STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125048	A. BUILDING _____ B. WING _____	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN PEARL NURSING FACILITY	45-181 WAIKALUA ROAD KANEOHE, HI 96744

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA). The facility was found not to be in substantial compliance with 42 CFR 483 Subpart B. Two facility reported incidences (FRI) from the Aspen Complaint/Incidents Tracking System (ACTS), #9013 and #9117, were substantiated. Survey Dates: March 8 to March 11, 2022 Survey Census: 60 Sample Size: 17	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives	F 578		4/25/22

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

Electronically Signed | 04/07/2022

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F 578	Continued From page 1 and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff members, the facility did not assure that two of six residents (R) in the sample (R20 and R16) exercised their right to formulate an advance health care directive (AHCD). The facility failed to ensure R20 was periodically given opportunities to formulate an AHCD. This deficient practice has the potential to cause harm to residents when they are provided medical care that is not in accordance with their wishes. Findings include: 1) R20 was admitted to the facility 02/03/20. Record review found a document titled, "Surrogate Decision Making Appointment" signed on 02/18/20 designating a surrogate decision maker. There was no documentation of whether the resident had an AHCD or was interested in	F 578	This plan of correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. Residents 20 and 16 were given the opportunity to execute advance directives as desired by the Social Worker. Facility residents have the potential to be affected by this alleged practice. The Social Worker was educated regarding Advance Directives by the Administrator. Current residents were	

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F 578	Continued From page 2 formulating an AHCD. On 03/10/22 at 08:45 AM the Social Worker (SW) provided a copy of the "Surrogate Decision Making Appointment" form and progress note dated 02/13/20 documenting admission packet was completed with R20's girlfriend. The surrogate form and Physician Orders for Life-Sustaining Treatment (POLST) was completed. It was documented the SW also discussed and provided document for AHCD. The SW confirmed the resident's girlfriend is deceased, the facility's progress note dated 07/28/21 documented resident became aware of his girlfriend's death via the obituaries in the newspaper. The SW confirmed there is no documentation of periodically offering R20 the opportunity to formulate an AHCD. The SW also confirmed R20 probably has the cognitive capacity to make health care decisions. A review of R20's annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 01/10/22 noted that R20 did not have short-term and long term memory problems. R20 was coded zero (independent) for cognitive skills for daily decision-making. 2) On 03/09/22 at 08:56 AM, R16's record was reviewed. R16 was admitted to the facility on 11/11/16. Quarterly MDS with an ARD of 01/3/22, stated R16's Brief Interview for Mental Status (BIMS) score is 14, meaning R16 is cognitively intact. R16's POLST stated, "Full Treatment". No AHCD documentation was found. On 03/10/22 at 07:18 AM, faciltiy administrator was interviewed. Administrator stated that R16 did not have an AHCD on file and that R16 only	F 578	reviewed for Advance Directives and offered the opportunity to execute them as desired. Advance Directives will be reviewed with each resident/responsible party quarterly and updated as needed. The Interdisciplinary Team (IDT) was educated regarding Advance Directives by the Administrator. The initial Social Services Assessment will include documentation that Advance Directives were reviewed with resident/responsible party. In-services will be ongoing as needed. The Social Worker will audit Advance Directives on admission, with quarterly care plans and any significant change for a minimum of 12 weeks or until substantial compliance has been achieved. The results of these audits will be brought to the monthly Quality Assurance/Performance Improvement (QAPI) meetings for review for a minimum of 3 months or until substantial compliance has been achieved.	

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F 578	Continued From page 3 had a POLST on file. On 03/11/22 at 07:20 AM, R16's "Care Conference Summary" dated 11/02/21, was reviewed with Social Worker (SW). SW confirmed under the section, "Social Services" she had documented, "Resident POLST on file is current, Full code. Resident is A&Ox4 [alert and oriented four times, person, place, time and situation] and able to make his needs known." SW confirmed that she had not documented whether an AHCD was discussed with R16 at the care conference meeting.	F 578		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 reviews and interviews, the facility failed to complete and maintain	F 610	Resident 159's incident was investigated and staff involved in care were	4/25/22

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F 610	Continued From page 4 documentation that an alleged violation was thoroughly investigated for one out of two incidents sampled. This deficient practice has the potential to affect all residents and robs them of their right to a fair and thorough investigation of alleged abuse and neglect against them. Finding includes: R159 was admitted to the facility on 06/21/21 and discharged to home with hospice on 08/13/21. Review of the Event Report completed by the facility on 07/30/21, the facility reported during routine rounds on 07/28/21 at 08:00 AM, R159 was assessed to have multiple purple bruises on her buttocks and anal area. "Medical Director assessed bruises and felt that they were likely trauma related as they were not over bony prominences and due to the fact that the daughter had stated yesterday that resident has difficulty pooping sometimes so she massages resident and "pokes" her. Daughter clarified "poking" to mean performing digital stimulation [involves moving the finger around in a circular motion inside the rectum to stimulate the bowel reflex]." Review of the facility's nursing progress note dated 07/28/21 " ...assessed resident's buttocks after CNA (certified nursing assistant) reported observed bruising when providing care. Sporadic purple/red bruising surrounding anus and dark purple bruise 0.3 cm (centimeter) by 0.5 cm on left buttocks. Family has previously reported digital stimulation. No comment by resident. Family visitation paused until further notice." On 03/10/22 requested from the facility the	F 610	re-educated by the Staff Development Coordinator (SDC) regarding reporting bruises. In-services will be ongoing as needed. Facility residents have the potential to be affected by the alleged practice. Nursing staff were re-educated regarding reporting of bruises and other incidents by the SDC/designee. Leadership team also in-serviced on investigative procedures. Alleged Abuse Investigation Checklist will be revised to include the following: APS notified of final outcome; Completed packet filed in Social Services Office. In-services will be ongoing as needed. SDC/DON/designee will audit for compliance through medical records and the 24-hour report review as well as weekly observations for a minimum of 12 weeks or until substantial compliance has been achieved. Administrator will audit all reportable incidents to ensure compliance with checklist. The results of these audits will be brought to the monthly Quality Assurance/Performance Improvement meetings for review for a minimum of 3 months or until substantial compliance has been achieved.	

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F 610	Continued From page 5	F 610		

facility's investigation reports. At 09:48 AM received the "Adult Protective Services (APS) Report Form for Vulnerable Adult Abuse" submitted to APS intake unit, progress notes dated 07/27/21 and 07/29/21, and two documented witness statements dated on 07/28/21 from the registered nurse (RN) and CNA who discovered the bruises on R159's buttocks and anal area.

On 03/10/22 at 11:16 AM interviewed Infection Preventionist (IP), stated she attended the care plan meeting for R159 but was not involved with the investigation for the incident, but the facility decided she would be the person to speak to it. IP clarified on 07/27/21, prior to the discovered bruising, in the care plan meeting R159's daughter " ...shared her mom has poor output and she massages and "pokes" her mom ... Which raised a red flag ..." IP further explained on discovery of the bruising on the buttocks and anal area on 07/28/21, it was assumed the bruising was due to what the daughter had mentioned at the care plan meeting on 07/27/21. IP stated, "If the daughter did not share that information, they would have to dig a little more." Inquired what day the daughter performed digital stimulation, IP reviewed R159's chart and stated she does not know. Concurrent review of the facility's "Witness Statements- Investigation Supplement," confirmed statements were only given by RN and CNA who discovered the bruising on 07/28/21 at 08:00 AM, " ...no statements from the shift before or other shifts."

During a follow-up interview with IP and Director of Nursing (DON) on 03/11/22 at 08:39 AM, IP confirmed there was no documentation of an interview with the daughter, R159 or other staff

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F 610	Continued From page 6	F 610		

members were completed. IP concurred there was no documentation to show a thorough investigation was done. Inquired with IP how she would have investigated the incident, IP explained in previous cases where a resident had a bruise, she would have reviewed the resident's skin assessments, interview CNAs that provided care to the resident, do at least a 24 hour look back and if needed up to a week, check what visitors came in, check the environment, resident lab documents, medications, " ...the works for sure ..."

Interview with Administrator on 03/11/22 at 1:03 PM regarding the completed investigation provided by the facility. Inquired with Administrator how she would have investigated the incident, Administrator stated she would have followed the facility's policy on abuse to get a thorough investigation. She would have reviewed who was working during the timeframe of the incident, interview as many witnesses or staff members that could have been involved. Admistrator further stated she would look into the reason before the report itself, specifically R159's bowel movements.

Review of the facility's "Comprehensive Abuse Policy and Prevention Program" last updated on 03/03/21, under Investigation Procedures, "The components of an internal investigation will be initiated immediately and may include: 1) an initial evaluation and interview, 2) a clinical history (if needed), 3) a physical examination (if needed), 4) a psychosocial examination (if needed), and interview with potential witnesses. 5) search of the premises 6) collecting of evidence 7) documentation ...All involved persons will be identified including the victim, alleged perpetrator,

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F 610	Continued From page 7 witness(es) and others with any information about the incident ..." Cross reference to F684. The facility failed to implement the physician ordered bowel movement regimen for R159.	F 610		
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 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	F 656		4/25/22

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F 656	Continued From page 8 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop and implement a person-centered comprehensive plan of care (POC) for two residents (R), R6 and R44, out of a total of 17 residents in the sample. Despite identifying R6 as a wanderer, a falls risk, and an elopement risk, his POC was not implemented consistently enough to prevent him from wandering outside of a secured unit, unsupervised, putting him at risk for injury. R44's POC did not include interventions to address the right-hand contracture(s) he was admitted with. As a result of this deficient practice, both R6 and R44 were placed at risk for avoidable injury and/or declines in their quality of life and were prevented from attaining their highest practicable well-being. This deficient practice has the potential to affect all the residents at the facility. Findings include: 1) R6 is a 72-year-old male admitted to the facility on 02/05/20 for long-term care services with diagnoses that include Alzheimer's dementia, chronic kidney disease, anemia, high blood pressure, diabetes, and hyperlipidemia (elevated	F 656	Residents 6 and 44 care plans were updated to reflect current interventions. Neither resident suffered injury. Unit managers were in-serviced regarding developing/implementing care plans by the SDC/MDS Coordinator/DON. In-services will be ongoing as needed. The MDS Coordinator reviewed current care plans for compliance. Facility residents have the potential to be affected by the alleged practice. Licensed nursing staff and the IDT were in-serviced regarding care plan development by the SDC/MDS Coordinator /DON. In-services will be ongoing as needed. MDS Coordinator/Unit Managers will audit for compliance through medical records review weekly for a minimum of 12 weeks or until substantial compliance has been achieved. The results of these audits will be brought to the monthly Quality Assurance/Performance Improvement	

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F 656	Continued From page 9 lipids). R6 has been housed in the facility's memory care unit (MCU) since 2020 after being identified as a resident who wanders, with a high-risk of elopement, and a risk for falls. On 03/08/22 at 09:20 AM, an observation was made of R6 standing outside of the MCU activity room, no door alarms were heard at the time. As soon as CNA4 noticed R6 outside, CNA4 exited the back door of the activity room and led R6 back inside. No door alarms were activated either time CNA4 opened the back door. At 09:39 AM, upon closer inspection of the back door of the activity room, it was observed that although it did have a door alarm, the sensor was not attached so that the alarm would be activated if the door was opened. An interview was done with CNA4 at that time, who immediately attached the sensor to activate the door alarm. CNA4 stated that the MCU was a secure unit, and that all exits had door alarms that should be kept activated except for the double-door fire exit in the dining room (DR). CNA4 explained that she believed R6 exited the unit through the DR, but that it should not have happened. At 09:45 AM, an inspection was done of the DR fire exit. Two heavy brown doors were observed with no alarm and no locks. When asked, CNA5 stated the fire doors were the only exit that were not locked or alarmed, but that the doors led to a gate outside that did have an alarm which remained activated at all times. At no other time throughout the day was R6 or any other resident observed outside or being taken outside. On 03/09/22 at 1:44 PM, an observation was made of the activity room's back door with the door alarm disconnected. The alarm on the side doors of the activity room were also noted to be	F 656	meetings for review for a minimum of 3 months or until substantial compliance has been achieved.	

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F 656	Continued From page 10	F 656		

disconnected. A tour of the outside patio area noted it was entirely paved with cement pathways and hand railings but had several wet areas following rain earlier in the day. There was an unsecured 6-foot folding ladder noted laying on the ground next to the pathway in one area, beneath a six-foot metal scaffolding. At no time throughout the day was R6 or any other resident observed outside or being taken outside.

On 03/09/22 at 2:30 PM, during a review of R6's comprehensive plan of care (POC), the following interventions were noted:
"Staff to ensure resident accompanied during ambulation to ensure no further injury."
"Place in Special Memory Care Unit. Ensure all door alarms/locks are armed to reduce the risk of ... [R6] leaving secure area."

On 03/10/22 at 3:46 PM, during medication administration with RN7, R6 could not be located inside the MCU. RN7 eventually was able to find R6 sitting alone outside at a table that was not visible from inside the MCU.

On 03/11/22 at 11:09 AM, an interview was done with the Resident Care Manager (RCM) at her station. The RCM stated that MCU residents are allowed to go outside during the day, and that is why the activity room doors are not secured during the day. The RCM agreed that this is not reflected in R6's CP and that if R6 is outside, he should always be supervised due to his risk for falls. When asked for facility documentation regarding leaving doors unsecured in the MCU during the day, the RCM stated she did not think the process had been formalized but was just something that they did so that residents could enjoy being outside.

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F 656	Continued From page 11	F 656		

2) R44 is a 77-year-old male admitted to the facility on 09/26/19 with admitting diagnoses that include right hand contracture (a shortening and hardening of muscles, tendons, or other tissue, leading to deformity and rigidity of joints), generalized muscle weakness, dementia, depression, high blood pressure, hemiplegia (paralysis of one side of the body), and hemiparesis (muscle weakness or partial paralysis on one side of the body) following a stroke.

On 03/08/22 at 12:27 PM, R44 was observed in the MCU DR with both hands clenched into fists. At 12:40 PM, R44 was observed feeding himself with his left hand, his right hand was still tightly clenched into a fist.

On 03/10/22 at 10:45 AM, an interview was done with CNA4 in the DR. CNA4 confirmed that R44 has contractures to the fingers of his right hand, and usually keeps the hand tightly clenched into a fist. CNA4 stated that she did not recall a rehabilitation therapist ever working with him and was unaware of any braces or hand splints for him. CNA4 explained that although there are no orders for it, they [the CNAs] do try to put a hand roll (towel) in his right hand, but that R44 usually "throws it on the side." A review of R44's electronic health record (EHR) was done at 11:00 AM. Nothing in his CP was found regarding contractures to his right hand or fingers. A review of his physician's orders also did not reveal any interventions for contractures.

On 03/11/22 at 1:02 PM, an interview was done with the Minimum Data Set Coordinator (MDSC) in her office. During a concurrent review of R44's

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F 656	Continued From page 12 EHR, the MDSC confirmed that despite the admitting diagnosis of right-hand contracture(s), nothing had been added to R44's POC to address it. The MDSC also could find no interventions ordered or signed refusals for treatment from either the resident or his family representative. The MDSC agreed that admitting diagnoses are usually addressed in the POC unless the resident or family has refused treatment.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the 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		4/25/22

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F 657	Continued From page 13 assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to review and revise the comprehensive plan of care (POC) for four residents, R159, R44, R47, and R54, out of a total of 17 residents in the sample. This deficient practice failed to effectively address the residents' status, condition, and needs, and therefore not assisting these residents attain their highest practicable physical and psychosocial well-being. This deficient practice has the potential to affect all the residents at the facility. Findings include: 1) R159 was admitted to the facility on 06/21/21 and discharged to home with hospice on 08/13/21. Review of the Event Report completed by the facility on 07/30/21, the facility reported during routine rounds on 07/28/21 at 08:00 AM, R159 was assessed to have multiple purple bruises on her buttocks and anal area. "Medical Director assessed bruises and felt that they were likely trauma related as they were not over bony prominences and due to the fact that the daughter had stated yesterday that resident has difficulty pooping sometimes so she massages resident and "pokes" her. Daughter clarified "poking" to mean performing digital stimulation [involves moving the finger around in a circular motion inside the rectum to stimulate the bowel reflex]." On 03/11/22 at 10:30 AM, reviewed R159's physician's order dated 06/21/21. The physician	F 657	Residents 159, 44, 47, and 54 care plans were updated to reflect current interventions. Unit managers were in-serviced regarding updating/revising care plans by the SDC/MDS Coordinator. In-services will be ongoing as needed. The MDS Coordinator reviewed current care plans for compliance. Facility residents have the potential to be affected by the alleged practice. Licensed nursing staff and the IDT were in-serviced regarding care plan updating/revision by the SDC/MDS Coordinator/DON. In-services will be ongoing as needed. MDS Coordinator/Unit managers will audit for compliance through medical records review weekly for a minimum of 12 weeks or until substantial compliance has been achieved. The results of these audits will be brought to the monthly Quality Assurance/Performance Improvement meetings for review for a minimum of 3 months or until substantial compliance has been achieved.	

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ordered bowel movement regimen include, Colace 100 milligrams (mg) twice a day for constipation; senna 17.2 mg twice a day for constipation; prune juice 120 milliliters (ml) PRN (as needed) if no bowel movement in two days; Milk of Magnesia (MOM) 30 milliliters PRN if no bowel movement in three days; Dulcolax suppository 10 mg PRN if no bowel movement in three days or no results from MOM; Enema Disposable PRN if no bowel movement in four days.

Review of a document provided by Infection Preventionist (IP) on 03/11/22 at 08:39 AM. The document revealed that on 06/29/21 the facility added half a cup of papaya to between meal snacks and on 07/01/21 added half a cup of papaya and prune juice daily for breakfast.

Interview with IP on 03/11/22 at 12:51 PM and concurrent review of R159's daily bowel movement output log and medication administration record (MAR). After the reported incident on 07/28/21, R159 did not have a bowel movement from 08/02/21 to 08/07/21, a total of six days, R159 was not administered the PRN physician ordered bowel movement regimen. IP stated, if the bowel movement regimen was followed, R159 would have been administered MOM on the third day of no bowel movement, 08/05/21. IP confirmed the POC was not revised to address treatment for constipation after an incident that resulted in R159's daughter to perform digital stimulation due to constipation.

Cross Reference to F684 Quality of Care. The facility failed to implement the physician ordered bowel movement regimen for R159.
2) R44 is a 77-year-old male admitted to the

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facility on 09/26/19 with admitting diagnoses that include right hand contracture (a shortening and hardening of muscles, tendons, or other tissue, leading to deformity and rigidity of joints), generalized muscle weakness, dementia, depression, high blood pressure, hemiplegia (paralysis of one side of the body), and hemiparesis (muscle weakness or partial paralysis on one side of the body).

On 03/08/22 at 12:27 PM, R44 was observed in the MCU DR with both hands clenched into fists. At 12:40 PM, R44 was observed feeding himself with his left hand, his right hand was still tightly clenched into a fist.

On 03/10/22 at 10:45 AM, an interview was done with CNA4 in the DR. CNA4 confirmed that R44 has contractures to the fingers of his right hand, and usually keeps the hand tightly clenched into a fist. CNA4 stated that she did not recall rehab (rehabilitation services) ever working with him and was unaware of any braces, hand splints, or exercises for him. CNA4 explained that although there are no orders for it, they [the CNAs] do try to put a hand roll (towel) in his right hand, but that R44 usually "throws it on the side."

On 03/11/22 at 2:17 PM, an interview and concurrent record review of R44's electronic health record (EHR) was done with Occupational Therapist (OT)1 in the Rehab/Exercise Room. It was noted that from 03/04/21 to 03/31/21, R44 had received occupational therapy services. In the occupational therapy assessment done on 03/04/21, OT1 documented " ...[R44] presents to therapy with decreased ... B [bilateral] UE [upper extremity] strength and ROM [range of motion] and decreased/inconsistent functional use of right

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hand." On 03/30/21, prior to discharging R44 from occupational therapy services, OT1 developed a Rehab [rehabilitation] In-Service Record and Home Exercise Program which included a review of the services provided, patient-centered reminders and interventions to apply to maintain and promote ROM, and instructions with illustrations of specific exercises to continue. OT1 used this document to instruct MCU staff, both RNs and CNAs, on her recommendations. When asked, OT1 stated she was never trained on how to access or update resident POCs, that usually that was done by nursing staff. An independent review of R44's comprehensive POC found no mention of OT1's recommendations or interventions regarding his right-hand contractures.

3) On 03/08/22 at 09:18 AM, an initial observation of R47 was done. R47 was sitting up in her wheelchair watching television in the activity room. Her left foot was visible underneath her blanket. It was swollen. Both of her legs were close to the ground.

On 03/08/22 at 12:05 PM, R47 was sitting up in her wheelchair in the activity room watching television and eating her lunch. Both of her legs were close to the ground.

On 03/08/22 at 12:30 PM, R47 was sitting up in her wheelchair, her legs close to the ground. She was observed to be asking RN6 to go back to her room. RN6 stated that she would need assistance back to her room and there was no staff available to help her.

On 03/08/22 at 1:00 PM, observed R47 assisted back to bed by CNA4. R47 stated that she was tired and that her legs were swollen. CNA4 stated

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that she will notify the nurse regarding her swollen legs.

On 03/08/22 at 1:07 PM, R47 was interviewed in her room. She stated that she formerly worked as a nurse. She also stated that her legs were swollen, but denied any pain. Her legs were not elevated on pillows.

On 03/09/22 at 08:39 AM, R47 was observed to be sitting up in her wheelchair, her legs low to the ground, eating her breakfast.

At 09:34 AM, Physician's Assistant (PA)2 visited R47. PA2 assessed R47's feet and stated that they were swollen. The PA2 instructed her to keep her legs elevated.

On 03/10/22 at 08:11 AM, R47 was eating her breakfast in the activity room and a black splint was noted on her left lower leg. Her legs were noted to be swollen. Her legs were low to the ground.

At 08:26 AM, R47 wheeled herself from the activity room to the dining room. Both of her legs were close to the ground. CNA4 assisted R47 to the restroom.

At 08:40 AM, R47 was back in the activity room watching television. Both of her legs remained close to the ground.

On 03/10/22 at 12:00 PM, a record review was done of R47's electronic health record (EHR). "Discharge Summary" from a hospital dated 12/13/21 stated that she had a left kneecap fracture that was "nondisplaced," or the bone was cracked in only one place that did not change the

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alignment of the knee, which did not require surgery. But if her knee did become displaced, then surgical intervention would be needed. R47 is an 86-year old female admitted to the facility on 12/13/21 for dementia, fracture of left humerus (left upper arm), fracture of left patella (kneecap), difficulty in walking, muscle weakness, and fall.

R47's POC, last reviewed/revised on 02/14/22, was read. The only entry regarding her left kneecap fracture was: "Resident has complaints of acute pain R/T [related to] fracture of left humerus and left patella fracture." Intervention included: "Left knee immobilizer to be used as ordered." There were no interventions to monitor and treat for leg swelling and possible displacement of her left kneecap.

Further review of R47's EHR revealed that there was no note by the PA2 regarding the education given to R47 to keep her legs elevated for the swelling and no order to keep R47's lower extremities elevated.

On 03/10/22 at 12:09 PM, the facility's policy "Care Plans, Comprehensive Person Centered" was reviewed. It stated, " ...13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change."

On 03/11/22 at 10:20 AM, RN6 was interviewed at the unit's nursing station. She stated that R47's legs should be elevated because they were swollen and that the RCM will revise the plan of care (POC) after she reviews the resident's health record.

Cross reference to F684. R47 did not receive the

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appropriate care and monitoring for her leg swelling.
4) On 03/08/22 at 10:52 AM, R54 was observed sitting up in her bed in her room. R54 had skid socks on her feet and both feet were resting on a pillow. A foam boot was on the bed. R54 greeted surveyor and continued eating breakfast.

On 03/08/22 at 12:59 PM, a concurrent interview and observation of R54 was done. Surveyor observed that R54 was not wearing her left boot. R54 stated that she was told by staff that she has an autoimmune disease that caused blisters on her left foot. R54 stated that wearing the foam boot will help the sores to heal.

On 03/09/22 at 1:04 PM, R54 was in her bed. R54's foam boot was on top of the R54's closet. R54 stated, "They put the heel boot on all the time except now."

On 03/09/22 at 5:23 PM, R54's record was reviewed. R54 was admitted to the facility on 12/22/21 for acute kidney failure and Guillain-Barre Syndrome (disorder of the immune system where the nerves are attacked by immune cells that causes weakness and tingling in arms and legs). Quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 02/16/22, stated that her Brief Interview Mental Status (BIMS) score was 13, meaning that she is cognitively intact. She requires use of an indwelling catheter for urinary retention. R54 requires two-person physical assist for bed mobility and transfers "Weekly Skin Assessment" dated 01/14/22, stated that R54 had blisters on her right and left ankle. "Weekly Skin Assessment" dated 02/25/22, stated that there were no new blisters, continue treatment for left

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F 657	Continued From page 20 ankle blisters, and that right foot blisters had healed. Review of R54's Orders dated 02/24/22 stated, "Left heel boot to be on at all times. Every Shift. Days, Evenings, Nights." R54's POC for "Problem: Resident has popped blisters that are infected" stated an approach dated 02/25/22, for "Heel boot to be used on left foot 24/7." On 03/10/22 at 09:49 AM, surveyor observed R54 in bed with heel boot on left foot. Surveyor observed Registered Nurse (RN)2 and Resident Care Manager (RCM) perform dressing change to left foot. The blister to the left foot had no drainage and appeared to be healing. RN2 and RCM put R54's heel boot back on her left foot and propped her feet on a pillow. On 03/10/22 at 2:41 PM, a concurrent interview and record review was done with RCM. RCM reviewed R54's order and POC for R54's heel boot to be applied continuously on the left foot. RCM stated that the order and POC were incorrect and were ordered by the facility's former physician. RCM stated that R54 can take off her heel boot off for rest periods and to check skin circulation. RCM stated that their wound Physician Assistant (PA)1 had discussed with staff that the heel boot was used to aid in healing the blisters but was not required to be worn at all times. RCM stated that she will update R54's POC and orders. RCM further reviewed "Wound Care SNF Consult Service Progress Note" for 02/15/22 and 03/08/22, and confirmed the PA1 did not recommend to use heel boots continuously for R54.	F 657		
F 684 SS=G	Quality of Care CFR(s): 483.25	F 684		4/25/22

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F 684	Continued From page 21 § 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, record reviews and interviews, the facility failed to provide resident centered needed care and services for three residents, R159, R20, and R47, out of a total of 17 sampled residents. The facility did not follow the physician ordered bowel regimen for R159 and R20, which resulted in a family member performing digital stimulation on R159. R159 and R20 potentially suffered discomfort and fecal impaction. R47 did not receive the appropriate care for her swollen legs and monitoring of her left kneecap for possible displacement. These deficient practices could potentially affect all residents in the facility. Findings include: 1) R159 was admitted to the facility on 06/21/21 and discharged to home with hospice on 08/13/21. Residents' primary language is Korean. Diagnosis include but not limited to, posterior reversible encephalopathy syndrome, unspecified encephalopathy, complete atrioventricular block, hypertensive emergency, unspecified combined systolic (congestive) and diastolic (congestive) hear failure, acute cystitis without hematuria, functional quadriplegia, dysphagia, cramp and spasm, muscle weakness, and unspecified pure	F 684	Residents 159, 20 and 47 were reviewed by the IDT and interventions were reviewed and put into place. SDC/DON in-serviced the staff involved with these residents regarding bowel protocol and wheelchair positioning interventions. RN was in-serviced regarding getting staff to assist when needed for residents' care. In-services will be ongoing as needed. Facility residents have the potential to be affected by the alleged practice. Current residents' bowel outputs reviewed by unit managers for compliance. Current residents' wheelchair positioning was reviewed by unit managers/therapy for compliance. IDT/Nursing staff were in-serviced regarding following bowel protocols and positioning interventions by the SDC/DON/designee. In-services will be ongoing as needed. DON/Unit Managers/designee will audit for compliance through observations and medical records review weekly for a minimum of 12 weeks or until substantial	

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F 684	Continued From page 22 hypercholesterolemia. Review of the Event Report completed by the facility on 07/30/21, the facility reported during routine rounds on 07/28/21 at 08:00 AM, R159 was assessed to have multiple purple bruises on her buttocks and anal area. "Medical Director assessed bruises and felt that they were likely trauma related as they were not over bony prominences and due to the fact that the daughter had stated yesterday that resident has difficulty pooping sometimes so she massages resident and "pokes" her. Daughter clarified "poking" to mean performing digital stimulation [involves moving the finger around in a circular motion inside the rectum to stimulate the bowel reflex]." On 03/10/22 at 11:16 AM interviewed Infection Preventionist (IP), IP clarified on 07/27/21, prior to the discovered bruising, in the care plan meeting R159's daughter " ...shared her mom has poor output and she massages and "pokes" her mom ... Which raised a red flag ..." IP did not know when and how often R159's daughter performed digital stimulation at the facility. IP shared R159 did have a history of constipation and was on bowel medication. Inquired what the protocol is for a resident who is constipated, " ...the nurses look at the bowel regimen. Prune juice day two, then milk mag. (milk of magnesium) day three ..." Concurrent review of R159's daily bowel movement output log and medication administration record (MAR), prior to the reported incident on 07/28/21, R159 did not have a bowel movement from 07/09/21 to 07/13/21, a total of five days, and from 07/15/21 to 07/21/21, a total of seven days. IP confirmed R159 was not administered the PRN (as needed) physician's	F 684	compliance has been achieved. The results of these audits will be brought to the monthly Quality Assurance/Performance Improvement meetings for review for a minimum of 3 months or until substantial compliance has been achieved.	

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ordered bowel movement regimen during those dates. Inquired if the bowel protocol should have been implemented from 07/15/21 to 07/21/21, IP stated the protocol should have been implemented, " ...the physician should have been called and it should have been documented."

Review of R159's physician's order dated 06/21/21. The physician ordered bowel regimen included Colace 100 milligrams (mg) twice a day for constipation; senna 17.2 mg twice a day for constipation; prune juice 120 milliliters (ml) PRN if no bowel movement in two days; Milk of Magnesia (MOM) 30 milliliters PRN if no bowel movement in three days; Dulcolax suppository 10 mg PRN if no bowel movement in three days or no results from MOM; Enema Disposable PRN if no bowel movement in four days.

Interview with Infection Preventionist (IP) and Director of Nursing (DON) on 03/11/22 at 08:39 AM, IP stated the facility was aware R159 was constipated.

On 03/11/22 at 10:15 AM, reviewed R159's nursing progress notes, on 06/24/21 "resident with no BM (bowel movement) since 6/21/21, suppository administered." On 06/27/21, "Observed resident with her gesture that she wanted to move her bowel. Resident on 3 days no BM." On 06/29/21 " ...resident needing frequent PRN medications to help with constipation, resident shows signs of grimacing and would occasionally yelp. Talked to resident's daughter and she said resident is constipated." on 07/01/21 in the care conference summary it was noted "Daughter mentioned that resident has been complaining of pain upon having a bowel movement. Dietary to add papaya and prune juice

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to assist." In another note dated 07/01/21, "Dtr. (Doctor) concerned about BM pattern. Resident has small BM on 06/30/21 ..." On 07/25/21, "Saline enema administered for 3 days no BM resident in distress, produced medium formed stool and resident expressed relief." On 07/29/21, "Resident daughter shared in care plan meeting that she performed an attempted rectal digital dis-impaction [a large, hard mass of stool that gets stuck so badly in your colon or rectum that you can't push it] outwithout nursing staff being aware. Daughter educated that any and all needs of the residents need to be performed by nursing staff only."

During a follow-up interview with IP on 03/11/22 at 12:51 PM and concurrent review of R159's daily bowel movement output log and medication administration record (MAR), after the reported incident and learning R159's daughter had performed digital stimulation, R159 did not have a bowel movement from 08/02/21 to 08/07/21, a total of 6 days, and R159 was not administered the PRN physician's ordered bowel regimen. IP stated, if the bowel regimen was followed, R159 would have been administered MOM on the third day of no bowel movement, 08/05/21.

Cross reference to F610. The facility failed to complete a thorough investigation of abuse. The facility concluded the bruises around R159's buttocks and anus area were because of R159's daughter massaging and performing digital stimulation due to constipation, with no documentation of interviews with R159, the daughter, and other staff members after the bruises were discovered.

Cross reference to F657. The facility failed to

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revise R159's plan of care (POC) to include treatment of constipation after investigating the incident. In result, R159 continued to have an episode of prolonged constipation without treatment from the physician's ordered bowel regimen.
2) R20 was admitted to the facility on 02/03/20 diagnoses which includes, nontraumatic intracerebral hemorrhage, unspecified; hemiplegia and hemiparesis following cerebral infarction affecting right dominant side; and major depressive disorder, single episode, unspecified.

On 03/08/22 at 09:30 AM a resident interview done, the resident reported having constipation, sometimes going three to four days without bowel movement. Further queried whether he is offered medication, resident responded he doesn't worry about that and then it just comes out.

On 03/09/22 at 2:45 PM a record review was done which found a physician's order for R20's bowel regimen, senna plus twice a day; prune juice, 120 ml (milliliter) for no bowel movement in two days; milk of magnesia 30 ml if no bowel movement in three days; and enema if no bowel movement in four days.

A review of the resident's output for January 2022, notes R20 did not have bowel movement from 01/05/22 to 01/07/22 and 01/28/22 to 01/31/22. In February 2022, R20 did not have bowel movement for the following periods, 02/01/22 to 02/07/22, 02/12/22 to 02/17/22, and 02/19/22 to 02/27/22. A review of the MAR for January and February could not find documentation that the physician ordered bowel regimen prescribed was implemented. A review of the nursing progress notes found refusal of

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interventions that were offered on 02/19/22, 02/25/22, 02/26/22, and 02/27/22. There is no documentation R20 was offered interventions during a five day period, from 02/20/22 to 02/24/22.

R20 did not have bowel movement from 03/04/22 to 03/07/22. There is no documentation in the MAR or progress notes indicating R20's bowel regimen was implemented.

Interview and concurrent record review was done with Infection Preventionist (IP) on 03/11/22 at 08:54 AM. IP confirmed R20 did not have bowel movement for two days (01/05/22 to 01/07/22), however, reported prune juice would have been offered on the 01/08/22. IP confirmed R20 did not have bowel movement from 01/28/22 to 01/31/22 and there was no documentation of R20 refusing any interventions.

Reviewed the output and MAR with IP for the month of February 2022. IP confirmed R20's bowel regimen was not implemented during the following time periods, 02/03/22 to 02/06/22 (four days), 02/12/22 through 02/17/22 (six days), and 02/19/22 through 02/27/22 (nine days) and 02/20/22 to 02/24/22 (five days). The IP confirmed there was no documentation in the MAR or progress notes of attempts to offer prune juice, milk of magnesia, and enema as prescribed.

IP confirmed R20 had no bowel movement from 03/04/22 to 03/07/22 and there is no documentation in the MAR or progress notes that R20 was offered and/or refused bowel protocol interventions.
3) On 03/08/22 at 09:18 AM, an initial observation

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of R47 was done. R47 was sitting up in her wheelchair watching television in the activity room. Her left foot was visible underneath her blanket. It was swollen. Both of her legs were close to the ground.

On 03/08/22 at 12:05 PM, R47 was sitting up in her wheelchair in the activity room watching television and eating her lunch. Both of her legs were close to the ground.

On 03/08/22 at 12:30 PM, R47 was sitting up in her wheelchair, her legs close to the ground. She was observed to be asking Registered Nurse (RN)6 to go back to her room. RN6 stated that she would need assistance back to her room and there was no staff available to help her.

On 03/08/22 at 1:00 PM, observed R47 assisted back to bed by CNA4. R47 stated that she was tired and that her legs were swollen. CNA4 stated that she will notify the nurse regarding her swollen legs.

On 03/08/22 at 1:07 PM, R47 was interviewed in her room. She stated that she formerly worked as a nurse. She also stated that her legs were swollen, but denied any pain. Her legs were not elevated on pillows.

On 03/09/22 at 08:39 AM, R47 was observed to be sitting up in her wheelchair, her legs low to the ground, eating her breakfast.

At 09:34 AM, Physician's Assistant (PA)2 visited R47. The PA assessed R47's feet and stated that they were swollen. The PA2 instructed her to keep her legs elevated.

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On 03/10/22 at 08:11 AM, R47 was eating her breakfast in the activity room and a black splint was noted on her left lower leg. Her legs were noted to be swollen. Her legs were low to the ground.

At 08:26 AM, R47 wheeled herself from the activity room to the dining room. Both of her legs were close to the ground. CNA4 assisted R47 to the restroom.

At 08:40 AM, R47 was back in the activity room watching television. Both of her legs remained close to the ground.

On 03/10/22 at 12:00 PM, a record review was done of R47's electronic health record (EHR). "Discharge Summary" from a hospital dated 12/13/21 stated that she had a left kneecap fracture that was "nondisplaced," or the bone was cracked in only one place that did not change the alignment of the knee, which did not require surgery. But if her knee did become displaced, then surgical intervention would be needed. R47 is an 86-year-old female admitted to the facility on 12/13/21 for dementia, fracture of left humerus (left upper arm), fracture of left patella (kneecap), difficulty in walking, muscle weakness, and fall.

R47's POC, last reviewed/revised on 02/14/22, was read. The only entry regarding her left kneecap fracture was: "Resident has complaints of acute pain R/T [related to] fracture of left humerus and left patella fracture." Intervention included: "Left knee immobilizer to be used as ordered." There were no interventions to monitor and treat for leg swelling and possible displacement of her left kneecap.

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F 684	Continued From page 29 Further review of R47's EHR revealed that there was no note by the PA2 regarding the education given to R47 to keep her legs elevated for the swelling and no order to keep R47's lower extremities elevated. On 03/10/22 at 12:09 PM, the facility's policy "Care Plans, Comprehensive Person Centered" was reviewed. It stated, " ...13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change." On 03/11/22 at 10:20 AM, RN6 was interviewed at the unit's nursing station. She stated that R47's legs should be elevated because they were swollen and that the RCM will revise the care plan after she reviews the resident's health record. Cross reference to F725. R47's request to go back to bed was not accomodated due to the insufficient number of nursing staff.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	F 686		4/25/22

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F 686	Continued From page 30 new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to prevent the development of multiple pressure ulcers (localized damage to the skin and/or underlying soft tissue usually over a bony prominence) in one resident, R48, out of a total of 17 sampled residents. The facility did not obtain the orthopedist consult which provided instruction for the removal of a boot used for R48's left ankle fracture to assess the skin on regular intervals. This deficient practice resulted in the development of avoidable multiple pressure ulcers and could potentially affect all residents. Findings include: R48 was admitted to the facility on 11/26/14. Diagnoses includes but not limited to unspecified dementia without behavioral disturbance, Type 2 diabetes mellitus without complications, unspecified osteoarthritis (unspecified site), peripheral vascular disease, and age-related osteoporosis without current pathological fracture. Record review was done on 03/10/22 at 07:15 AM. A progress note documented on 09/27/21 at 07:26 AM, R48 complained of pain to her left foot and ankle. A physician order for an x-ray was obtained. The x-ray revealed a fracture of left distal tibia (ankle). R48 was seen by the orthopedist and returned to the facility with a "left leg cast" on 10/05/21. The nurse that accompanied R48 to the orthopedist reported R48 needs to wear the "leg cast" 24/7 (24 hours, seven days a week). R48's physician was notified on 10/05/21 at 12:02 PM and ordered "aircast" to left leg be worn 24/7 until further	F 686	Resident 48's wounds were fully healed on 2/8/22. Unit managers were in-serviced regarding obtaining the physician visit report and follow up with devices and skin assessment by the SDC/DON. Wound care team reviewed current residents for compliance. In-services will be ongoing as needed. Facility residents have the potential to be affected by the alleged practice. Nursing staff were re-in-serviced regarding skin assessments/devices and obtaining physician reports after appointments by the Unit Managers/SDC/DON. In-services will be ongoing as needed. DON/Unit Managers/designee will audit for compliance through observations and medical records review weekly for a minimum of 12 weeks or until substantial compliance has been achieved. The results of these audits will be brought to the monthly Quality Assurance/Performance Improvement meetings for review for a minimum of 3 months or until substantial compliance has been achieved.	

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notice.

Progress note dated 10/24/21 documents weekly skin check was performed. The assessor noted three pressure ulcers under R48's "air cast" to the left lower extremity. R48 was assessed with an unstageable pressure ulcer to the top of the left foot measuring 2 centimeter (cm) (length, L) by 2.8 cm (width, W) with eschar (dead tissue) covering the wound. A second unstageable pressure ulcer was identified to the ball of the left foot, measuring 2 cm (L) by 6 cm (W) and covered with yellow tissue, unable to determine the depth of injury. The third pressure ulcer was assessed as a Stage Two (superficial tissue injury) to the bottom of the second toe on the left foot, measuring 1.4 cm (L) x 1.5 cm (W) with beefy red wound bed. Assessor also noted purulent exudate on the foot and air cast. R48 reported pain to her foot.

Review of skin assessments found no documentation of assessments were performed from 10/05/21 (application of boot) through 10/16/21. The skin assessment for 10/17/21 documents "no new skin issues noted." Skin was warm, dry, normal color, no petechiae, normal skin turgor, and no alterations to the skin.

Interview and concurrent record review were done with the Infection Preventionist (IP) and Director of Nursing (DON) on 03/11/22 at 09:19 AM. Staff members confirmed physician's order for weekly skin assessments with a start date of 07/28/20. Staff members confirmed skin assessments were not done from 10/05/21 through 10/16/21. Inquired how would nurses assess R48's skin while wearing a boot? IP responded, the order was not to remove the boot

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so the nurse would assess the skin that is not covered by the boot, pain, temperature changes, and areas that could contribute to a pressure ulcer. Requested to review the orthopedist consult note, the type of boot the resident was wearing, and what lead to the nurse opening the resident's boot on 10/24/21.

Interview, review of requested documentation, and record review were done with the Administrator, DON, and Regional Clinical Operations Specialist (RCOS) on 03/11/22 at 10:13 AM. RCOS confirmed that there was miscommunication regarding the orthopedist's instruction for R48 to wear the boot 24/7. A copy of the physician order was provided, "left air cast to be worn 24/7 till further notice" which was signed on 10/06/21. RCOS reported the facility was following the physician's order.

The team confirmed the facility did not obtain the orthopedist report and the reports were requested on 03/10/22. The orthopedist report was provided for review on 03/11/22 at 11:28 AM. Review of the orthopedist report, dated 10/05/21 documents the following, "This CAM [Controlled Ankle Movement boot is an adjustable device that limits ankle and foot movement which is comprised of a flexible liner which the foot fits into and a rigid shell supports and protects the leg] boot can be removed or repositioned as necessary to keep the patient in a position of comfort and to assess the skin on regular intervals for reassessment."

The facility provided documentation of weekly skin assessment for 10/17/21 and 10/24/21. RCOS reviewed the progress notes for possible documentation of skin assessments from

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F 686	Continued From page 33 10/05/21 through 10/17/21. It was confirmed weekly skin assessments were not done during this period. RCOS was unable to recall what type of boot R48 was prescribed. The DON reported due to the use of a boot, R48's skin should be checked for sensation, color, temperature and swelling. Staff members reported, R48's boot was removed on 10/24/21 due to foul-smelling odor as documented in the progress note. Cross Reference to F689. As a result of improper transferring, R48 sustained an avoidable injury, left tibia/fibula fracture to her left foot.	F 686		
F 689 SS=E	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 observations, record reviews and interviews, the facility failed to: 1) provide appropriate care and supervision for residents(R), R48, R42, and R45, out of 17 residents sampled, 2) provide an environment free from hazards for residents in rooms 6 and 111 from extremely hot water temperatures, and 3) provide an environment free from hazards for residents who suffer from memory loss who could potentially be poisoned due to an incomplete	F 689	The unit was not short staffed on the date of Resident 48's incident. The CNA involved admitted to the administrator, at the time, in his initial interview that he chose to transfer the resident himself rather than get help because it was quicker. There was staff available to help. He no longer works at the facility. Residents 42 and 45 suffered no injury. Staff involved in these events were re-in-serviced regarding transfers and	4/25/22

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F 689	Continued From page 34 assessment of R16's smoking device. These deficient practices could negatively impact all residents in the facility by causing them harm. Findings include: 1) The facility submitted a report of an injury of unknown origin to the State Agency (SA) on 09/27/2. R48 was complaining of pain to the left foot and ankle and there was noted swelling of the left ankle, extending midway down dorsal aspect of foot was observed. R48's physician ordered an x-ray of left foot and ankle. An x-ray was ordered which showed a fracture of the left distal tibia. The facility conducted an investigation to determine the cause of the injury. The facility reported CNA6 did not implement R48's plan of care (POC) for transferring. R48 requires a mechanical lift (devices to assist with transfers and movements of individuals who require support for mobility beyond the manual support provided by caregiver alone) with two person assist, CNA6 performed a "stand-pivot" transfer of the resident alone. CNA6 submitted resignation notice on 09/30/21. A review of the quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 08/30/21 notes for transfers (how resident moves between surfaces, including to or from: bed, chair, wheelchair, standing position) R48 is totally dependent (full staff performance) with two plus persons physical assist. R48's POC dated 09/09/20 identifies approach (intervention) for "mechanical lift for all transfers". On 03/10/22 at 10:25 AM a telephone interview	F 689	supervision by the SDC/DON. In-services will be ongoing as needed. Water temperatures were addressed immediately. EVS Manager ordered a mixing valve to help regulate water temperatures that is due to arrive the middle of April. EVS Manager met with MCU staff regarding water temperatures and discussed safety measures. Resident 16 was reassessed regarding his vape device/content. Policy was updated to reflect full assessment. Facility residents have the potential to be affected by the alleged practice. Nursing staff, Activity staff, and the IDT were in-serviced regarding assisting residents in transfers and supervision by the SDC/DON/designee. IDT and nursing staff were in-serviced regarding vape devices and content. Administrator/designee re-in-serviced Environmental Services (EVS) team regarding water temperatures and regular monitoring of water temperatures. In-services will be ongoing as needed. DON/Unit Managers/designee will audit for compliance through observations and medical records review weekly for a minimum of 12 weeks or until substantial compliance has been achieved. The results of these audits will be brought to the monthly Quality Assurance/Performance Improvement meetings for review for a minimum of 3 months or until substantial compliance has been achieved.	

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F 689	Continued From page 35 was conducted with CNA6. CNA6 recalled being assigned as a floater on the day of the event, they were short of staff and he was assigned to shower the residents residing in two wings, going back and forth between two nursing units. CNA6 went to shower R48 and noticed his coworkers were all busy so he transferred R48 from bed to the shower chair alone. After the shower, CNA6 stated his coworker was still busy so he transferred R48 alone from the shower chair back to bed. CNA6 reported R48 did not fall. CNA6 reported he tried to comfort the resident and massaged her foot as she said it was sore. CNA6 was asked what kind of transfer did R48 require. CNA6 responded, two man assist and use of the lift. Further asked how he transferred R48. CNA6 responded, he stood the resident up and turned her to sit in the shower chair. On 03/10/22 at 10:58 AM an interview was conducted with the Infection Preventionist (IP) as the staff members that conducted the investigation are no longer employed at the facility. The IP reported she participated in the investigation of this incident. IP recalled R48 presented with foot pain and following an x-ray was diagnosed with left foot fracture. The facility initiated an investigation to determine how R48 got injured. Staff members were interviewed. CNA6 reported he transferred R48 without a lift, CNA6 reportedly picked her up to stand and she said "oowww". IP stated CNA6 was rushing to get the showers done and was not malicious, he made a bad choice. IP reported R48's care plan indicates to transfer resident with mechanical lift with assist of two people. IP further reported two people are always used with a mechanical lift.	F 689	EVS Manager/designee will monitor water temperatures weekly as part of preventive maintenance utilizing temperature logs. Results of the audits will be brought to the monthly Quality Assurance/Performance Improvement meetings for review for a minimum of 3 months or until substantial compliance has been achieved.	

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IP recalled during the interview, CNA6 recalled during the transfer R48 said "ouch". CNA6 reportedly stated he asked R48 if she was okay, R48 responded she was sore. CNA6 also reported he attempted to massage the resident's foot and she did not say ouch.

The facility's investigation was completed on 09/30/21. The facility substantiated the deficient practice and implemented a corrective action plan. A Performance Improvement Plan (PIP) was developed. The identified problem was staff chose to perform a manual transfer vs. using 2-man assist mechanical lift transfer as indicated in the resident's plan of care. The goal of the PIP was for staff to transfer residents only according to care determination documented in the Resident Profile.

The interventions of the PIP included the following: auditing of resident' plan of care for those residents requiring two man assist mechanical lift was included in the plan of care and Resident Profile; re-inservice of staff to ensure they know how to find transfer information in the Resident Profile; provide information regarding safe transfer for residents at the general staff meeting; and complete mechanical lift competency for CNAs.

A review of the facility's PIP project found documentation the facility completed the auditing of residents' care plans on 09/29/21 to ensure residents' that required 2-man assist mechanical lift was included in the plan of care and Resident Profile. An inservice was provided for "Resident Transfers and Mechanical Lift" was done on 09/29/21, the facility provided documentation of

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inservice attendance. The facility conducted competency checks for "Transferring a Resident Using A Mechanical Lift". CNA competency checks were conducted on 10/05/21 and 10/06/21. The facility provided supporting documentation of the competency checks. The facility also presented the need for safety during the general staff meeting on 10/07/21. Random audits were also conducted in September, October, November and December in conjunction with infection control (also ensuring proper sanitization of equipment). The Administrator reported results of the PIP were brought to the Quality Assurance and Performance Improvement (QAPI) meeting for review. The PIP was successfully closed during QAPI meeting on 12/29/21.

Cross Reference F686. R48 developed pressure ulcers related to the use of Controlled Ankle Movement (CAM) boot to treat the left distal tibia fracture.

Cross Reference F725. R48 sustained a left ankle fracture due to CNA6 performing a transfer with R48 without assistance due to short staffing. 2) On 03/08/22 at 12:05 PM, R42 was observed in the activity room sitting up in a recliner eating his lunch. He was coughing forcefully, pushed the bedside table with his lunch tray on top away from him, got up from the recliner, and started walking without his walker that was placed to the side of him. CNA5 saw him from the adjacent dining room and intervened. She asked him where he was going, grabbed his walker, placed it in front of R42 and walked with him approximately 50 feet down the hallway to a recliner where he sat down. He continued to cough forcefully while walking down the hallway with CNA5. While he sat in the

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recliner, a bedside table was placed in front of him with a newspaper. No staff were observed to be in any of the resident's rooms or hallway.

From 12:05 PM to 12:52 PM, R42 was in the line of sight of state agency (SA) and no staff were noted to have checked R42 while he sat in the recliner secluded approximately 50 feet away from other residents and staff. There was no staff in the activity room supervising three residents (R49, R41, and R47) because all three staff (CNA4, CNA5, and RN6) scheduled for the unit were assisting residents in the dining room with their lunches or helping residents to the restroom and monitoring two residents (R23 and R6) who were actively wandering.

On 03/09/22 at 08:55 AM, R42 got up from the recliner in the activity room, walked without his walker into the adjacent dining room carrying a newspaper. RN6 intervened, asked him what he wanted to do and CNA4 stated that R42 needed to use the restroom and assisted him.

On 03/09/22 at 3:10 PM, R42's electronic health record (EHR) was reviewed. R42 is a 64-year old male admitted to the facility on 11/04/19. His diagnoses include dementia, anxiety, disorientation, aphasia (disorder to express language), unsteadiness on feet, history of falling, and history of transient ischemic attacks (TIAs, also known as mini-strokes) either caused by plaques narrowing the blood pathway of arteries or small blood clots in the brain.

R42's "John Hopkins Fall Risk Assessment Tool" dated 01/19/21 was reviewed and revealed R42 as being a "High Fall Risk."

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His plan of care (POC) with last reviewed/revised date of 02/15/22 revealed a problem for "Risk for falls due to impaired mobility, dementia with impulsive behaviors" with an intervention of "Assist with transfers and ambulation using FWW [front wheeled walker]." A problem was also revealed for: " ...has history of Wandering Behavior, unable to locate his room, going into other residents (sic) rooms and laying in bed." One of the interventions for this problem was, "Resident in secured memory care unit due to his daily wandering."

R42's medication administration record (MAR) was reviewed. It revealed that he was on Clopidogrel tablet (medication that prevents platelets from forming blood clots) 75 milligrams (mg) to be taken at 08:00 AM and is used to treat his TIAs. There was no entry on R42's care plan to monitor for increased bleeding or to prevent accidents which may cause unwanted bleeding.

A review of R42's MDS with ARD of 02/14/22 revealed for "Section G Functional Status," "G0300. Balance During Transitions and Walking" that R42 is "Not steady, only able to stabilize with staff assistance" when "moving from seated to standing position."

On 03/11/22 at 10:20 AM, RN6 was interviewed in the unit's nursing station. She stated that it was difficult to supervise all residents in the unit because there are about four to five residents who need assistance with meals and the two CNAs and one RN are assisting them, in addition to helping other residents that need to use the restroom and two residents (R23 and R6) who actively wander.

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On 03/11/22 at 2:15 PM, an interview was done with the DON in the conference room next to the Administrator's office. She stated that a day shift float certified nursing assistant (CNA) assists with meals. Surveyor observed only three staff (two CNAs and one RN) assist during lunch on 03/08/22, for breakfast and lunch on 03/09/22 and breakfast on 03/10/22.

Cross reference to F725. R42 was not adequately supervised due to lack of staff and could suffer a potential fall.

3) On 03/09/22 at 2:40 PM, screaming was heard in the dining room while surveyor made observations in the adjacent activity room. The activity aide (AA)1 rushed out of the dining room, calling out for one of the CNAs. R45 was seen gripping the dining room table of where she was slipping under from her wheelchair. There was no staff observed in the dining and activity rooms. After approximately two minutes, CNA11 and AA1 rushed into the dining room to assist R45. RN7 followed after CNA11 called to him for assistance.

CNA11 was queried after the incident, and she stated she was assisting a resident in their room and CNA9 was giving a shower to another resident. She stated that she asked AA1 "to keep an eye" on the residents in the dining room.

On 03/10/22 at 2:13 PM the Activities Director (AD) was interviewed. She stated that she was not aware of R45's near fall and stated that AA1 should have used her walkie-talkie to call CNA11 for assistance instead of leaving the residents in the dining room unattended. She further stated only AAs with CNA experience can assist residents with care, such as assisting them to the

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restroom.

On 03/10/22 at 3:14 PM, AA1 was asked why she did not use her walkie-talkie to call CNA11 for R45's near fall and she stated that she does not like to use it and did not provide a reason, despite further prodding by SA.

On 03/10/22 at 3:30 PM, R45's EHR was reviewed. R45 is an 89 year old female admitted on 04/02/20. Her diagnoses include dementia, anxiety, restlessness, and agitation, generalized muscle weakness, and "presence of an automatic (implantable) cardiac defibrillator" (a device placed under the skin to provide electric shocks to the heart when irregular heart rates are detected).

R45's "John Hopkins Fall Risk Assessment Tool" dated 12/10/21 revealed that she is a "High Fall Risk."

R45's POC revealed a problem for "Impaired communication due to Cantonese as primary language and impaired hearing." Another problem listed was, "Resident with agitated behaviors, taking antidepressants." An intervention included, " ...potential for bruising as resident gets restless & attempts to get out of her chair by dangling legs or sliding down from the WC [wheelchair]." Another problem was, "Risk for falls due to impaired mobility related to weakness" in which an intervention was to "Provide music, snack or toileting when (resident) gets restless."

Cross reference to F725. R45 was not adequately supervised due to lack of staff and suffered a potential fall.

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4) On 03/08/22 at 09:12 AM, during a tour of the memory care unit (MCU), a unit composed of seventeen elderly residents who had all been diagnosed with dementia, the sink water was checked in room 6. The hot water was found to feel too hot to comfortably hold your hands under, within 10 seconds of turning on the water. This room was noted to house four female residents. There was no shower in the room.

On 03/11/22 at 07:15 AM, the Maintenance Supervisor (MS) was asked to round with the state agency (SA) checking water temperatures. During the tour, temperatures were taken on the MS's digital thermometer within 15 seconds of the water being turned on. The MS confirmed that the goal was for the water coming out at the faucet to be below 120° (degrees) Fahrenheit (F). In room #6 of the MCU, the water temperature read 120°F. In the dining room (DR) restroom closest to the MCU entrance, the water temperature read 121°F. In the second DR restroom (closest to the maintenance area entrance), the water temperature read 135°F. In room #111 the water temperature read 128°F. The MS reported that there were two boilers that were responsible for heating the water for the facility. When asked to see them, the SA observed that the boiler inside the maintenance room was set to 127°F, and the second boiler (located outside the MCU) was set to 140°F.

According to the U.S. Consumer Product Safety Commission, Publication 5098, Avoiding Tap Water Scalds (https://www.cpsc.gov/), "Most adults will suffer third-degree burns [a type of burn that destroys the skin and damages the underlying tissue, requiring hospitalization]... with

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a thirty second exposure to 130 degree [°F] water. Even if the temperature is 120 degrees, a five minute exposure could result in third-degree burns."

5) On 03/08/22 at 2:10 PM, R16 was concurrently observed and interviewed in his room. R16 sat upright in bed and moved his arms and hands to work on his laptop computer. R16 answered questions appropriately. He stated that he vapes (a form of smoking utilizing an electronic device to inhale vapor containing nicotine or flavoring that can either be manually refilled with vaping liquid or can either use a disposable pre-filled closed cartridge) in an outside area in front of the facility and keeps his vape in a bag which is stored in a cabinet in his room.

On 03/09/22 at 08:56 AM, R16's record was reviewed. R16 was admitted to the facility on 11/11/16. Quarterly MDS with an ARD of 01/3/22, stated R16's Brief Interview for Mental Status (BIMS) score of 14, meaning R16 is cognitively intact. He has diagnoses of paraplegia (paralysis of all or part of your trunk, legs, and pelvic organs). He requires two-person assist with bed mobility transfers and uses an electric wheelchair to move around the facility. R16's "Smoking Risk Observation Report" dated 01/08/22 stated, "Other - Vapes" as R16's smoking materials and that R16 was a safe smoker. Review of R16's POC for smoking stated an intervention dated 03/26/2021 that "Making sure resident is safe with vaping or smoking." No documentation was found regarding R16's type of vape or where R16's vape is stored.

On 03/10/22 at 12:10 PM, R16 was interviewed in

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the first-floor dining area. R16 stated that his vape is a cartridge that contains no nicotine. A follow up interview was done with R16 in his room at 1:55 PM and he refused to show State Agency (SA) his vape when requested.

On 03/10/22 at 1:34 PM, Registered Nurse (RN)2, was interviewed. RN2 stated that she was not sure what type of vape R16 has.

On 03/10/22 at 2:20 PM, surveyor asked facility administrator if she knew what type of vape R16 has. The administrator stated that she was not sure what type of vape R16 has.

On 03/11/22 at 07:20 AM, Administrator was interviewed. Administrator stated that the Director of Nursing (DON) spoke to R16 yesterday and that he has stated that his vape is purchased already assembled and is thrown away after it is used. Surveyor asked Administrator if the DON physically saw R16's vape. Administrator responded that she would follow-up with the DON.

On 03/11/22 at 07:59 AM, a concurrent interview and record review was done with the DON. DON stated that she spoke to R16 yesterday and physically saw R16's vape. She stated that R16's vape was a cartridge and contained no nicotine. The vape can be used until it is done and can be thrown away. The vape was stored in his room in a blocked area where no one can access. DON confirmed that R16's "Smoking Risk Observation Report" did not document the type of vape that R16 was in possession of nor where the vape was stored.

Review of facility's "Smoking Policy" dated

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F 689	Continued From page 45 04/15/21 states "E-Cigarettes, vapor devices, etc. may remain with residents if shown safe to smoke on their own." Policy does not address where e-cigarette or vapor device should be stored nor processes to follow if e-cigarette or vapor device is refillable.	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F 725		4/25/22

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F 725	Continued From page 46 Based on multiple observations, interviews, and record reviews, the facility failed to provide a sufficient amount of nursing staff which includes registered nurses (RN) and certified nursing assistants (CNA) for five residents (R), R48, R42, R45, R47, and R6, out of 17 residents in the sample, to assure their safety and to maintain their highest practicable physical, mental, and psychosocial well-being. This deficient practice has the potential to affect all residents' safety and outcomes in accordance with the residents' plans of care (POC). Findings include: 1) On 03/11/22 at 09:37 AM, a concurrent interview and record review was done with Administrator and Director of Operations (DO). Casper Report for MDS (Minimum Data Set) 3.0 Facility Level Quality Measure Report was reviewed. DO confirmed that the facility's measures for falls, antipsychotic medications, and behavioral symptoms affecting others measured higher/comparable to the comparison group state and national averages. For example, for falls the facility observed percent was 53.8% compared to the State average of 32.6% and National average of 43.8%. For antipsychotic medications, the facility observed percent was 14.3% compared to the state average of 9.1% and National average of 14.6%. Behavioral symptoms affecting others was 21.6% for the facility, 19.6% for State average, and 19.4% for National average. When asked if the current number of staff is adequate for the facility's needs based on the Casper Report, DO stated that their dementia unit Hale Ho'olu, currently has "3 staff and 16 patients, which would be a staff ratio of 1:5 or 1:6. That's one RN (registered nurse) and	F 725	Residents 48, 42, 45, 47 and 6 were reviewed for care needs. Staffing was reviewed and adjusted as needed to meet residents' needs. Facility residents have the potential to be affected by the alleged practice. Administrator and DON reviewed staffing for facility overall. Adjustments were made as needed. Scheduler/Unit Managers/IDT/SDC were in-serviced regarding staffing. In-services will be ongoing as needed. DON/Unit Managers/Administrator/designee will audit for compliance through observations and scheduling review weekly for a minimum of 12 weeks or until substantial compliance has been achieved. The results of these audits will be brought to the monthly Quality Assurance/Performance Improvement meetings for review for a minimum of 3 months or until substantial compliance has been achieved.	

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two CNAs (certified nursing assistants) for the unit. That is enough staff for that unit."

On 03/11/22 at 10:48 AM, the Infection Preventionist (IP) was interviewed. IP stated that the facility currently uses agency nurses: two licensed practical nurses (LPN) and no CNAs.
2) The facility submitted a report of an injury of unknown origin to the State Agency (SA) on 09/27/22. R48 was complaining of pain to the left foot and ankle and there was noted swelling of the left ankle, extending midway down dorsal aspect (top) of foot was observed. R48's physician ordered an x-ray of left foot and ankle. An x-ray was ordered which showed a fracture of the left distal tibia (ankle).

The facility conducted an investigation to determine the cause of the injury. The facility reported that CNA6 did not implement R48's care plan for transferring. R48 requires a mechanical lift (devices to assist with transfers and movements of individuals who require support for mobility beyond the manual support provided by caregiver alone) with two person assist, CNA6 performed a "stand-pivot" transfer of the resident alone. CNA6 submitted resignation notice on 09/30/21.

A review of the quarterly MDS with an ARD of 08/30/21 notes for transfers (how resident moves between surfaces, including to or from: bed, chair, wheelchair, standing position) R48 is totally dependent (full staff performance) with two plus persons physical assist. R48's POC dated 09/09/20 identifies approach (intervention) for "mechanical lift for all transfers".

On 03/10/22 at 10:25 AM a telephone interview

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was conducted with CNA6. CNA6 recalled being assigned as a floater on the day of the event, they were short of staff and he was assigned to shower the residents residing in two wings, going back and forth between two nursing units. CNA6 went to shower R48 and noticed his coworkers were all busy so he transferred R48 from bed to the shower chair alone. After the shower, CNA6 stated his coworker was still busy so he transferred R48 alone from the shower chair back to bed. CNA6 reported R48 did not fall. CNA6 reported he tried to comfort the resident and massaged her foot as she said it was sore. CNA6 was asked what kind of transfer did R48 require. CNA6 responded, two man assist and use of the lift. Further asked how he transferred R48. CNA6 responded, he stood the resident up and turned her to sit in the shower chair.

On 03/10/22 at 10:58 AM an interview was conducted with the Infection Preventionist (IP) as the staff members that conducted the investigation are no longer employed at the facility. The IP reported she participated in the investigation of this incident.

IP recalled R48 presented with foot pain and following an x-ray was diagnosed with left foot fracture. The facility initiated an investigation to determine how R48 got injured. Staff members were interviewed. CNA6 reported he transferred R48 without a lift, CNA6 reportedly picked her up to stand and she said "oowww". IP stated CNA6 was rushing to get the showers done and was not malicious, he made a bad choice. IP reported R48's POC indicates to transfer resident with mechanical lift with assist of two people. IP further reported two people are always used with a mechanical lift.

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3) On 03/08/22 at 12:05 PM, R42 was observed in the activity room sitting up in a recliner eating his lunch. He was coughing forcefully, pushed the bedside table with his lunch tray on top away from him, got up from the recliner, and started walking without his walker that was placed to the side of him. CNA5 saw him from the adjacent dining room and intervened. She asked him where he was going, grabbed his walker, placed it in front of R42 and walked with him approximately 50 feet down the hallway to a recliner where he sat down. He continued to cough forcefully while walking down the hallway with CNA5. While he sat in the recliner, a bedside table was placed in front of him with a newspaper. No staff were observed to be in any of the resident's rooms or hallway.

From 12:05 PM to 12:52 PM, R42 was in the line of sight of SA and no staff were noted to have checked R42 while he sat in the recliner secluded approximately 50 feet away from other residents and staff. There was no staff in the activity room supervising three residents (R49, R41, and R47) because all three staff (CNA4, CNA5, and RN6) scheduled for the unit were assisting residents in the dining room with their lunches or helping residents to the restroom and monitoring two residents (R6 and R23) who were actively wandering.

On 03/09/22 at 08:55 AM, R42 got up from the recliner in the activity room, walked without his walker into the adjacent dining room carrying a newspaper. RN6 intervened, asked him what he wanted to do and CNA4 stated that R42 needed to use the restroom and assisted him.

On 03/09/22 at 3:10 PM, R42's electronic health

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record (EHR) was reviewed. R42 is a 64-year -old male admitted to the facility on 11/04/19. His diagnoses include dementia, anxiety, disorientation, aphasia (disorder to express language), unsteadiness on feet, history of falling, and history of transient ischemic attacks (TIAs, also known as mini-strokes) either caused by plaques narrowing the blood pathway of arteries or small blood clots in the brain.

R42's "John Hopkins Fall Risk Assessment Tool" dated 01/19/21 was reviewed and revealed R42 as being a "High Fall Risk."

His plan of care (POC) with last reviewed/revised date of 02/15/22 revealed a problem for "Risk for falls due to impaired mobility, dementia with impulsive behaviors" with an intervention of "Assist with transfers and ambulation using FWW [front wheeled walker]." A problem was also revealed for: " ...has history of Wandering Behavior, unable to locate his room, going into other residents (sic) rooms and laying in bed." One of the interventions for this problem was, "Resident in secured memory care unit due to his daily wandering."

R42's medication administration record (MAR) was reviewed. It revealed that he was on Clopidogrel tablet (medication that prevents platelets from forming blood clots) 75 milligrams (mg) to be taken at 08:00 AM and is used to treat his TIAs. There was no entry on R42's care plan to monitor for increased bleeding or to prevent accidents which may cause unwanted bleeding.

A review of R42's MDS with ARD of 02/14/22 revealed for "Section G Functional Status," "G0300. Balance During Transitions and Walking"

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that R42 is "Not steady, only able to stabilize with staff assistance" when "moving from seated to standing position."

On 03/11/22 at 10:20 AM, RN6 was interviewed in the unit's nursing station. She stated that it was difficult to supervise all residents in the unit because there are about four to five residents who need assistance with meals and the two CNAs and one RN are assisting them, in addition to helping other residents that need to use the restroom and two residents (R6 and R23) who actively wander.

On 03/11/22 at 2:15 PM, an interview was done with the DON in the conference room next to the Administrator's office. She stated that a day shift float certified nursing assistant (CNA) assists with meals. Surveyor observed only three staff (two CNAs and one RN) during lunch on 03/08/22 and for breakfast and lunch on 03/09/22 and during breakfast on 03/10/22.

4) On 03/09/22 at 2:40 PM, screaming was heard in the dining room while surveyor made observations in the adjacent activity room. The activity aide (AA)1 rushed out of the dining room, calling out for one of the CNAs. R45 was seen gripping the dining room table of where she was slipping under from her wheelchair. There was no staff observed in the dining and activity rooms. After approximately two minutes, CNA11 and AA1 rushed into the dining room to assist R45. RN7 followed after CNA11 called to him for assistance.

CNA11 was queried after the incident, and she stated she was assisting a resident in their room and CNA9 was giving a shower to another resident. She stated that she asked AA1 "to keep

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an eye" on the residents in the dining room.

On 03/10/22 at 2:13 PM the activities director (AD) was interviewed. She stated that she was not aware of R45's near fall and stated that AA1 should have used her walkie-talkie to call CNA11 for assistance instead of leaving the residents in the dining room unattended. She further stated only AAs with CNA experience can assist residents with care, such as assisting them to the restroom.

On 03/10/22 at 3:14 PM, AA11 was asked why she did not use her walkie-talkie to call CNA11 for R45's near fall and she stated that she does not like to use it and did not provide a reason, despite further prodding by SA.

On 03/10/22 at 3:30 PM, R45's EHR was reviewed. R45 is an 89-year-old female admitted on 04/02/20. Her diagnoses include dementia, anxiety, restlessness, and agitation, generalized muscle weakness, and "presence of an automatic (implantable) cardiac defibrillator" (a device placed under the skin to provide electric shocks to the heart when irregular heart rates are detected).

R45's "John Hopkins Fall Risk Assessment Tool" dated 12/10/21 revealed that she is a "High Fall Risk."

R45's POC revealed a problem for "Impaired communication due to Cantonese as primary language and impaired hearing." Another problem listed was, "Resident with agitated behaviors, taking antidepressants." An intervention included, " ...potential for bruising as resident gets restless & attempts to get out of her chair by dangling legs

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or sliding down from the WC [wheelchair]." Another problem was, "Risk for falls due to impaired mobility related to weakness" in which an intervention was to "Provide music, snack or toileting when [resident] gets restless."

5) On 03/08/22 at 12:30 PM, R47 was sitting up in her wheelchair, her legs close to the ground. She was observed to be asking RN6 to go back to her room. RN6 stated that she would need assistance back to her room and there was no staff available to help her.

On 03/08/22 at 1:00 PM, observed R47 assisted back to bed by CNA4. R47 stated that she was tired and that her legs were swollen. CNA4 stated that she will notify the nurse regarding her swollen legs.

On 03/08/22 at 1:10 PM, R47 was interviewed in her room. She stated that she was a former nurse.

On 03/10/22 at 12:00 PM, a record review was done of R47's electronic health record (EHR). "Discharge Summary" from a hospital dated 12/13/21 stated that she had a left kneecap fracture that was "nondisplaced," or the bone was cracked in only one place that did not change the alignment of the knee, which did not require surgery. But if her knee did become displaced, then surgical intervention would be needed. R47 is an 86-year-old female admitted to the facility on 12/13/21 for dementia, fracture of left humerus (left upper arm), fracture of left patella (kneecap), difficulty in walking, muscle weakness, and fall.

On 03/11/22 at 10:20 AM, RN6 was interviewed at the unit's nursing station. She stated that R47's

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legs should be elevated because they were swollen and confirmed that R47 was a retired nurse.

6) R6 is a 72-year-old male admitted to the facility on 02/05/20 for long-term care services with diagnoses that include Alzheimer's dementia, chronic kidney disease, anemia, high blood pressure, diabetes, and hyperlipidemia (elevated lipids). R6 has been housed in the facility's memory care unit (MCU) since 2020 after being identified as a resident who wanders, with a high-risk of elopement, and a risk for falls.

On 03/08/22 at 09:20 AM, an observation was made of R6 standing outside of the MCU activity room, no door alarms were heard at the time. As soon as CNA4 noticed R6 outside, CNA4 exited the back door of the activity room and led R6 back inside. No door alarms were activated either time CNA4 opened the back door. At 09:39 AM, upon closer inspection of the back door of the activity room, it was observed that although it did have a door alarm, the sensor was not attached so that the alarm would be activated if the door was opened. An interview was done with CNA4 at that time, who immediately attached the sensor to activate the door alarm. CNA4 stated that the MCU was a secure unit, and that all exits had door alarms that should be kept activated except for the double-door fire exit in the dining room (DR). CNA4 explained that she believed R6 exited the unit through the DR, but that it should not have happened. At 09:45 AM, an inspection was done of the DR fire exit. Two heavy brown doors were observed with no alarm and no locks. When asked, CNA5 stated the fire doors were the only exit that were not locked or alarmed, but that the doors led to a gate outside

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that did have an alarm which remained activated at all times. At no other time throughout the day was R6 or any other resident observed outside or being taken outside.

On 03/09/22 at 1:44 PM, an observation was made of the activity room's back door with the door alarm disconnected. The alarm on the side doors of the activity room were also noted to be disconnected. A tour of the outside patio area noted it was entirely paved with cement pathways and hand railings but had several wet areas following rain earlier in the day. There was an unsecured 6-foot folding ladder noted laying on the ground next to the pathway in one area, beneath a six-foot metal scaffolding. At no time throughout the day was R6 or any other resident observed outside or being taken outside.

On 03/09/22 at 2:30 PM, during a review of R6's comprehensive plan of care (POC), the following interventions were noted:
"Staff to ensure resident accompanied during ambulation to ensure no further injury."
"Place in Special Memory Care Unit. Ensure all door alarms/locks are armed to reduce the risk of ... [R6] leaving secure area."

On 03/10/22 at 08:20 AM, R6 walked to R41, who had finished eating breakfast and sat up in his wheelchair at a table in the activity room. R6 began to handle R41's dishes on his breakfast tray. There was no staff present in the activity room to redirect him.

On 03/10/22 at 3:46 PM, during medication administration with RN7, R6 could not be located inside the MCU. RN7 eventually was able to find R6 sitting alone outside at a table that was not

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F 725	Continued From page 56 visible from inside the MCU. On 03/11/22 at 11:09 AM, an interview was done with the Resident Care Manager (RCM) at her station. The RCM stated that MCU residents are allowed to go outside during the day, and that is why the activity room doors are not secured during the day. The RCM agreed that this is not reflected in R6's CP and that if R6 is outside, he should always be supervised due to his risk for falls. When asked for facility documentation regarding leaving doors unsecured in the MCU during the day, the RCM stated she did not think the process had been formalized but was just something that they did so that residents could enjoy being outside.	F 725		
F 732 SS=F	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a	F 732		4/25/22

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F 732	Continued From page 57 daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post nurse staffing information with a resident census, in a clear and readable format, and in a prominent place readily accessible to residents and visitors. As a result of this deficient practice, the facility's staffing information was not readily available in a readable format to residents and visitors at any given time. Findings include: 1) On 03/09/22 at 09:00 AM, a concurrent interview and observation was done with Resident Care Manager (RCM). Surveyor inquired with RCM where daily nurse staffing was posted. RCM brought surveyor to a bulletin board located in the hallway across from Nursing Station 1. The hallway was located on the other side of the building away from the visitor meeting area. Surveyor observed that the daily nurse	F 732	The daily staff posting was taken down and replaced with an updated one. DON/Administrator/SDC in-serviced Scheduler/Licensed Nursing Staff on posting requirements. Facility residents have the potential to be affected by the alleged practice. Daily staffing posting was moved to a location in the common area. It was updated to include all required components. DON/Administrator/SDC/designee in-serviced Scheduler/Licensed Nursing Staff on posting requirements. In-services will be ongoing as needed. DON/Unit managers/Administrator/designee will	

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F 732	Continued From page 58 staffing was printed on one 8 x 11-inch paper and contained staffing information for all three units for the day, evening, and nocturnal shift for 03/09/21. The font size of the daily nurse staffing was less than 10-point font in some areas, making the words small and difficult to read. There was no facility census number documented. Names of the nurses scheduled, and the type of nurse was identified for each shift and unit. Below the names of each nurse were two or three names with no job title. RCM stated, "The names below the nurse are the certified nursing assistants for that unit." 2) On 03/11/22 at 2:15 PM, an interview was conducted with the administrator, DON, and Director of Operations (DO) in the conference room next to the administrator's office. The DO agreed that the daily nurse staffing posting should be done in a different format to be easily read and seen by residents and visitors.	F 732	audit for compliance through observations weekly for a minimum of 12 weeks or until substantial compliance has been achieved. The results of these audits will be brought to the monthly Quality Assurance/Performance Improvement meetings for review for a minimum of 3 months or until substantial compliance has been achieved.	
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, interviews and record reviews, the facility failed to ensure one resident (R), R6, out of six residents sampled, received the appropriate treatment and services, for his dementia, to attain or maintain his highest practicable physical, mental, and psychosocial well-being. As a result of this deficient practice, R6 did not have his needs met, and was placed	F 744	RN 7 was re-in-serviced by SDC regarding Dementia services. In-services will be ongoing as needed. Resident 6 was reassessed and care plan was updated to reflect current interventions. Facility residents have the potential to be affected by the alleged practice.	4/25/22

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F 744	Continued From page 59 at risk for a decline in his quality of life. This deficient practice has the potential to affect all the residents at the facility. Findings include: R6 is a 72-year-old male admitted to the facility on 02/05/20 for long-term care services with diagnoses that include Alzheimer's dementia, chronic kidney disease, anemia, high blood pressure, diabetes, and hyperlipidemia (elevated lipids). R6 has been housed in the facility's memory care unit (MCU) since 2020 after being identified as a resident who wanders, with a high-risk of elopement, and a risk for falls. On 03/08/22 at 09:20 AM, an observation was made of R6 standing outside of the MCU activity room. As soon as CNA4 noticed R6 outside, CNA4 exited the back door of the activity room and led R6 back inside. During this interaction, CNA4 was observed speaking softly to R6, gently holding his hand, and with his cooperation, lead him back into the MCU. On 03/08/22 at 12:37 PM, RN6 was observed interacting with R6 when she noticed him wandering. RN6 gently led R6 to a chair in the activity room, provided him with a stuffed animal (dog), and asked him to watch the dog for her. R6 was then observed holding, petting, kissing, and talking to the dog, and remained occupied with that task for several minutes. On 03/09/22 at 2:30 PM, during a review of R6's comprehensive plan of care (POC), the following interventions were noted: "Staff to ensure resident accompanied during ambulation to ensure no further injury."	F 744	Dementia training was provided for facility staff by DON/SDC/designee. In-services will be ongoing as needed. Unit Managers/designee will audit for compliance through observations weekly for a minimum of 12 weeks or until substantial compliance has been achieved. The results of these audits will be brought to the monthly Quality Assurance/Performance Improvement meetings for review for a minimum of 3 months or until substantial compliance has been achieved.	

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"Assess potential physical causes for wandering (need for toilet, water, food, pain relief)."
"Provide diversional activities (folding, rummaging box, packing/unpacking)."
"Redirect ... behavior/activity when wandering is observed."

On 03/09/22 at 2:57 PM, R6 was observed wandering down the hallway by Room #6. When RN7 noticed him wandering, RN7 firmly grabbed him by the hand and walked him back to the activity room. No interaction (such as asking him questions) or attempts at redirection were observed.

At 3:07 PM, R6 was observed walking around the activity room holding the stuffed dog. RN7 grabbed his hand again and firmly walked him to a chair to sit. No interaction (such as asking him questions) or attempts at redirection were observed.

At 3:09 PM, R6 was observed walking around the activity room. RN7 immediately grabbed his hand and firmly pulled him into the dining room (DR) where he sat him down on the couch in front of the television. RN7 did not provide him with a magazine or the stuffed dog to occupy him, he was not observed interacting verbally with R6, nor did he turn the television on before walking away. Despite being at risk for falls, RN7 did raise a bedside table to the highest setting and wedged it next to R6 as he sat on the couch, making it difficult for R6 to rise to a standing position.

At 3:12 PM, R6 stood, with some effort to get around the bedside table, and walked to the activity room entrance. Without a word, RN7 immediately grabbed his hand and firmly pulled

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F 744	Continued From page 61	F 744		

him to a seat by the window.

At 3:24 PM, R6 was observed standing again, with RN7 immediately grabbing his hand and firmly pulling him into the DR. R6 appeared resistant to the pulling but went along without any observed verbal protests. RN7 then approached the Activities Aide (AA)1, who was working with another resident, and asked her if she could watch R6. AA1 was observed immediately grabbing the stuffed dog from the activity room and giving it to R6 as she pulled out her phone and began to play music. AA1 then sat on the couch next to R6 and started singing songs with him.

On 03/10/22 at 1:08 PM, an interview was done with the Infection Preventionist (IP) and the Director of Infection Prevention (DIP), both of whom were also responsible for staff education, in the Education Room. When the previous day's observations of RN7 were shared, both the IP and DIP stated that the behavior sounded unusual for RN7 and did not align with what staff were trained to do.

At 1:35 PM, the IP provided the state agency (SA) with documentation of the dementia training that RN7 had last completed on 10/15/21. A review of the dementia training provided noted the following under "BPSD (Behavioral & Psychological Symptoms of Dementia) Management Concepts":
"Go with it if others not disturbed and safety is not an issue ..."
"Distract by presenting other topic verbally or presenting other stimuli ..."

Under "Management of BPSD," the following was noted:

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F 744	Continued From page 62 "Assess unmet needs ..." "Identify and implement pleasant events ..." "Sensory stimulation ..." "Diversional activities ..." "Anticipate safety issues ..." "Maintain dignity - do not treat an adult like a child."	F 744		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and interview, the facility failed to adequately monitor medication for one resident (R), R12, out of 17 residents sampled. As a result of this deficient	F 757	Resident 12 has not had any side effects or negative outcomes from the medication. Care plan and Medication Administration Record was updated to	4/25/22

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F 757	Continued From page 63 practice, R12 was put at risk for adverse side effects such as excessive bleeding and bruising from his antiplatelet (stops blood clots from forming) medication. Findings include: On 03/08/22 at 09:20 AM, R12 was observed sitting up in bed in his room watching television. On 03/09/22 at 08:41 AM, R12's record was reviewed. R12 was admitted to the facility on 11/29/21 for acute ischemic heart disease (not enough blood and oxygen going to the heart). His diagnoses include congestive heart failure (heart unable to pump blood effectively) and peripheral vascular disease (narrowing of arteries which results in reduced blood flow to head, arms, stomach and legs). Quarterly Review of MDS with ARD 01/03/22, stated that R12's BIMS score was 13, meaning that he is cognitively intact. He requires two-person physical assist for bed mobility and transfers and requires a wheelchair to ambulate. He is incontinent of bowel and bladder. Review of R12's POC stated that resident is at risk for falling related to impaired mobility. R12's orders stated, "Clopidogrel tablet (antiplatelet medication); 75 mg [milligram]; amt [amount]: 75 mg; oral. Special Instructions: Prophylaxis [preventive]. Once a day 08:00. Start date 11/30/21." Review of R12's POC did not indicate a problem for bleeding and interventions for monitoring the adverse side effects of Clopidogrel use. On 03/10/22 at 10:28 AM, a concurrent interview and record review was done with the Resident Care Manager (RCM). RCM reviewed R12's orders and POC and confirmed that there were	F 757	reflect monitoring for side effects of anticoagulants. SDC in-serviced IDT and licensed nurses regarding monitoring for side effects of medications. In-services will be ongoing as needed. Facility residents on anticoagulants have the potential to be affected by the alleged practice. SDC in-serviced IDT and licensed nurses regarding monitoring for side effects of medications. In-services will be ongoing as needed. Current residents were reviewed for compliance and updated as needed. Unit Managers/designee will audit for compliance through medical record reviews and observations weekly for a minimum of 12 weeks or until substantial compliance has been achieved. The results of these audits will be brought to the monthly Quality Assurance/Performance Improvement meetings for review for a minimum of 3 months or until substantial compliance has been achieved.	

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F 757	Continued From page 64 no orders or POC to monitor the side effects from R12's Clopidogrel medication. RCM also reviewed and confirmed that R12's medication administration record (MAR) did not document any monitoring for adverse side effects from taking Clopidogrel such as bleeding.	F 757		
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 observations, interviews, and record reviews, the facility failed to ensure that the facility was free of medication errors greater than 5% as evidenced by three medication errors out of 26 medication passes observed (11.54% error rate). One resident (R), R28, out of 17 residents sampled was affected. As a result of this deficient practice, R28 was put at risk for adverse health complications due to improper administration of her medications. This deficient practice has the potential to affect all residents. Findings include: On 03/10/22 at 07:30 AM, a concurrent observation and interview was done with RN2. Surveyor observed RN prepare R28's medications. R28's medications included three inhalers (medications inhaled through the mouth to open lung airways): A) Spiriva Respimat	F 759	Resident 28 was reassessed for self-administration. Resident 28's orders were updated to reflect self-administration. Daily medication administration record was updated to reflect Resident 28's self-administration. Facility residents who self-administer medications have the potential to be affected by the alleged practice. SDC in-serviced licensed nurses regarding self-administration of medications and documentation. Current residents were reviewed for compliance and updated as needed. In-services will be ongoing as needed. Unit Managers/designee will audit for compliance through medical record reviews and observations weekly for a minimum of 12 weeks or until substantial	4/25/22

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F 759	Continued From page 65 B) Albuterol Sulfate C) Symbicort RN2 stated that R28 can self-administer the three inhalers and that the documents for R28 to self-administer medication were on file. At 08:00 AM, surveyor observed R28 in her room eating breakfast. RN2 proceeded to give R28 her medications. RN2 then left R28's three inhalers on R28's bedside table and stated, "Ring the call light when you need me to pick it up." RN2 then left the room. On 03/10/22 at 10:30 AM, R28's record was reviewed. R28 was admitted to facility on 06/30/21 for chronic obstructive pulmonary disease (COPD, which is a disease with respiratory symptoms such as progressive breathlessness and cough). Quarterly review for MDS with an ARD of 01/29/22, stated that her BIMS score was 15, meaning that R28 is cognitively intact. R28 requires two-person assist for bed mobility and transfers and one-person assist setup for eating. Review of R28's orders listed the following medication to be given: A) Spiriva Respimat (tiotropium bromide) mist; 2.5 mcg (microgram)/actuation; amt (amount): 2 puffs; inhalation Special Instructions: DX (diagnosis): COPD. Rinse mouth after use. Once A Day at 09:00. B) Albuterol sulfate. HFA (hydrofluoroalkane, a propellant) aerosol inhaler; 90 mcg/actuation; amt: 2 puffs; inhalation. Special Instructions: DX: COPD. Once A Day at 09:00. C) Symbicort (budesonide-formoterol) HFA aerosol inhaler; 160-4.5 mcg/actuation; amt: 2	F 759	compliance has been achieved. The results of these audits will be brought to the monthly Quality Assurance/Performance Improvement meetings for review for a minimum of 3 months or until substantial compliance has been achieved.	

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F 759	Continued From page 66 puffs; inhalation. Special Instructions: DX: COPD. Use aero chamber spacer (attached to inhaler to improve its use) w/ (with) administration. Rinse mouth after use. Twice A Day at 20:00, 09:00. Review of the "Self-Medication Assessment Form" dated 01/10/22 stated R28 was "safe to administer inhalers. RN to provide inhalers and retrieve after administration" and that the medications to be self-administered were "Albuterol sulfate HFA aerosol, Spiriva Respimat inhaler, Symbicort HFA aerosol inhaler." On 03/10/22 at 2:51 PM, a concurrent record review and interview was done with Minimum Data Set Coordinator (MDSC). MDSC reviewed R28's medication orders and confirmed that the orders for R28's inhalers did not include instructions for R28 to self-administer the inhalers. MDSC reviewed R28's medication administration record (MAR) for the time period of 02/10/22 to 3/10/22. MDSC confirmed that the inhalers were signed as administered by staff and that the MAR did not document that R28 had self-administered the inhalers. MDSC stated that the facility does not have a policy regarding documenting when a resident self-administers medications daily, however MDSC stated that the facility used to have a resident that would self-administer medication and sign a daily medication log documenting that he/she had self-administered his/her medication. MDSC stated that R28 does not have a daily medication log to sign showing that R28 had self-administered the three inhalers.	F 759		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3)	F 838		4/25/22

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F 838	Continued From page 67 §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles;	F 838		

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F 838	Continued From page 68 (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure the documented Facility Assessment included information on cultural, religious, staffing, training, and personnel resources necessary and available to care for its residents competently. This deficient practice affects all the residents in the facility because it does not identify the resident population and their specific needs needed to achieve their highest practicable physical, mental, and psychosocial well-being. Findings include: On 03/11/22 at 08:30 AM, a review of the Facility Assessment documentation was done. It was noted that for cultural and religious factors,	F 838	Facility assessment was reviewed and updated as needed. Administrator consulted with the Director of Operations regarding facility assessment options. Facility residents have the potential to be affected by the alleged practice. Administrator in-serviced Leadership Team regarding the facility assessment. In-services will be ongoing as needed. Facility assessment template was updated to better reflect the facility. Administrator/designee will audit for compliance through facility assessment review and update monthly for a minimum	

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F 838	Continued From page 69 including activities, food, and nutrition services necessary to care for the resident population, there were lists of different items, but no data had been collected to reflect the residents' potential needs in these areas. For example, under "Spiritual/Religious Services" there was the following list: Catholic Jehovah's Witness Other Christian Buddhist Other faith or world religion There was no information to indicate how many, if at all, there were of each faith listed. None of the categories were defined or clarified, such as "Other faith or world religion". There was no indication if the residents actively practiced their faiths, or what their spiritual/religious needs might be as a person actively practicing their faith. The lists of categories lacking collected data reflecting the resident population continued throughout the cultural, and religious sections. Under the Staffing, Training, Services and Personnel section, it was noted that there were lists of resident needs (functional, mobility, disease-specific, etc.) with three columns titled: Overall Staffing, Staff Competencies, Services. Below each of the three columns, instead of data indicating what the staff resources, education, training, and competencies were, the word "Evaluated" was repeated for every category in the list. On 03/11/22 at 09:37 AM, a concurrent record review and interview was done with the	F 838	of 3 months or until substantial compliance has been achieved. The results of these audits will be brought to the monthly Quality Assurance/Performance Improvement meetings for review for a minimum of 3 months or until substantial compliance has been achieved.	

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F 838	Continued From page 70 administrator and Director of Operations (DO). Both administrator and the DO reviewed the Facility Assessment. When questioned about the lacking data and the word "Evaluated", the administrator and DO stated that the data is in a separate attachment. Review of attachments, "2022 Annual Competencies Calendar and 2022 Required Education Calendar" listed subjects that were reviewed with staff each month; however, administrator and DO confirmed that the calendars did not explain what subjects were identified because of the facility assessment. On 03/11/22 at 2:15 PM, the DO, Administrator, and DON were interviewed in the conference room next to the Administrator's office. The DO agreed that the Facility Assessment did not provide a clear picture of the facility's resident population and their needs and stated that the program that produces the Facility Assessment documentation will be changed.	F 838		
F 880 SS=D	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:	F 880		4/25/22

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F 880	Continued From page 71 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections 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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125048	A. BUILDING _____ B. WING _____	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN PEARL NURSING FACILITY	45-181 WAIKALUA ROAD KANEOHE, HI 96744

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F 880	Continued From page 72 identified under the facility's IPCP and the corrective actions taken by the facility. §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 and interviews with staff members, the facility failed to ensure staff followed hand hygiene practices when distributing meals, to six residents (R), R33, R37, R55, R43, R2, and R39, of 20 residing on a nursing unit, to prevent the development and transmission of communicable diseases and infections. This deficient practice has the potential to affect all residents. Findings include: On 03/08/22 at 12:01 PM during lunch time on a nursing unit, observed Health Information Management staff (HIM) take a meal tray out of the meal cart, open and close R33's room door using the door handle to deliver R33's lunch and return to the meal cart grabbing a meal tray for another resident, R37, without hand sanitizing. HIM then delivered lunch to R37 and was overheard asking R37 if he wanted rice inside his soup. HIM returned to the meal cart with a small empty red bowl and plate cover from R37's meal tray, put the items into the meal cart, and grabbed a meal tray for R55 without hand sanitizing. HIM was observed closing R55's privacy curtain and	F 880	Residents 33, 37, 55, 43, 2 and 39 suffered no ill effects. Staff involved in the meal pass were re-in-serviced regarding hand hygiene and infection control practices by the SDC/designee. Facility residents have the potential to be affected by the alleged practice. SDC in-serviced facility staff regarding hand hygiene and infection control practices. In-services will be ongoing as needed. The following in-services were used "Sparkling Surfaces" and "Clean Hands" as directed. A root cause analysis was performed by the clinical team, Infection Preventionist, and QAPI/IDT. Education and training were developed from identified information from the RCA and provided to the facility staff. SDC/designee will audit for compliance through in-service record reviews and observations weekly for a minimum of 12 weeks or until substantial compliance has been achieved. The results of these	

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F 880	Continued From page 73 overheard saying " ...get some rest ..." HIM turned off the light switch in R55's room and put R55's meal tray back into the meal cart. Without hand sanitizing, HIM then grabbed R43's meal tray and brought it to R43's room. HIM inquired with R43 if she was hungry then returned with R43's meal tray and put it back into the meal cart. HIM then borrowed CNA19's pen, and after using the pen, returned to R43's room and offered R43 a sandwich. HIM did not hand sanitize after using the pen, continued to take R2's meal tray out of the meal cart and brought R2's lunch to his room. HIM then grabbed R39's meal tray from the meal cart and delivered it to R39. HIM assisted R39 by placing a large napkin over R39's chest, handing R39's fork to her and taking off the covers and lids of the food and drink items on her meal tray. HIM did not hand wash or hand sanitize between residents (R33, R37, R55, R43, R2, and R39) while distributing meal trays. Interview with HIM on 03/08/22 at 12:14 PM, stated staff are supposed to hand sanitize between residents when delivering meal trays. Interview with Infection Preventionist (IP) on 03/10/22 at 11:40 AM, stated if staff are touching other items while delivering meal trays, such as taking lids and covers off food or drink items on the meal trays, staff should be hand sanitizing between residents.	F 880	audits will be brought to the monthly Quality Assurance/Performance Improvement meetings for review for a minimum of 3 months or until substantial compliance has been achieved.	
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully	F 888		4/25/22

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F 888	Continued From page 74	F 888		

vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.

§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those

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ANN PEARL NURSING FACILITY	45-181 WAIKALUA ROAD KANEOHE, HI 96744

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F 888	Continued From page 75	F 888		

staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;
(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;
(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not

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F 888	Continued From page 76	F 888		

the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Effective 60 Days After Publication:
§483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;

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F 888	Continued From page 77 This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with facility staff, the facility failed to ensure their COVID-19 vaccination policies and procedures included a process for the implementation of additional precautions intended to mitigate the transmission and spread of COVID-19, for all staff who were not fully vaccinated for COVID-19. As a result of this deficient practice, the facility placed staff, residents, and visitors at risk for the transmission of COVID-19. This deficient practice has the potential to affect all health care personnel, residents, and visitors of the facility. Findings include: On 03/08/22 at 2:15 PM, while reviewing the staff and resident COVID-19 vaccination lists, it was noted that there were three staff members, one full-time certified nursing assistant (CNA), one full-time registered nurse (RN), and one on-call RN, who remain unvaccinated due to facility-approved religious exemptions. It was also noted that one resident in the facility had declined vaccination. During a comparison of the two lists, it was revealed that the unvaccinated full-time RN is assigned to provide direct care on the same housing unit that the unvaccinated resident lives on. On 03/08/22 at 2:20 PM, an interview with the Infection Preventionist (IP) was conducted in the Education Room. IP was asked about mitigation strategies used by the facility with regards to the unvaccinated staff, the IP stated that the full-time staff were required to take COVID-19 tests twice a week, and the on-call staff was tested each time she worked. When asked about personal	F 888	The facility mitigation plan was updated to reflect the added precautions for unvaccinated staff and residents. The SDC in-serviced the unvaccinated staff regarding the updated plan. Unvaccinated staff are tested regularly per transmission rate and must wear N-95 / shields. Facility residents have the potential to be affected by the alleged practice. SDC/DON/designee in-serviced facility staff regarding the updated mitigation plan. In-services will be ongoing as needed. SDC/designee will audit for compliance through observation of staff weekly for a minimum of 12 weeks or until substantial compliance has been achieved. The results of these audits will be brought to the monthly Quality Assurance/Performance Improvement meetings for review for a minimum of 3 months or until substantial compliance has been achieved.	

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protective equipment (PPE) utilized by the unvaccinated staff, the IP stated that they were required to wear the same PPE as all other staff, a procedure mask and face shield, in all resident areas of the facility and follow the same precautions, regardless of staff or resident vaccination status.

On 03/10/22 at 12:30 PM, during a review of the facility Mandatory COVID-19 Vaccination Policy, updated 09/2021, the following was noted:

"4. Exemption Process & Procedures ...Health Care Personnel will be notified within 14 days of submission of their application if it is approved or denied, and if approved, of any protective and/or preventative restrictions or requirements they will be required to follow so long as they remain unvaccinated."

On 03/10/22 at 1:08 PM, an interview was done with the IP and the Director of Infection Prevention (DIP) in the Education Room. Regarding unvaccinated staff, the IP reported that all staff wear a procedure mask and face shield, and all efforts are made to ensure staff assignments remain consistent for continuity of care. Besides the facility testing requirement, neither the IP nor the DIP were aware of any other facility mitigation plans to prevent the transmission of COVID-19, confirming that there were no limitations on direct care or areas worked, nor were there any additional precautions followed by staff that were unvaccinated. The IP also confirmed that there were no formal mitigation plans, protective or preventative restrictions or requirements, that had been written and provided to the three unvaccinated staff.

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E 000	Initial Comments The facility was found to be in compliance with Section 483.73, Requirement for Long Term Care (LTC) Facility Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types, State Operations Manual.	E 000		

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

Electronically Signed | 04/07/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125048	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/24/2022**

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ANN PEARL NURSING FACILITY	**45-181 WAIKALUA ROAD** **KANEOHE, HI 96744**

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K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: K-291 Emergency Lighting This STANDARD is not met as evidenced by: Based on record review with staff members, the facility failed to test and maintain the emergency lighting with a 90 minute annual inspection and testing in accordance with NFPA 101, Life Safety Code, 2012 edition, sections 7.9 and 19.2.9.1 This deficiency could affect all residents, staff, and visitors during an emergency requiring evacuation from the facility. Findings include: During record review on 3/24/22 at approximately 12:15 pm revealed that the facility failed to provide documentation for the annual 90 minute emergency lighting test. These findings were verified at the exit conference with the staff members on 3/24/22 at 2:30 pm.	K 291	Emergency lighting 90-minute test will be completed by 4/15/2022. Facility residents have the potential to be affected by the alleged practice. TELS Preventive Maintenance system updated to include notification of when 90-minute emergency lighting annual test is due. Environmental Services (EVS) Manager will audit the TELS system monthly to ensure Preventive Maintenance (PM) for 90-minute emergency lighting test is functioning. EVS Manager will ensure a second process is in place for tracking by utilizing a hard copy of the Maintenance calendar. Results of the audits will be reported in the Quality Assurance/Performance Improvement (QAPI) Committee on a monthly basis for a minimum of 3 months or until substantial compliance is achieved.	4/25/22

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E 004 SS=D	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (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 all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [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. * [For ESRD Facilities at §494.62(a):] Emergency	E 004		4/25/22

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E 004	Continued From page 1 Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: E-004 Emergency Prep This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) document in accordance with Appendix Z of the State Operations Manual (SOM) and 42 CFR 483.73 for long term care facilities. Proof of an annual review was not documented. This deficiency could affect all residents, staff, and visitors during an emergency due to the lack of the required updates which would maintain current details of the facility EPP. Findings include: An observation on 3/24/22 at approximately 1:30 pm revealed that the facility's Emergency Preparedness Plan was not reviewed and updated during the past year which is 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 3/24/22 at 2:30 pm.	E 004	This plan of correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. Emergency Preparedness Plan (EPP) was reviewed and updated to include all pertinent policies and procedures. Documentation of this will be kept in the front of the EPP. Facility residents have the potential to be affected by the alleged practice. Administrator will audit the EPP monthly to ensure documentation is complete and current. Results of the audit will be reported monthly in the Quality Assurance/Performance Improvement (QAPI) Committee for a minimum of 3 months or until substantial compliance is achieved.	