-term rehabilitation on 07/21/21, following a stroke that resulted in left-sided paralysis and weakness. Due to her condition, R78 has been mostly confined to her room since admission. On 11/17/21 at 08:41 AM, during an interview with R78 in her room on the first floor, R78 shared that she doesn't like the food because there is not much variety, and it does not suit her tastes, "it's too mainland." R78 stated that she does not get to choose what she is going to have, has never seen a menu, and does not know what will be on her meal tray(s), "I just get what I get." If she doesn't like what is on her meal tray, R78 stated she is not offered a substitution, and was not made aware that there was an alternate menu or that she could request something else. No menu was observed anywhere in the resident's room. 2) Resident (R)6 is a 64-year-old male admitted to the facility on 04/07/12 following a traumatic spinal cord injury. Due to a skin condition, R6 stated that he has been confined to his room "for the past year and a half." R6 is alert and oriented and actively participates in his goal setting and care planning. During an interview with R6 in his room on the first floor on 11/17/21 at 10:00 AM, R6 complained that he gets the same food all the time. R6 stated that he has asked for different foods or local foods, but feels his requests are not honored. R6 knows that there is a menu but	F 803	available. Dated Menus will be posted at the nurse's station weekly. A welcome packet describing the meal services will be placed in the new patient information packet and reviewed during admissions. Residents will also be given the opportunity to review and select a resident meal monthly during resident council. E3: The Menus and adequate nutrition policy was updated and reviewed and deemed appropriate. Staff will be educated on Menu and adequate nutrition policy and procedure. E4: The Food service manager will audit 20% of residents weekly for x 8 weeks, to ensure residents have access to a menu and that they are offered a substitute meal if the meal is not to their liking. The results of findings will also be reviewed at resident council meetings monthly. Audit results will be reviewed by the Risk Management/Quality Assurance Committee monthly x 3 months until a lesser frequency is deemed appropriate E5: The administrator is ultimately responsible for compliance Corrective action completion date: 2/4/22	

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F 803	Continued From page 91	F 803		

stated that he never sees one, so he has no idea what will be served for any meal. When he receives a meal tray that he doesn't like, R6 stated that he is not offered an alternative. No menu was observed anywhere in the resident's room.

During a tour of the first-floor unit on 11/18/21 at 09:19 AM, it was observed that there were no menus posted in any of the resident rooms or in the hallways. A 4-week rotation menu was located posted at the front of the nurses' station. Each week's menu was printed on a standard sheet of paper in no larger than 14-font, and were all dated "2/26/2021", printed "3/18/2021." Although the menus were labeled "Week 1" through "Week 4", there was no indication of which week was currently being served.

On 11/23/21 at 10:15 AM, an interview was done with the Food and Nutrition Services Director (FSD) in her office. The FSD confirmed that residents are not provided with a choice menu, and the 4-week rotation menu is currently posted only at the nurses' station on the first-floor unit. The FSD acknowledged that for any resident confined to their room, the menu would be inaccessible. Regarding substitutions, the FSD stated there is an "All Time Favorites Menu" that can be offered to the residents but was unsure if this alternative menu was posted anywhere.

On 11/23/21 at 12:25 PM, an interview was done with Long-Term Care Coordinator (LTCC)1 at the first-floor nurses' station. When questioned about alternate menus, LTCC1 was not familiar with the "All Time Favorites Menu." LTCC1 stated she had seen an alternate menu before, but did not know where to find it, and did not think the

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WAHIAWA GENERAL HOSPITAL	128 LEHUA STREET WAHIAWA, HI 96786

(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 803	Continued From page 92 certified nurse aides (CNA) who distributed the meal trays were aware of it. At 12:28 PM, brief interviews were done with CNA12 and CNA29 outside of room 168. Neither CNA were aware of an alternate menu but stated that they knew that residents could request something else if they did not like what was on their tray.	F 803		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care	F 842		2/4/22

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F 842	Continued From page 93 operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations and record reviews, the facility failed to provide an accurate behavioral	F 842	E1: The IDT team will hold a behavioral meeting for resident R48. Based on the	

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F 842	Continued From page 94 picture of one resident, ((R)48), in the sample. This deficient practice could result in the medical mismanagement of R48 making it difficult for him to achieve his highest possible level of functioning and well-being and could potentially affect all residents needing behavioral monitoring from the nursing staff. Findings include: On 11/17/21 at 08:26 AM, R48 was observed to be yelling out angrily, "Stay away!" out the door to staff passing by his room. R48 was now dangling at the edge of his bed with his bedside table pushed to the side and was throwing items from his breakfast tray out the door. R48 was occasionally mumbling to himself. R48 became verbally abusive and threw more items out of room into the hallway. Long term care coordinator (LTCC)2 picked up items from the floor and discarded them into the trash. She did not engage with R48. R48 then threw his breakfast plate out the door, the plate loudly crashing onto the floor. Several staff tried to engage with R48, but he angrily yelled, "Get the fuck out!" On 11/18/21 at 2:42 PM, R48's electronic health record (EHR) was reviewed. His diagnoses included: sepsis (blood infection) stemming from cellulitis (serious bacterial skin infection) of both legs, Wernicke's encephalopathy (problems with memory and disorientation arising from thiamine (vitamin B1) deficiency), urinary tract infection, homelessness, and liver disease. He was admitted to the facility on 04/08/21. R48's "Behavior Monitoring" flowsheet was reviewed for the time period of 10/23/21 to 11/21/21. Behaviors of "Rejection of Care"	F 842	results of the meeting resident R48 care plan & kardex will be updated to reflect his current psychosocial needs. E2: Residents have the potential to be affected. The residents with known behaviors will have a behavior meeting to ensure the correct interventions are in place . Daily clinical review will be conducted to evaluate residents for a clinical change will be conducted, based on the review the DON or designee will make revisions for appropriate care plan interventions. E3: The Behavior Health services policy was updated and reviewed and deemed appropriate. The IDT, registered & licensed nurses will be educated on the Behavior Management Plan policy and procedure E4: The Director of Nursing Services (DNS), or designee, will complete random weekly audits of patients with known behaviors for (8) consecutive weeks. Audits will be completed to ensure that appropriate documentation of interventions are care planned. Audit results will be reviewed by the Risk Management/Quality Assurance Committee monthly x 3 months until a lesser frequency is deemed appropriate. E5: The administrator is ultimately responsible for compliance Corrective action completion date: 2/4/22	

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F 842	Continued From page 95 occurred eight of the 20 days in November, no behaviors were documented for the latter part of October. "Yelling/Screaming" occurred only two of the 20 days in November, none in October. There were no behaviors marked for those observed by the surveyor on 11/17/21. R48's progress notes were reviewed. In a note documented by team leader (TL)2 on 10/28/21 at "22:03" (10:03 PM), R48 refused care, yelled at the certified nurse aide (CNA) and "swear at her." Another note documented on 11/17/21 at "03:01" by TL3 stated, "Trying to throw stuff and curse to the CNA." R48's "Behavior Monitoring" flowsheet did not have documentation for "Rejection of Care," "Yelling/Screaming," and "Abusive Language" on 10/28/21. "Abusive Language," and "Threatening Behavior" also were not marked for 11/17/21.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		1/26/22

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F 880	Continued From page 96	F 880		

and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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F 880	Continued From page 97 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure appropriate protective and preventive measures for COVID-19 and other communicable diseases and infections. Findings include: 1) On 11/22/21 at 10:20 AM, this surveyor entered Resident (R)53's room. R53 receives enteral formula nutrition as a result of the resident's inability to safely swallow food without aspiration. Observed a bag of Jevity formula hanging and actively infusing at 40 milliliters per hour (ml/h). The Jevity formula bag and tubing did not have a date and time indicating when it was hung. This surveyor conducted a concurrent observation and interview of this surveyor's findings with Nursing Supervisor (NS)2. NS2 confirmed the formula and tubing did not contain a date or time when the formula was started and should have been. NS2 stated that once the formula is hung it is good for 24 hours. At 01:28 PM, a review of the facility's policy and procedure documented staff should date and initial all tube feeding bottles and tubing. During an interview with the Infection	F 880	E1: Resident 53 tube feeding container was dated upon notification of concern. Resident 89 Nasal cannula was changed upon notification of the concern. The staff member who provided the care for resident 282 is no longer with WNRC. E2: Residents have the potential to be affected. A root cause analysis will be performed to determine the root of the deficiencies E3: The Infection Prevention and Control, Handwashing policy was updated and reviewed and deemed appropriate. All staff will be educated on Infection control & Handwashing policy and procedure. The licensed and registered nurses will be educated on the Wound Care Policy and Procedure. All Staff will also be required to watch the following videos & review the following Modules from CMS Clean Hands - https://youtu.be/xmYMUly7qiE Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw Lessons - https://youtu.be/YYTATw9yav4 Module 6A and Module 7 from the QSO 19-10 NH dated 3/11/19	

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F 880	Continued From page 98 Preventionist (IP) on 11/22/21 at 02:00 PM, the IP confirmed the formula bag and tubing should be dated and timed to ensure the resident is not receiving formula which could be expired, to prevent diarrhea from bacteria build-up. 2) On 11/16/21 at 01:22 PM, Resident (R)89's visitor came to the nursing station and alerted Team Lead (TL)5 that R89 was having difficulty breathing. TL5 removed R89's nasal cannula to administer an Albuterol Sulfate (2.5 milligrams per 3 milliliter) nebulization solution using a mask. TL5 placed the nasal cannula tubing on top of R89's blanket. When the Albuterol treatment was completed, TL5 removed the mask and attempted to apply the nasal cannula tubing back onto R89, and the nasal cannula tubing fell on the ground. TL5 picked the tubing off the ground and placed the tubing (which dropped) onto the resident. Inquired with TL5 if the tubing should have been discarded and replaced with a clean nasal cannula. TL5 confirmed the nasal cannula and tubing should have been discarded and not placed back onto R89. During an interview with the Infection Preventionist (IP) on 11/22/21 at 02:01 PM, the IP confirmed once the nasal cannula fell on the floor it is considered "dirty" and should have been thrown away and a new nasal cannula should have been used. 3) On 11/19/21 at 09:57 AM, R282's stage four pressure ulcer (wound extending down to muscle and bone) dressing change by TL2 was observed. Certified Nurse Aide (CNA)6 and CNA19 did personal care for R282 and he was lying on his left side. TL2 removed the old dressing from R282's tailbone area and removed his gloves. He went into the bathroom and	F 880	E4: The Director of Nursing Services (DNS), or designee, will complete random hand washing audits for staff and residents twice a week for 4 weeks and then weekly thereafter. During the audit the timing and technique of hand hygiene procedure will be monitored to ensure staff are performing the procedure in accordance with our facility's Practice Guideline. Tube Feeding contains will be audited to ensure they are dated three times a week for 8 weeks This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. E5: The administrator is ultimately responsible for compliance Corrective action completion date: 1/26/22	

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F 880	Continued From page 99	F 880		

washed his hands for less than 20 seconds and donned on new gloves. He cleansed the pressure ulcer wound with a gauze soaked with an antiseptic solution and removed his gloves. He did not perform hand hygiene before donning on clean gloves and did this same process four more times during R282's dressing change.

At 10:10 AM, CNA6 left R282's room to dispose of the trash and dirty linen. She came back into R282's room to use the bathroom sink to perform hand hygiene. She was queried if it would be easier to perform appropriate hand hygiene between clean and dirty tasks while caring for the resident if there was a hand sanitizing station in the room and she stated yes.

According to the Centers for Disease Control and Prevention (CDC), hand hygiene should be performed immediately after glove removal.
4) On 11/16/21 at 12:33 PM on Unit 1 Side B, surveyor observed certified nurse aide (CNA)12 not performing hand hygiene before and after serving meals for residents in Rooms 161, 162, and 163. Residents were not offered hand hygiene before eating their meals. CNA12 was observed taking a meal tray out of the food warmer and carrying it into room 163. CNA12 then set up the meal tray on the resident's table by touching the bedside table, placing the entree and drinks from the tray on the bedside table, and then opening the entree cover and drink containers. CNA12 did not offer hand hygiene to the resident. CNA12 took the empty tray out of the room and placed it back on top of the food warmer. Without washing her hands, CNA12 then took out the next tray out of the warmer and proceeded into room 162. CNA12 set up the resident's bedside table in the same process.

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F 880	Continued From page 100 Resident in room 162 was not offered hand hygiene by CNA12. CNA12 then took the empty meal tray out of the room and placed it back on top of the food warmer. Without washing her hands, CNA12 then took a meal tray out from the food warmer and went into room 161. CNA12 did not offer resident hand hygiene before setting up the bedside table with the meal tray. CNA12 then took the empty meal tray out of the room 161 and placed it back on top of the food warmer.	F 880		

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E 000	Initial Comments A recertification survey was conducted by the Office of Health Care Assurance on 11/16/21 - 11/23/21. The facility was found not to be in substantial compliance with §483.73, Requirement for Long-Term Care (LTC) Facilities of Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types, State Operations Manual.	E 000		
E 006 SS=D	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:	E 006		2/4/22

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

Electronically Signed | 01/09/2022

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E 006	Continued From page 1 (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 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: Based on interview and record review, the facility failed to develop an emergency preparedness plan that included a facility-based approach	E 006	E1: No resident was identified E2: Residents have the potential to be	

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E 006	Continued From page 2 regarding missing residents. With no systematic plan in place, this deficient practice placed the residents at risk of not being identified and quickly located should they go missing from the facility. Findings include: During review of the facility's Emergency Operation Plan (EOP) by Surveyor (S)2 on 11/19/21 at 10:00 AM, it was noted that the Emergency Plan did not include preparations in the event of a missing resident. On 11/19/21 at 01:08 PM, an interview was done with the Administrator, and the Chief Operating Officer, who also served as the Safety Officer (SO). Both acknowledged that the EOP failed to include a plan for missing residents. The SO stated that the deficient practice had been identified earlier in the year, and that the EOP was currently being revised.	E 006	affected. E3: The Patient Care & Support & Missing Resident/ Elopement policy was updated and reviewed and deemed appropriate. Staff will be educated on the Missing Resident/Elopement & Patient Care & Support policy and procedure E4: The policy will be reviewed at QAPI and updated annually E5: The administrator is ultimately responsible for compliance Corrective action completion date: 2/04/22	

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K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: K-345 Fire Alarm System-Testing and Maintenance This STANDARD is not met as evidenced by: Based on record review and observation of the fire alarm panel with staff members, the facility failed to maintain the facility's fire alarm system in a fully operable condition in accordance with NFPA 70, National Electric Code, 2011 edition, NFPA 72 National Fire Alarm and Signaling Code, 2010 edition, NFPA 101, Life Safety Code, 2012 edition, section 9.6.1.2 through 9.6.1.5 This deficiency could affect all residents, staff, and visitors during a fire due to the lack of an operable fire alarm system. Findings include: During record review on 1/6/22 at approximately 12:15 pm revealed that the facility failed to address the issues causing a "trouble signal" on the fire alarm panel and inspection records. The fire alarm system is undergoing repairs and a fire watch was required by the surveyor. These findings were verified at the exit conference with the staff members on 1/6/22 at 2:00 pm.	K 345	Upon notification, the facility started to perform a fire watch. The fire watch will continue until the facility fire system is no longer signaling trouble. The fire system does connect to the monitoring station. It will trigger an alarm if a pull station is activated or if the fire alarm is triggered by smoke or heat. The fire watch policy was reviewed and deemed appropriate. The maintenance director will be in-serviced on the fire watch policy. The expected completion date of the repair is 4/1/22. The administrator or designee will audit the random fire watch documents weekly to ensure compliance with the fire watch policy. The expected compliance date is 4/1/22 The administrator is responsible for compliance.	4/1/22
K 531 SS=C	Elevators CFR(s): NFPA 101	K 531		2/28/22

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

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	125015	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/06/2022**

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K 531	Continued From page 1 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: K-531 Elevators This STANDARD is not met as evidenced by: Based on record review and interview with staff members, the facility failed to produce documentation for an annual inspection for the facility's elevators in accordance with NFPA 101, Life Safety Code, 2012 edition, section 9.4.6.1. This deficiency could affect all residents, staff, and visitors due to the lack of an annual inspection to ensure proper elevator operations. Findings include: During record review on 1/6/22 at approximately 12:15 pm revealed that the facility failed to provide documentation for the annual elevator inspection. These findings were verified at the exit conference with staff members on 1/6/22 at 2:00 pm.	K 531	The Elevator Maintenance policy was reviewed and deemed appropriate. HIOSH - Boiler & Elevator Inspection Branch will conduct the annual inspection in February 28 2022. The maintenance director will be educated on the Elevator Maintenance policy. The preventive maintenance audit tool was updated to include the annual inspection of the facility elevator. The Elevator maintenance policy will be reviewed at QA annually. The expected compliance date is February 28 2022 The administrator is responsible for	

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K 531	Continued From page 2	K 531	compliance.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: K-761 Maintenance, Inspection and testing-Doors This STANDARD is not met as evidenced by: Based on record review and interview with staff members, the facility failed to produce documentation for an annual inspection for the fire doors in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 edition, sections 5.2, and 5.2.3. This deficiency could affect all residents, staff, and visitors during a fire due to the lack of an annual inspection to ensure proper protection from fire and smoke extension within the facility. Findings include: During record review on 1/6/22 at approximately 12:45 pm revealed that the facility failed to provide documentation for the annual fire door	K 761	The fire and smoke door policy was reviewed and deemed appropriate. The facility has contracted with Fire Door Solutions Will conduct the annual inspection & train the facility maintenance director on performing the annual fire door inspection. The preventive maintenance audit tool was updated to include the inspection of the fire and smoke doors. The maintenance director will be educated on the fire and smoke door policy. The fire and smoke door policy will be reviewed at QA annually. The expected compliance date is 2/8/22	2/8/22

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K 761	Continued From page 3 inspection. These findings were verified at the exit conference with staff members on 1/6/22 at 2:00 pm.	K 761	The administrator is responsible for compliance.	
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.	K 918		2/1/22

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K 918	Continued From page 4 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: K-918 Electrical Systems-Essential Electric System Maintenance and Testing This STANDARD is not met as evidenced by: Based on record review and staff interview with staff members, the facility failed to produce documentation for an annual testing of diesel fuel in accordance with NFPA 99 Healthcare Facilities Code, 2012 edition, section 6.5.4, and NFPA 110 Standard for Emergency and Standby Power Systems, 2010 edition, section 8.3.8. This deficiency could affect all residents, staff, and visitors during an interruption of grid power due to the lack of an annual diesel fuel test to ensure proper operation of the standby power system. Findings include: An observation on 1/6/22 at approximately 12:45 pm revealed that the facility failed to provide documentation for the annual diesel fuel test. These findings were verified at the exit conference with the facility staff members on 1/6/22 at 2:00 pm.	K 918	The generator was serviced on 1/19 & 1/20 by Cummins. The facility emergency generator testing policy was reviewed and deemed appropriate. The facility preventive maintenance checklist was reviewed and deemed appropriate. The maintenance director was educated on the emergency generator testing policy. The facility emergency generator testing policy will be reviewed by the quality assurance committee annually. The expected compliance date is 2/1/22 The administrator is responsible for compliance.	

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E 006 SS=B	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		2/21/22

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

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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. This deficiency could affect all residents, staff, and visitors during an emergency due to the lack of available policies and procedures to provide guidance and structure. Findings include:	E 006	The emergency preparedness training and testing policy was updated, reviewed, and deemed appropriate. The facility will audit all employees to determine who is in compliance with the facility Testing and training program. A schedule will be developed to ensure all current employees have the appropriate training and education in accordance with appendix z. Additionally, all new employees & current employees will have to be educated upon hire and annually on the Emergency preparedness program. The expected compliance date is 2/21/22.	

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E 006	Continued From page 2 An observation on 1/6/22 at approximately 1:00 pm revealed that the facility's Emergency Preparedness Plan was missing sections such as Testing and Training of the EPP and Policies and Procedures were 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 1/6/22 at 2:00 pm.	E 006	The administrator or designee will audit random staff members monthly to ensure compliance with the Emergency Preparedness Training and testing policy. The results of the findings will be reported during the quarterly quality meetings. The expected compliance date is 2/21/22. The administrator is responsible for compliance.	