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	125048	A. BUILDING: _____ B. WING _____	03/11/2022

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

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4 000	Initial Comments A relicensing survey was conducted by the Office of Healthcare Assurance (OHCA). The facility was found not to be in substantial compliance with Hawaii Administrative Rules, Title 11, Chapter 94.1 Nursing facilities. Survey dates: March 8 to March 11, 2022 Survey Census: 60 Sample size: 17	4 000		
4 089	11-94.1-16(b) Governing body and management (b) The facility shall ensure that: (1) Staff sufficient in number and qualifications shall be on duty twenty-four hours a day to carry out the policies, responsibilities, assessed care needs of the residents and program of the facility; and (2) The numbers and categories of personnel shall be determined by the number, acuity level, and needs of residents. This Statute 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.	4 089	This plan of correction constitutes our written allegation of compliance or 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.	4/25/22

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4 089	Continued From page 1 Findings include: On 03/11/22 at 08:30 AM, a review of the Facility Assessment was done. It was noted that for cultural and religious factors, 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	4 089	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 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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4 089	Continued From page 2 the list. On 03/11/22 at 09:37 AM, a concurrent record review and interview was done with the 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.	4 089		
4 118	11-94.1-27(7) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (7) The right to refuse treatment, to refuse to	4 118		4/25/22

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4 118	Continued From page 3 participate in experimental research, and to formulate an advance directive; □ This Statute 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 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	4 118	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 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	

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4 118	Continued From page 4 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 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.	4 118	compliance has been achieved.	

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4 133	Continued From page 5	4 133		
4 133	11-94.1-29(d) Resident abuse, neglect, and misappropriation (d) The facility shall maintain a record that all alleged violations were thoroughly investigated, and shall take all reasonable steps to prevent further abuse while the investigation is in progress. This Statute is not met as evidenced by: Based on record reviews and interviews, the facility failed to complete and maintain documentation that an alleged violation was thoroughly investigated for one out of two incidents sampled. This deficient practice the potential to affect all residents and robs them of their right to a fair and thorough investigation of an alleged violation of abuse and neglect. 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	4 133	Resident 159's incident was investigated and staff involved in care were 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	4/25/22

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4 133	Continued From page 6 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 0.3cm (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 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	4 133	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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4 133	Continued From page 7	4 133		

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 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

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4 133	Continued From page 8 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, witness(es) and others with any information about the incident ..."	4 133		
4 148	11-94.1-39(a) Nursing services (a) Each facility shall have nursing staff sufficient in number and qualifications to meet the nursing needs of the residents. There shall be at least one registered nurse at work full-time on the day shift, for eight consecutive hours, seven days a week, and at least one licensed nurse at work on the evening and night shifts, unless otherwise determined by the department. This Statute is not met as evidenced by: 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).	4 148	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	4/25/22

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4 148	Continued From page 9 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 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	4 148	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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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 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.

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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.

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

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4 148	Continued From page 12	4 148		

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 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

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4 148	Continued From page 13 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 (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	4 148		

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4 148	Continued From page 14 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 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.	4 148		

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4 148	Continued From page 15 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." 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.	4 148		

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4 148	Continued From page 16 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 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	4 148		

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4 148	Continued From page 17	4 148		

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 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

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4 148	Continued From page 18 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 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.	4 148		
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not	4 149		4/25/22

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4 149	Continued From page 19 limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty- first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided. This Statute 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 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:	4 149	Resident 6's care plan was updated to reflect current interventions. Resident 6 did not sustain an 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. 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.	

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4 149	Continued From page 20 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." "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."	4 149	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. Dementia training was provided for facility staff by DON/ SDC/designee. 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. 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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4 149	Continued From page 21 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 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	4 149		

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4 149	Continued From page 22	4 149		

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:
"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."

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4 159	Continued From page 23	4 159		
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute 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	4 159	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	4/25/22

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4 159	Continued From page 24 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 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.	4 159	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.	
4 174	11-94.1-43(b) Interdisciplinary care process (b) An individualized, interdisciplinary overall plan of care shall be developed to address prioritized	4 174		4/25/22

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4 174	Continued From page 25 resident needs including nursing care, social work services, medical services, rehabilitative services, restorative care, preventative care, dietary or nutritional requirements, and resident/family education. This Statute 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 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	4 174	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 meetings for review for a minimum of 3 months or until substantial compliance has been achieved.	

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4 174	Continued From page 26 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 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	4 174		

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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.

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

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4 174	Continued From page 28 (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 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.	4 174		

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4 175	11-94.1-43(c) Interdisciplinary care process (c) The overall plan of care shall be reviewed periodically by the interdisciplinary team to determine if goals have been met, if any changes are required to the overall plan of care, and as necessitated by changes in the resident's condition. This Statute 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	4 175	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.	4/25/22

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"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 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

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perform digital stimulation due to constipation.

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).

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

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extremity] strength and ROM [range of motion] and decreased/inconsistent functional use of right 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

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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. 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

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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.

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.

4) On 03/08/22 at 10:52 AM, R54 was observed

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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 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

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4 175	Continued From page 36 "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.	4 175		
4 185	11-94.1-46(b) Pharmaceutical services (b) A facility shall have a current pharmacy policy manual consistent with current pharmaceutical practices developed and approved by the pharmacist, medical director/medical advisor, and director of nursing that:	4 185		4/25/22

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4 185	Continued From page 37 (1) Includes policies and procedures, and defines the functions and responsibilities relating to pharmacy services, including the safe administration and handling of all drugs and self-administration of drugs. Policies and procedures shall include pharmacy functions and responsibilities, formulary, storage, administration, documentation, verbal and telephone orders, authorized personnel, recordkeeping, and disposal of drugs; (2) Is reviewed at least every two years and revised as necessary to keep abreast of current developments in overall drug usage; and (3) Has a drug recall procedure that can be readily implemented. This Statute 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	4 185	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	

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4 185	Continued From page 38 to open lung airways): A) Spiriva Respimat 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.	4 185	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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4 185	Continued From page 39 C) Symbicort (budesonide-formoterol) HFA aerosol inhaler; 160-4.5 mcg/actuation; amt: 2 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.	4 185		

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4 203	Continued From page 40	4 203		
4 203	11-94.1-53(a) Infection control (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute 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.	4 203	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.	4/25/22

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4 203	Continued From page 41 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 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	4 203		

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4 203	Continued From page 42 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.	4 203		
4 269	11-94.1-65(d)(6) Construction requirements (d) The facility shall have adequate toilet and bath facilities: (6) An adequate supply of potable running water shall be provided at all times. Temperatures of hot water at plumbing fixtures used by the residents shall be automatically regulated and shall not be below 100 or above 120 degrees Fahrenheit; This Statute is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide an environment free from hazards for residents in rooms 6 and 111 from extremely hot water temperatures.This deficient practice could negatively impact all residents in the facility by causing them harm. Finding includes: 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	4 269	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. In-services will be ongoing as needed. Facility residents have the potential to be affected by the alleged practice. Administrator/designee re-in-serviced Environmental Services (EVS) team regarding water temperatures and regular monitoring of water temperatures.	4/25/22

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4 269	Continued From page 43 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 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."	4 269	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.	