STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	04/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOLO CHINESE HOME	2459 10TH AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance. The facility was found not to be in substantial compliance with 42 CFR 483, Subpart B. Three facility reported incidents (FRI) were investigated (ACTS #9046, 9403, 9432). There were no deficient practices cited related to the FRI investigations. On 04/22/22 at 08:49 AM, the Administrator and Director of Nursing were notified of the facility's failure to ensure residents' right to be treated with respect and dignity was honored. This deficient practice constituted substandard quality of care (SQC) at F550, §483.10(a)(1) Resident Rights. An extended survey was conducted. Survey Dates: 04/18/22 to 04/22/22 Survey Census: 91 residents Sample Size: 21	F 000		
F 550 SS=F	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 550		5/20/22

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

Electronically Signed | 05/20/2022

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F 550	Continued From page 1 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, interviews with staff members and residents, and a review of the facility's policy and procedures, the facility failed to ensure residents are treated with respect and dignity and were provided with care in a manner and in and environment that promotes maintenance or enhancement of residents' quality of life. This deficient practice has the potential to affect residents' psycho-social	F 550	1. For R52, the Director of Nursing/designee on 04/19/22 the resident□s care plan was updated to include behavioral interventions. On 04/19/22 the resident□s Ensure order was updated to 1 cartoon Ensure Plus BID; 04/20/22 may have additional 2 cartoons of Ensure Plus PRN if requested by resident (up to 4 cartons a day); 05/11/22	

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F 550	Continued From page 2 well-being Findings include: Review of facility's policy and procedures on "Resident Rights" reviewed and revised on 11/01/21 documents under "4. Respect and dignity. The resident has a right to be treated with respect and dignity, including: ...c. The right to reside and receive services in the facility with reasonable accommodations of resident needs and preferences, except when to do so would endanger the health or safety of the resident or other residents ...f. the right to receive written notice, including the reason of the change, before the resident's room or roommate in the facility is changed." 1) Resident (R)52 was admitted to the facility on 12/16/21. Diagnosis includes but not limited to Alzheimer's disease, dementia in other disease classified elsewhere without behavior disturbances, unstageable pressure ulcer of right heel, unspecified chronic obstructive pulmonary disease chronic right heart failure, and type 2 diabetes mellitus without complications. A review of R52's significant change Minimum Data Set (MDS) with an assessment reference date (ARD) of 03/07/2022 found R52 with a score of 12 [moderate cognitive impairment] when the Brief Interview for Mental Status (BIMS) was administered. Section E0200. Behavioral Symptoms - Presence & Frequency documents the following behaviors were not exhibited for physical behavioral symptoms toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing other sexually), verbal behavioral symptoms directed toward other (e.g.,	F 550	order was revised to Ensure Plus 2 times/day for nutrition, give 1 cartoon 237 ml. May have an additional 2 cartons of Ensure Plus PRN if requested by resident (up to 4 cartons of Ensure Plus a day). Nurse RN4 was suspended pending investigation on 04/20/22 and terminated on 04/25/22. The Director of Nursing/Social Services Manager/Activities Manager: On 05/17/22 R49 was supported with her incident and should have been informed of the reason for the room change; will be administered medications in a positive and supportive manner; called by a proper name; a grievance report was filed for the 01/14/22 incident. On 05/16/22 R42 was supported those medications will be administered as ordered in a timely, positive and supportive manner. Call lights will be placed within reach. The Social Services Manager completed a grievance report. On 05/16/22 R75 was supported that pain medications will be administered positively and supportively. By 04/22/22 R52□s picture of his private area was removed from the medical records. RNs 04/22/22 were educated to ensure that pictures of private areas are not taken and posted. On 05/17/22 R45 was supported those medications will be administered as ordered on a timely, positively and supportively. On 04/22/22 R20 will be using napkins and not use an adult clothing protector.	

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F 550	Continued From page 3 threatening others, screaming at others, cursing at others), and other behavioral symptoms not directed toward others (e.g., physical symptoms ...). On 04/19/22 at 03:50 PM in the Pikake dining room, R52 could be overheard loudly yelling from the Lehua Unit and Pikake Unit shared hallway. R52 was observed in the dining room, seated at a table in his wheelchair, yelling he wanted Ensure (a nutritional shake and drink used as a meal supplement, occasional meal replacement, or convenient between-meal snack) and Registered Nurse (RN)4 was observed to be pacing while speaking to R52, inaudible due to R52's loud yelling. Other residents and staff members were observed to be in the dining room. RN4 could be heard loudly yelling as she walked away from R52 that she would be calling her supervisor. R52 continued to yell loudly, "AYE! AYE! AYE!...I want Ensure!" After using the phone, RN4 was observed to quickly walk toward R52, released R52's wheelchair brakes and attempt to push R52 out of the dining room without informing or asking him. R52 struggled to stop RN4 from pushing his wheelchair by grabbing the hand rims of the wheelchair. Another staff member was heard yelling "Watch his hands!" RN4 paused, briefly walked away, and returned to R52 to remove him from the dining room with the help of Certified Nursing Aide (CNA)2. RN4 and CNA2 were observed pushing R52 to the hallway as R52 continued to yell for Ensure and stating "You are not taking me there. Get me back over there now, you get me Ensure." At 03:57 PM observed R52 was brought back to the dining room and given an Ensure. R52 continued to yell loudly even after Ensure was given, " ...they should put a time when they bring it ...they don't tell the truth,	F 550	The family was called on 05/18/22 and informed of the change. CP updated 05/18/22 by nurse. On 04/22/22 the nursing and activity staff were educated on the incident involving residents R67 and R50 and ensured that the television was turned on. R67□s care plan was verified for 05/18/22 activities due to his Chinese language. On 05/18/22 all nursing/social services/administrative staff was in serviced in treating residents with respect and dignity and to complete the grievance process. 2. All residents were surveyed to ensure that each were being treated with respect and dignity. On 05/18/22 the Director of Nursing/designee observed all meals that residents were using napkins to protect their clothing during meals and removed immediately after meals; reviewed and deleted inappropriate pictures. On 05/18/22 the Activity Manager will audit and observe the care plan and implementation of daily activities for all residents to ensure that care plans are individualized and implemented. 3. On 04/22/22, the Director of Nursing Designee and Administrator educated all facility staff on the facility□s Resident□s Rights - & to reside and receive services in the facility with reasonable accommodations of resident needs and preferences; &. the right to receive written notification, including the reason of a change, before the resident□s room is changed. All new hire staff will be in serviced at orientation and annually thereafter.	

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F 550	Continued From page 4 they are liars ..." and proceeded to loudly state to get what you want you need to yell. On 04/19/22 at 04:15 PM, during a record review of R52's electronic health record (EHR), R52 had a current order for Ensure Plus with a start date of 03/08/22, that read: "...as needed for Supplement 237 ml [milliliters] upon RESIDENT REQUEST up to 2 times/day." Review of R52's medication administration record (MAR) noted no documentation Ensure Plus was given for the entire month of April. On 04/20/22 at 09:19 AM during an interview with R49, R49 stated yesterday afternoon she could hear R52 from her room yelling for Ensure even while wearing headphones. R49 did not understand why R52 could not get Ensure on his request and proceeded to state that she heard from nursing staff that RN4 would not let any of the CNAs get R52 the Ensure until he ate his sandwich. R49 stated RN4 does not have compassion for the people she serves. On 04/20/22 at 03:13 PM interview with RN6 stated she worked on 04/19/22 when she heard R52 yelling. RN6 was not sure what he was yelling about. RN6 stated she has worked in the facility since 03/12/22 and provided care for R52 a few times. RN6 had no incidents with R52 during her shift and had " ...never experienced R52 yelling or demanding." On 04/20/22 at 03:23 PM interview with CNA2 stated he worked on 04/19/22 and was the assigned CNA for R52 during the evening shift when the incident happened. CNA2 stated he was helping other residents when he heard R52 screaming and demanding Ensure at the dining	F 550	4. The Director of Nursing/designee will complete monthly audits with residents to ensure that they are being treated with respect and dignity with services such as with medication administration, call lights within reach, use of clothing protector and care plans are individualized and being followed. The Activity Manager, each month will audit activity care plans and ensure that each is being implemented and will review the results of observation reports and any corrective measures taken with the Resident/Family Group Council during their monthly meetings for complaints, grievances, comments and suggestions. The Social Service Manager will audit each month room changes for written notifications. Each area will report to the QA Committee which will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee. 05/20/22.	

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room. As CNA2 approached R52 he saw RN4 talking to R52 but could not hear what she was saying. CNA2 asked RN4 if he could give R52 Ensure, RN4 told CNA2 that she would handle it. CNA2 helped RN4 in an attempt to bring R52 to his room but R52 did not want to go to his room and stopped in the hallway. CNA2 stated R52 was mad and " ...he never had outburst like this with Ensure." CNA2 further stated it is common for R52 to request for Ensure and he usually gets two Ensures a day. CNA2 did not know if R52 received his second Ensure prior to the incident. Inquired how CNA2 would check if R52 received Ensure, "I would ask nurse and previous CNA ..." and it would be documented in R52's chart if he received Ensure that day.

On 04/20/22 at 03:58 PM interview with CNA4 stated on 04/19/22, she was helping another resident when she heard R52 yelling that he wanted Ensure. As CNA4 approached R52, RN4 waved at CNA4 indicating not approach R52 and not give R52 Ensure. Inquired why RN4 did not want CNA4 to approach or offer R52 Ensure, CNA4 stated RN4 thought R52 might get violent and " ...if you get him what he wants ...yelling, going to keep yelling what he wants." CNA4 stated she never provided care for R52 but has never seen him violent with someone else and has heard him yell before, but nothing like the incident on 04/19/22.

On 04/20/22 at 04:17 PM interview with CNA3 stated she worked on 04/19/22 and was helping another resident shower when she heard and recognized R52's voice yelling for Ensure. CNA3 stated she is familiar with R52 and is usually assigned to him at least once a week. CNA3 described R52 as calm with staff members he is

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familiar with, but does get attention from other staff by yelling if he does not get what he wants right away. CNA3 heard R52 yell before but " ...yesterday was the worst one. I think he wanted Ensure, I think he waited too long but wants to get it right away." Inquired how often does R52 receive Ensure a day, CNA3 explained R52 can have Ensure twice a day. "He gets one in the morning and one in the afternoon. He gets Ensure about three [03:00 PM] in the afternoon. He usually asks for more than two Ensure." Inquired what happens if R52 asks for more Ensure than what is prescribed, CNA3 replied, staff will inform the nurse and either they talk to R52 or the nurse instructs the CNA to give him another one. CNA3 stated nursing staff documents when Ensure is given and can check the EHR how many has been administered to him that day. CNA3 stated she has worked with RN4 before and described RN4 as " ...outspoken, her voice is loud. She is nice and concerned about the resident. But sometimes the voice is kind of high, sometimes residents feel like she is yelling .... residents complain because of the high voice." Inquired if RN4 spoke to residents respectfully, CNA3 stated "Honestly, I'd say no due to her voice is high."

On 04/21/22 at 08:32 AM an interview and concurrent review of R52's medical record was done with RN17. RN17 stated on 04/19/22 she was doing her rounds when she arrived to the dining room. RN17 observed R52 sitting with other residents in the dining room, he had an Ensure and a sandwich, R17 described R52 as angry, aggressive, and yelling, R52 " ...had foul language it had something to do with Ensure." R52 told RN17 that he " ...had to make a big fuss about it" before he received an Ensure. RN17

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spoke with RN4 regarding the incident, RN4 reportedly explained to RN17 that R52 is constantly asking for Ensure and " ...we are serving dinner soon ...[RN4] ...wanted him to calm down ...". RN4 attempted to offer a sandwich instead but R52 wanted an Ensure. RN4 reported to RN17 that R52 had demanded for Ensure in the past and RN4 wanted to correct his behavior instead of " ...feeding into it." RN4 informed RN17 that she did not ask R52 to go somewhere else and talk privately because he was combative, and she was afraid to approach him. RN17 stated RN4 should have handled things differently and explained R52 has dementia " ...you cannot argue with him ..." Inquired with RN17 how she would have handled the situation, "I would talk to the resident, let's go for a walk ..." If R52 refused and continued to ask for Ensure, RN17 stated she would call the doctor and dietitian to inform them that R52 is upset and received the maximum daily amount prescribed but wants another Ensure. RN17 stated she " ...didn't think it was a big deal ..." for R52 to have another Ensure. RN17 further stated "This is their home we should give it to them if it's safe." Inquired if it is appropriate to forcefully remove a resident from an area if they refused to leave, RN17 stated if a resident refuses " ...we shouldn't be forcing him. We are not following his wishes ..." and is considered seclusion when trying to remove a resident against their will. During concurrent review of R52's EHR, RN17 stated that when nutritional shakes are given, nursing staff should be documenting on the MAR. After reviewing the MAR, RN17 confirmed that there were no nutritional shakes documented for R52, on 04/19/22, or any other day for the month of April.

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On 04/21/22 at 01:37 PM an interview and concurrent record review was conducted with CNA1 stated she worked on 04/19/22 and was retrieving an item for another resident when R52 asked CNA1 for Ensure. Prior to the incident, CNA1 recalled R52 as being " ...in a good mood ..." R52 greeted CNA1 and requested for a vanilla Ensure. RN4 told CNA1 she had a sandwich for R52 and gave R52 a sandwich, R52 stated he did not want a sandwich and just wanted his Ensure and would yell if he did not get his Ensure. R52 began yelling very loudly and CNA1 noticed another resident seated next to R52 was distressed, CNA1 tried to comfort the other resident and observed CNA4 and CNA2 at different times approach R52 but RN4 told CNA4 and CNA2 to get away from him. CNA1 stated RN4 " ...was getting a little frazzled already ..." and stated she was going to call her supervisor and after getting off the phone "I did notice she [RN4] tried to roll him out of the room ..." CNA1 yelled to RN4 to watch R52's hands as he was holding onto the hand rims of the wheelchair " ...because he is trying to stay ..." CNA1 observed RN4 and CNA2 take R52 down the hallway. CNA1 stated R52 is " ...stuck in a wheelchair how do you think he would feel. That would throw more wood in a fire. I think she should of stayed away from him and have ..." CNA2 speak with R52, and described CNA2 as calm. CNA1 stated during the incident she wanted to give R52 Ensure " ...so bad because we are in-house, and we don't need that drama, but I don't know if he is diabetic."

CNA1 described RN4 as a " ...good nurse, if you need help ...she will get her hands dirty ...she is a little high strung ....she comes off a little strong ...she can tone it down a little bit ...she is loud,

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abrupt ...I think someone needs to tell her to cool down ..." CNA1 explained that a resident expressed she was afraid of RN4 due to her voice and brought it to RN4's attention. RN4 reportedly explained to CNA1 that she had been an Emergency Room nurse and is loud. During a concurrent review of R52's point-of-care (POC) documentation in his EHR, CNA1 confirmed that there was no documentation that R52 had been given a nutritional shake that day. CNA1 stated that the CNAs should be documenting on the POC "under fluid intake" if a nutritional shake is given. CNA1 explained that a nutritional shake can usually be distinguished on the POC because it is 237 ml, a unique measurement of fluid intake.

On 04/21/22 at 10:07 AM interview with Social Services Coordinator (SSC) stated she received a phone call from RN4 on 04/19/22, RN4 stated she needed SSC for support and SSC could hear R52 yelling over the phone. SSC stated she went to the dining room as soon as possible and saw RN4 give R52 Ensure when she arrived. Then R52 demanded RN4 to prepare the Ensure with a straw for him. SSC described R52 as hard of hearing and tended to speak loudly but has " ...never seen him get like that before. SSC spoke to one of the nurses who reported that is the biggest outburst and only recently has been like that. Doesn't know why, he hasn't been exhibiting behaviors before." SSC stated that after the incident, RN17 and SSC met with RN4, RN4 reported she did not want to give R52 Ensure because if staff keep giving him things when he yells, he will continue to yell to get what he wants.

On 04/21/22 at 10:19 AM interview with Social Services Manager (SSM) stated he was not there during the incident on 04/19/22 but spoke with

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RN4 after to understand what happened. "According to her [RN4's] report ...[R52] ...was requesting for Ensure. He was already yelling when approached. The resident did not want a sandwich, she reminded him to remain calm and encouraged to take him to his room ....An Ensure was given to the resident ..." R52 demanded RN4 to open and prepare it for him. SSM was told that R52 continued to yell even after Ensure was given to him. RN4 explained to SSM that R52 " ...is on 2 Ensure PRN [as needed] ..." and if staff continue to give Ensure to him, he will continue to ask and yell. SSM stated RN4 tired to deescalate the situation by taking R52 out of the dining room but if R52 refused and she continued to remove him, it could be considered isolation if taken to his room and " ...it could be taking control and dominance over the resident."

On 04/22/22 at 08:49 AM interview with Director of Nursing (DON) with Administrator present, DON stated the incident on 04/19/22 was RN4's " ...last leg, once I told her she was suspended she knew it was termination." DON explained RN4 did not return the facility's calls to inform her of her suspension and to set up an interview with State Surveyors. DON stated, "What got me, she [RN4] still didn't get it. If ...[R53] asked for Ensure ...to go back and forth with the resident, you can't do that ..."

The State Agnecy requested to interview RN4 on 04/20/21, however, the facility suspended RN4 on 04/20/21. RN4 reportedly was suspended via a telephone call. The facility's administration attempted to contact RN4, RN4 did not return their calls.

2) Cross Reference to F585 Grievances. The

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facility failed to document any corrective action taken as a result of R49's grievance.

Cross Reference to F559 Notified of Room Change. The facility failed to provide R49 with written notice and reason for her room change.

Cross Reference to F761. Storage of Drugs. The facility failed to ensure during a medication pass, medications are under the direct observation of the person administering the medications.

R49 was admitted to the facility on 07/01/21. Diagnosis include but not limited to morbid obesity due to excess calories, unspecified single episode major depressive disorder, unspecified insomnia, alcoholic cirrhosis of liver without ascites, muscle weakness, unspecified heart disease, other chronic pain, adjustment disorder with anxiety, presence of left artificial knee joint, cerebral infarction due to unspecified occlusion or stenosis of right middle cerebral artery, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.

A review of R49's quarterly MDS with an ARD of 03/04/2022 found R49 with a score of 15 [cognitively intact] when the BIMS was administered.

On 04/19/22 at 01:15 PM interview with R49, R49 reported RN4 made her cry twice. The first time was on 01/14/22, she remembered the date because every day R49 documented what medications she received, the time, and the nurse that administered the medications. On 01/14/22 she wrote isolation. R49 reported on 01/14/22 RN4 stormed into her room and informed her she was going to go into isolation,

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RN4 did not give R49 time to gather some of her belongings. R49 stated she felt rushed and dragged to another unit in another building by RN4. RN4 did not tell her the reason for isolation and room change. When R49 asked for the reason, RN4 responded " ...never mind why, you just come ..." After R49 was in isolation, she was told by the other nursing staff she tested positive for COVID-19.

The second time R49 reported RN4 made her cry was on either 01/31/22 or 02/01/22 during night shift. R49 reported she requested for her cough medication and pain medication during the night shift and did not see RN4 set her medication on the over bed tray. R49 asked a CNA for her pain medication again. RN4 came to her room, picked up the medications left on her over bed tray, slammed them down and told R49 to open her eyes they are right in front of her. R49 stated she has difficulty seeing especially with her left eye and did not see the medications that were left on her over bed tray.

On 04/19/22 at 01:33 PM reviewed the facility's grievance binder, a written grievance report was not completed for the incident on 01/14/22. For the incident on 01/31/22 or 02/01/22 a written grievance report was completed and dated on 02/02/22. The grievance report documented R49's description of the incident and reported "She had me in tears. Her moods have to stop, from everything I have heard, those moods are getting out of control." The grievance report included RN4's written report and explanation dated 02/05/22, RN4 reported "I joked with resident "Babe, look with your eyes. It is right there." Then, I left the room. I did not know that I had offended the resident ..."

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F 550	Continued From page 13 On 04/20/22 at 01:10 PM interview with Social Services Manager (SSM), SSM stated he was not aware of the incident on 01/14/22 but stated it is " ...the resident's right to know why she is going on isolation and changing rooms." On 04/21/22 at 10:19 AM a second interview with SSM was done. SSM stated he was aware of the incident on 01/31/22 or 02/01/22. Inquired if RN4 treated R49 with dignity and respect, SSM stated no. On 04/21/22 at 12:50 PM interview and concurrent review of the grievance report with the Director of Nursing (DON), review of the statement "Babe, look with your eyes. It is right there" in RN4's written report and explanation dated 02/05/22, DON stated "It is not respectful ...cannot call her a babe ...they are all supposed to understand those are not words to use in the facility. Needs to be more careful on words going forward." 3) Cross Reference to F585 Grievances. The facility did not investigate a grievance and follow the grievance process. During an interview with R42 on 04/18/22 at 09:44 AM, the resident stated staff did not treat her with respect and dignity on two occasions. R42 stated she woke up in the middle of the night, felt itchy, and requested anti-itch medication from RN4. RN4 reportedly responded to R42 in a rude tone and manner, "You already took all of your medications, you don't have any more (medication), you have to wait 'til you can	F 550		

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get it again." R42 told RN4 that she did have medication available and RN4 responded by walking out of room without verbally responding to the resident's statement. RN4 eventually came back and administered the medication to R42. R42 stated she was so upset at the way RN4 handled the incident. R42 was visibly upset when she told this surveyor that RN4 had no right to treat her like she was dumb and RN4's response of walking out of the room when R42 informed her that she did have medication was extremely rude. R42 stated she became even more upset when RN4 came back into the room, administered the anti-itch medication, and RN4 did not apologize for the way she spoke to the resident.

R42 reported a second incident during which RN4 told the resident that she had been using the call light too much, then placed the call light behind the resident's bed, out of the resident's reach. R42 recalled feeling so upset and stated, "how was I supposed to call them if I needed help? It's not like I can get out of bed and walk to the nurse's station."

During an interview with the Social Services Manager (SSM) on 04/20/22 at 10:33 AM, inquired if SSM was aware of R42's complaints involving RN4. SSM stated that R42 was upset about the way RN4 treated her when she requested medication one evening and that staff had placed the resident's call light out of the resident's reach. SSM confirmed R42 had verbally reported an allegation of mistreatment by RN4. SSM confirmed that a formal investigation was not done at the time of the resident's verbal complaint because the incident happened at the end of the day and staff did not complete a

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written grievance form. SSM confirmed a formal investigation should have been completed and acknowledged that R42's verbal complaint should have been handled like an allegation of neglect and/or abuse, but did not. SSM confirmed RN4 did not treat R42 with respect and in a dignified manner that enhanced the resident's quality of life.

Review of the facility's Resident Rights policy and procedure, under Respect and dignity, the resident has the right to be treated with dignity and respect, including the right to receive goods and services and the facility must promote and facilitate resident self-determination through support of the resident choice.

4) Cross Reference to F585 Grievance. The facility did not investigate a grievance and follow the grievance process.

R75 is a 74-year-old male who was admitted to the facility on 03/16/22 on hospice services with diagnosis that include Chronic Obstructive Pulmonary Disease (COPD), depression, palliative care, chronic respiratory failure with hypoxia, malnutrition, emphysema, and Post Traumatic Stress Disorder (PTSD). R75 also suffers from chronic pain to the neck and both lower extremities.

On 04/18/22 at 12:20 PM, conducted an interview with R72. R72 reported having chronic pain. Inquired if he felt like staff treated him with respect and dignity. R72 shook his head side to side, indicating his answer was no. When asked to elaborate why he answered no, R72 did not want to share specific details.

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On 04/20/22 at 10:58 AM, conducted a review of R72's EMR. The resident's admission Minimum Data Set (MDS) with an Assessment reference Date (ARD) of 03/22/22, Section O. 0100. Special Treatments, Procedures, and Patterns documented R72 was receiving hospice services as a resident and Section V. A19 identified pain as a care area. Review of the care plan documented an intervention for pain is for staff to "administer pain medications per order ..." for complaint of abdominal pain 6-7 on a scale of 10 (10 indicates severe pain) managed by as needed medications. Review of R72's Physician Orders documented orders for Acetaminophen 650 mg and Fentanyl patch 72 hours for pain management.

Review of the resident's hospice Interdisciplinary Team (IDT) notes documented an incident during which R72 had become upset with how a facility nurse treated him when he requested medication for pain management. R72 reported being unhappy at the facility, felt uncomfortable there after a nurse made comments about his request for more pain medications. Nurse reportedly was rude to him. R72 stated "I don't deserve to be treated like that". The notes document that it is important for R72 to be treated with respect, he did not feel like the facility understood that and as a result of the incident requested to be transferred out of the facility.

During an interview on 04/20/22 at 10:35 AM, SSM confirmed R72 was not treated in a respectful and dignified manner that enhanced his quality of life when he was made to feel uncomfortable when he requested prescribed medication for pain management.

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Review of the facility's Resident Rights policy and procedure (reviewed/revised on 11/01/21), documented the resident has the right to be treated with dignity and respect, including the right to receive goods and services and the facility must promote and facilitate resident self-determination through support of the resident choice.

5) R52 is a 95-year-old male admitted to the facility on 12/16/21 for long-term care with admitting diagnoses that include COPD (chronic obstructive pulmonary disease), heart failure, Alzheimer's disease, diabetes, and respiratory failure.

On 04/19/22 at 02:30 PM, while conducting a review of R52's electronic health record (EHR) to determine the current status of his pressure ulcer(s), the following close-up photos of R52's genitalia were noted:

"#21 - Rash - groin"
02/20/22 photo of scrotum with penis held up and out of photo
02/10/22 photo of penis and scrotum
02/01/22 photo of penis and scrotum

"#16 - MASD [moisture-associated skin damage characterized by inflammation (redness) of the skin] - IAD [incontinence-associated dermatitis (rash)]- groin"
02/20/22 partial photo of scrotum
02/10/22 photo of scrotum
01/31/22 photo of penis and scrotum

Of the six photos observed, three photos included R52's penis despite there being no sign of a rash

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or MASD to the penis itself. No written description of the skin assessments were found accompanying the photos.

On 04/22/22 at 09:17 AM, an interview was done in the Chapel with the Administrator and Director of Nursing (DON). When asked about the policy for photo documentation of skin conditions, the DON stated that the previous DON had met with her regarding the issue and had updated their policy prior to leaving earlier this year. The DON stated her expectation is that staff are to use photos to document wounds only, not a rash. Both the Administrator and DON agreed that care should be taken when photographing and uploading images of genitalia to the EHR. The facility was unable to produce the requested copies of the old and the updated policies.

6) Resident (R)45 is a 63-year-old female admitted on 11/19/21 for skilled nursing services following a left third toe amputation and a right below-the-knee amputation, with admitting diagnoses that include resolved sepsis, acute respiratory failure, insulin-dependent diabetes, asthma, congestive heart failure, and chronic kidney disease.

During an interview with R45 on 04/20/22 at 01:58 PM in her room, she stated that there are several staff members who treat her disrespectfully. R45 continued to state that one RN4 in particular has a way about her that she described as "harsh." R45 explained that RN4 would consistently bring her medication late, and instead of apologizing, would belittle R45 by saying things like, "well, I'm here now, do you

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want the meds or not?" R45 also reported that RN4 always either called her "boss or baby girl," instead of addressing her by name as she asked her to several times.

7) R20 is an 80-year-old male admitted on 10/22/18 for long-term care with admitting diagnoses that include stroke with cognitive and physical impairments, congestive heart failure, chronic kidney disease, diabetes, Alzheimer's disease, and dysphagia (difficulty or discomfort in swallowing).

On 04/20/22 at 09:31 AM, observations were done in the dining room/common area of a unit, which also served as the main entrance point of the 3-unit building. R20 was observed sitting in a high-backed wheelchair, wearing a long Hawaiian-print adult clothing protector that was secured around his neck and extended to his lower abdomen. R20's face and hands were clean and dry, and the table in front of him had been cleared of any food or drink. Three other residents were also present in the dining room, none of whom were wearing an adult clothing protector. Asked Certified Nurse Aide (CNA)9 and Registered Nurse (RN)3 why R20 was still wearing the clothing protector when the breakfast meal had been cleared over an hour ago. Both staff members stated clothing protectors are usually removed after the meal is done. CNA9 went to remove the clothing protector from R20 but then returned to Surveyor and RN3 to state that she believed the clothing protector might still be on him because he was "drooling a little." RN3 responded, "oh yeah, because he is up in the wheelchair," then explained to Surveyor "it's [adult clothing protector] provided by the family for him." Asked if the clothing protector was

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F 550	Continued From page 20 provided by the family to be used for meals or kept on at all times. RN3 answered, "no, it is usually removed after the meal is done." On 04/21/22 at 09:46 AM, during a review of R20's comprehensive care plan (CP), it was noted that R20 was a "Resident performance: Eating - Total assist/one-person physical assist" for meals. Clothing protectors were not included in R20's CP. 8) Cross Reference to F679 Activities. Residents were not engaged in activities, the television was on with the volume off. On 04/18/22 observation from 10:13 AM through 11:16 AM found residents (Residents 67 and 50) seated in the dining room/activity area on the Ilima unit. The residents were not engaged in activities and were placed facing the television. The television was not turned on. At lunch, observed, three residents seated in the dining room. The residents were facing the television, it was tuned to the "SBS" station (Korean language) and there was no volume. Resident (R)67 is Chinese-speaking and R50 is English speaking.	F 550		
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement.	F 559		5/20/22

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F 559	Continued From page 21 §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and review of the facility's policy and procedures, the facility failed to provide Resident (R) 49 with written notice of a room change, including the reason for the change, before the resident's room in the facility was changed. Findings include: Resident (R)49 was admitted to the facility on 07/01/21. A review of R49's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 03/04/2022 found R49 with a score of 15 [cognitively intact] when the Brief Interview for Mental Status (BIMS) was administered. On 04/19/22 at 01:15 PM interview with R49, R49 reported on 01/14/22, Registered Nurse (RN)4 "stormed" into her room and informed her she was going to isolation. RN4 did not give R49 time to gather some of her belongings. R49 stated she felt rushed and dragged to another unit in another building by RN4. RN4 did not tell her the reason for isolation and room change. When R49 asked for the reason, RN4 responded " ...never mind why, you just come ..." After R49 was in isolation, she was told by the other nursing staff she tested positive for COVID-19. RN49 stated she did not get written notice of a room change. Review of facility's policy and procedures on "Resident Rights" which was reviewed and	F 559	1. On 05/17/22 R49 was supported with her incident and should have been informed of the reason for the room change; will be administered medications in a positive and supportive manner; a grievance report was filed for the 01/14/22 incident, Social Services Manager. 2. On 05/18/22 the Social Service Manager surveyed all residents with room changes were informed of the reasons for a room change, in writing. 3. On 04/22/22, the Director of Nursing Designee and Administrator educated all facility staff on the facility□s Resident□s Rights - &the right to receive written notification, including the reason of a change, before the resident□s room is changed. All new hire staff will be in serviced at orientation and annually thereafter. 4. The Social Service Manager will audit each month room changes for written notifications and will report findings to the QA committee. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee. . 05/20/22.	

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F 559	Continued From page 22 revised on 11/01/21 documented under "4. Respect and dignity. The resident has a right to be treated with respect and dignity, including: ...f. the right to receive written notice, including the reason of the change, before the resident's room or roommate in the facility is changed." On 04/20/22 at 01:10 PM interview with Social Services Manager (SSM), SSM stated he was not aware of the incident on 01/14/22 but stated it is " ...the resident's right to know why she is going on isolation and changing rooms." At 01:19 PM SSM called Minimum Data Set Coordinator (MDSC) and included him on speaker phone during the interview. MDSC stated there was a nursing note documenting R49 was transferred to another unit and room on 01/14/22 by RN4. SSM and MDSC both stated they do not see written notification of the room change on 01/14/22 documented in R49's Electronic Health Record (EHR). On 04/22/22 at 10:02 AM interview with Clerk (C)1 explained when a resident moves to another room the clerks fill out the "Room Change Form". The form is used for facility staff and is not provided to the resident. Residents do not get a written notification when their room is changed but it is documented in nursing notes that the resident was notified.	F 559		
F 577 SS=D	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as	F 577		5/20/22

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F 577	Continued From page 23 client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the results of the most recent survey of the facility conducted by State surveyors and the plan of correction in effect with respect to the facility was posted in a place readily accessible to residents, family members, and legal representatives of the residents or posted a notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. Findings include: On 04/20/22 at 01:15 PM, while conducting observations on Weinberg Unit, this surveyor did not observe posting of survey results from the most recent survey or where the survey results are posted on the Weinberg unit. This surveyor	F 577	1. On 04/20/22 the Director of Nursing/designee ensured that Weinberg Hall had a posting of its most recent survey results. Both RN 56 and CNA 61 was educated on its location. 2. On 04/20/22 all of the nursing units were verified to have a posting of its most recent survey by the Director of Nursing. 3. On 05/18/22 all of the nursing staff was educated on the requirement and location of having the most recent survey and plan of correction for residents and family members to review by the Director of Nursing/designee. 4. The Director of Nursing/designee will audit each month that there is a posting of recent surveys and plan of correction at each nursing station and that nurses are	

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F 577	Continued From page 24 made observations of all readily accessible bulletin boards, unit wall postings, near or in the grievance folder, and the Weinberg nurse's station. Inquired with Registered Nurse (RN)56 and Certified Nurse Aide (CNA)61 where the most recent survey results or notice of its availability of the report was located on the Weinberg unit. RN56 and CNA61 both looked around the nurse's station and unit, then confirmed the most recent survey results/availability of the recent survey results were not posted on the Weinberg unit. CNA61 stated survey results were posted on the Pikake unit. RN56 and CNA61 confirmed visitors of residents on Weinberg unit enter from the outside directly onto the Weinberg unit and do not pass through the Pikake unit at any point during visitation. Thus, the Weinberg unit residents and their visitors would not readily have access to the most recent survey results.	F 577	able to verbalize each and report findings to the QA Committee. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee. . 05/20/22.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken),	F 583		5/20/22

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F 583	Continued From page 25 written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to respect the right to personal privacy for one resident (R) in the sample. The facility failed to provide visual privacy for R20 as he lay in his bed. As a result of this deficient practice, R20 had his privacy compromised and was placed at risk of a decreased quality of life. This deficient practice has the potential to affect all the residents at the facility. Findings include: Resident (R)20 is an 80-year-old male admitted on 10/22/18 for long-term care with admitting diagnoses that include stroke with cognitive and physical impairments, congestive heart failure, chronic kidney disease, diabetes, Alzheimer's disease, and dysphagia (difficulty or discomfort in	F 583	1. On 04/22/22 R20□s curtains were closed for privacy. The nursing staff was educated on the requirement to ensure a resident□s privacy by closing the curtains. RN 9 and CNA 10 was educated on the requirement to ensure a resident□s privacy by closing the privacy curtains by the Director of Nursing/designee. 2. On 04/22/22 the Director of Nursing/designee made rounds to ensure that all resident□s privacy was maintained with the use of the privacy curtains. 3. On 04/22/22 all staff were educated on, the requirement to ensure resident privacy and the use of the privacy curtains to ensure that privacy by the Director of Nursing/designee. 4. The Director of Nursing/designee will audit each month that each resident□s	

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F 583	Continued From page 26 swallowing). On 04/18/22 at 10:26 AM, an observation was done of R20 asleep in his room. R20 occupied the bed closest to the door in a room located next to the dining room of the unit. His sliding room door, with an observation window, was wide open, and his privacy curtain was pulled all the way open. The dining room was consistently occupied by at least two residents for the entire survey period and is traversed by residents, staff, and visitors. R20 could be seen sleeping with his mouth open by anyone passing in the hallway, as well as from certain areas of the dining room. Similar observations were made of R20 whenever he was in his room throughout the survey period, and it was noted that R20's room was the only room in that hallway which left the resident in the first bed consistently visible. On 04/21/22 at 10:19 AM, an interview was done with Certified Nurse Aide (CNA)10 in the hallway outside R20's room. CNA10 was asked why R20's door and privacy curtain were always left wide open. CNA10 responded that it was so staff could keep an eye on him to ensure that "he does not slide onto the floor." CNA10 was asked if staff would be able to see R20 through the observation window on the room door. CNA10 indicated that she did not know. On 04/21/22 at 10:27 AM, an interview was done with Registered Nurse (RN)9 in the dining room of R20's unit. When asked why R20's door and privacy curtain were always left wide open, RN9 responded that "he is a high falls risk." When asked why other residents on the unit who were identified as high falls risk did not have their doors and privacy curtains left open, exposing	F 583	privacy is maintained with the use of the privacy curtains and report findings to the QA Committee. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee. 05/20/22.	

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F 583	Continued From page 27 them as they lay in bed, RN9 had no answer. On 04/21/22 at 01:15 PM, during a review of R20's comprehensive care plan (CP), it was noted that although his risk for falls is care planned, there is no intervention to keep his room door or privacy curtain open at all times.	F 583		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		5/20/22

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F 584	Continued From page 28 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to exercise reasonable care for the protection of one resident's property from misappropriation and loss, as evidenced by Resident (R)45's complaint that her personal items had been gone through and/or went missing during the time she had been admitted to the acute hospital. This deficient practice has the potential to affect all the residents at the facility. Findings include: Cross-reference to F585 Grievances. The facility failed to address a resident's grievance the grievance in a timely manner. R45 is a 63-year-old female admitted on 11/19/21 for skilled nursing services following a left third toe amputation and a right below-the-knee amputation, with admitting diagnoses that include resolved sepsis, acute respiratory failure, insulin-dependent diabetes, asthma, congestive heart failure, and chronic kidney disease. On 03/04/22, R45 was transferred to the acute hospital for five days and was re-admitted to the facility on 03/09/22.	F 584	1. On 05/17/22 R45 personal property was found/replaced. A formal grievance was filed and completed by the Director of Nursing/designee. 2. On 05/16/22 all residents were surveyed to ensure that all each need were being met by the Social Services Manager. All grievances were reviewed, followed-up and completed by the Director of Nursing/designee. 3. On 05/18/22 nursing and social services were in serviced on the importance of following the grievance process, by the Director of Nursing/designee. 4. The CEO/designee will audit each month that each resident□s grievance is being investigated and corrected within the designated timeline and report findings to the QA Committee. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee. 05/20/22.	

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F 584	Continued From page 29 On 04/18/22 at 09:49 AM, an interview was done with R45 in her room. R45 stated that when she returned to the facility on 03/09/22, she noticed that her personal property that she kept at her bedside had been moved, gone through, and/or was missing. R45 explained that she immediately noticed the inner cap of her facial moisturizer had been placed upside down, preventing the outer cap from being able to close properly. R45 emphatically stated that this is something she would never do, as the moisturizer is expensive, and she is incredibly careful with it. R45 could not tell if any moisturizer was missing, but the thought that someone had placed their fingers in it which was "very upsetting." R45 stated she also noticed her metal extendable back scratcher was missing, and that her makeup bag, which she kept in a white box at her bedside, was unzipped and the makeup inside had been turned upside down. Observed R45 was very neat and orderly, with her personal property carefully placed. R45 stated she spends most of her time in her room, so she likes to keep everything in its proper place. This makes it easier for her to find things when she needs them. R45 stated that she did file a formal grievance about the incident, because it was so unsettling to her, as she had not heard anything about it since.	F 584		
F 585 SS=F	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or	F 585		5/20/22

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reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency,

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Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility

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F 585	Continued From page 32 or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, and review of the facility's policy and procedures, the facility failed to make prompt efforts to investigate and resolve the grievances filed by four residents in the sample (Residents 45, 75, 42, and 49). As a result of this deficient practice, these residents experienced a decreased quality of life, feeling as if the concerns they voiced were not being taken seriously, or even noticed. This deficient practice has the potential to affect all the residents at the facility who voice a concern. Findings include: 1) Cross Reference to F550 Resident Rights. The facility failed to treat residents with respect and dignity. On 04/18/22 at 09:44 AM, during an interview with Resident (R)42, R42 informed this surveyor of an incident, involving staff, during which the resident was not treated in a dignified and respectful manner. R42 reported, she requested anti-itch medication from Registered Nurse (RN)4. RN4 spoke to the resident in a rude tone and manner, informing R42 she would have to wait until the morning. RN4 eventually came	F 585	1. On 05/16/22 R42 was supported those medications will be administered as ordered in a timely, positive and supportive manner. Call lights will be placed within reach by the Director of Nursing/designee. The Social Service Manager completed a grievance report. The Director of Nursing/designee: On 05/16/22 R75 was supported that pain medications will be administered positively and supportively. On 05/17/22 R45 personal property was found/replaced. A formal grievance was filed and completed. On 05/17/22 R49 was supported with her incident and should have been informed of the reason for the room change; will be administered medications in a positive and supportive manner; a grievance report was filed for the 01/14/22 incident. RN4 was suspended pending investigation on 04/20/22 and terminated on 04/25/22 by the Administrator. On 05/18/22 all staff □ administrator,	

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F 585	Continued From page 33 back with the medication and administered it without apologizing for reportedly being rude to the resident. On another occasion, RN4 took R42's call light and placed it out of the resident's reach and told the resident she was calling for staff too often. This caused R42 to feel emotionally upset and elicited feeling of helplessness. Inquired with R42 if the resident received a written notification that an investigation was completed and if she was made aware of the investigation results. R42 confirmed she was not provided the results of the investigation or any corrective actions for RN4 . On 4/20/22 at 10:35 AM, conducted an interview with the Social Services Manager (SSM) regarding the incidents reported by R42. SSM confirmed that he was aware of the incidents and is responsible for conducting a formal investigation related to resident grievances. Requested to review the formal investigation conducted by the SSM and was informed that a formal investigation was not conducted. SSM stated at the time he did not recognize R42's complaints as potential abuse or neglect of care, but now identifies that it could have been. SSM informed this surveyor that it was not handled like a grievance because he did not receive a written grievance form from staff. On 04/20/22 at 11:00 AM, reviewed the facility's Grievance Log. The grievance log did not include documentation of R42's complaint of mistreatment by RN4. Review of the facility's Resident and Family Grievances policy and procedure (reviewed/revised on 11/01/21) documented the staff member receiving the grievance will record	F 585	nursing, social services were in serviced in treating residents with respect and dignity provide services as needed in a positive and supportive manner; and to procedure in completing the grievance process by the CEO/designee. 2. On 05/16/22 the Social Services Manager surveyed all residents to ensure that each were being treated with respect and dignity; and reviewed and completed all grievances with the CEO. 3. On 05/18/22 all staff were in-services on the Grievance P/P. All new hire staff will be in serviced at orientation and annually thereafter by the Director of Nursing/designee. 4. The CEO will audit each month all grievances to ensure a timely and complete follow-up and will report finding to the QA Committee. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee. 05/20/22.	

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the nature and specifics of the grievance on the designated grievance form or assist the resident or family member to complete the form. The Grievance Officer will take steps to resolve the grievance, and record the information about the grievance, and those actions on the grievance form. Review of the facility's Grievance/Concern/Missing Item Policy, located in the grievance folder at the Weinberg nurse's station, documents the residents have a right to verbally express grievances or complaints at any time regarding the behavior of staff.

2) R75 is a 74-year-old male who was admitted to the facility on 03/16/22 on hospice services with diagnosis that include Chronic Obstructive Pulmonary Disease (COPD), depression, palliative care, chronic respiratory failure with hypoxia, malnutrition, emphysema, and Post Traumatic Stress Disorder (PTSD). R75 also suffers from chronic pain to the neck and both lower extremities.

During the review of R72's Electronic Medical Record (EMR) on 04/20/22 at 10:58 AM, a hospice Interdisciplinary Team (IDT) notes documented an incident during which R72 had become upset with a facility nurse treated him rudely when he requested pain medication for pain management. As a result of this incident, the resident reported being unhappy and feeling uncomfortable, stating "I don't deserve to be treated like that." The IDT notes also documented that it is important for R72 to be treated with respect, he did not feel like the facility understood that and requested to be transferred out of the facility.

On 04/20/22 at 10:35 AM, SSM confirmed that

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PALOLO CHINESE HOME	2459 10TH AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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the grievance procedure was not followed for staff's treatment of R72, and a formal investigation was not conducted. SSM stated that staff's mistreatment of the resident was a form of abuse and could have a negative psychosocial effect on a hospice resident transitioning. Inquired as to why a formal investigation was not completed, SSM stated that the allegation was made at the end of the workday.

Review of the facility's Resident and Family Grievances policy and procedure (reviewed/revised on 11/1/21) documented the staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form or assist the resident or family member to complete the form. The Grievance Officer will take steps to resolve the grievance, and record the information about the grievance, and those actions on the grievance form. Review of the Palolo Chinese Home Grievance/Concern/Missing Item Policy, located in the Grievance folder at the Weinberg nurse's station, documented the residents have a right to verbally express grievances or complaints at any time regarding the behavior of staff. (Cross Reference to F550- Resident Rights).
3) Cross Reference to F584. the facility failed to ensure safe keeping of resident's personal property during her absence (hospitalization).

R45 is a 63-year-old female admitted on 11/19/21 for skilled nursing services following a left third toe amputation and a right below-the-knee amputation, with admitting diagnoses that include resolved sepsis, acute respiratory failure, insulin-dependent diabetes, asthma, congestive heart failure, and chronic kidney disease. On 03/04/22, R45 was transferred to the acute

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hospital for five days and was re-admitted to the facility on 03/09/22.

On 04/18/22 at 09:49 AM, R45 was interviewed in her room R45 reported after hospitalization she returned to the facility and found her personal items had been "gone through" (moisturizer, make up bag) and had a missing back scratcher.

On 04/21/22 at 01:57 PM, during a review of R45's electronic health record (EHR), it was noted that Registered Nurse (RN)16 had documented R45's complaint on 03/11/22 in a progress note and had completed a " ...Grievance form ...per resident's request. Gave form to SW [Social Worker] for follow-up."

On 04/21/22 at 02:40 PM, an interview was done with the Social Services Manager (SSM) in the Chapel. When asked about R45's grievance filed on 03/11/22, the SSM stated he had not seen it or heard about it yet. Requested to see the Grievance Log, and the SSM stated he was not certain if the facility kept one. Requested a copy of the grievance in question. The SSM stated he was having difficulty locating it. Stated he would continue to look for it, but " ...even if I find it, I'm sure I didn't follow up on it."

4) Cross Reference to F550 Resident Rights. The facility failed to ensure R49 was treated with dignity and respect by a staff member.

Cross Reference to F761 Storage of Drugs. The facility failed to ensure during a medication pass, medications are under the direct observation of the person administering the medications.

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Resident (R) 49 was admitted to the facility on 07/01/21. A review of R49's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 03/04/2022 found R49 with a score of 15 [cognitively intact] when the Brief Interview for Mental Status (BIMS) was administered.

On 04/19/22 at 01:15 PM interview with R49 reported she filed a written grievance against Registered Nurse (RN)4 for an incident on 01/31/22 or 02/01/22 during the night shift that made her cry. R49 stated she did not see RN4 place her cough and pain medication on her over bed tray and when requested again for her pain medications RN4 picked them up, slammed them down and told R49 to open her eyes they are right in front of her. R49 noted with a visual impairment, unable to see clearly from her left eye.

On 04/19/22 at 01:33 PM reviewed the facility's grievance binder, on 01/31/22 or 02/01/22 a written grievance report was completed and dated on 02/02/22. The grievance report documented R49's statement, "She had me in tears. Her moods have to stop, from everything I have heard, those moods are getting out of control."

The grievance report under "Steps taken to investigate grievance:" documented the ADON (Assistant Director of Nursing) interviewed RN4 and requested for a written report and explanation." RN4's written report dated 02/05/22 documented " ...This RN went to resident's room with PRN [as needed] medications cough med in 30 cc [cubic centimeter] med cup and 2 oxycodone pain pills in another 30 cc med cup. As I approached resident, resident was sitting up

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in bed with both eyes closed appeared to be resting. No signs of 10/10 pain as previously reported by resident. Body relax with no facial expression noted. This RN left room with medications in front of resident. As I was approaching med cart in Lehua hallway, CNA [Certified Nursing Aide] reports resident asking for pain medication. This RN to resident's room. Oxycodone 2 tab noted in 30 cc med cup in front of resident. Cough PRN medication was missing. When resident asked "I took it. I need my pain medication." I joked with resident "Babe, look with your eyes. It is right there." Then, I left the room. I did not know that I had offended the resident ..." In the written grievance report under "Summary of Findings/Conclusion:" documented "NOD did not intend to offend resident; and apologized to resident" and under "Corrective action taken:" documented "N/A [not applicable]."

On 04/21/22 at 10:07 AM interview and concurrent review of the written grievance report with Social Services Coordinator (SSC) stated she was not familiar with the grievance. Inquired if the report documented RN4 received any education or training when interacting with residents and/or medication administration, SSC stated no.

On 04/21/22 at 10:19 AM interview and concurrent review of the written grievance report with Social Services Manager (SSM) was done. SSM stated he was aware of the incident on 01/31/22 or 02/01/22. SSM reported the previous ADON spoke with RN4 after the incident and explained her joke can be perceived as rude and she needs to be a little gentler. SSM stated RN4 was educated by ADON on how to approach residents. SSM stated he did not follow-up with

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grievance because ADON told him it was taken care of. SSM could not find documentation that RN4 received education after the incident.

On 04/21/22 at 12:50 PM interview and concurrent review of the grievance report was done with Director of Nursing (DON), DON stated she remembered the incident on 01/31/22 or 02/01/22 " ...I believe that ADON...had to investigate what happened..." DON further stated ADON trained and educated RN4 " ...instead of waiting and addressed it on the spot." Inquired with DON what training or education did ADON provide, DON stated she would need to look.

On 04/21/22 at 02:52 PM interviewed the Human Resource Director (HRD) stated if a supervisor takes disciplinary action of a staff member, it is verbal warning or written warning, the supervisor will do a formal write up and provide it to Human Resources (HR) to be kept in the staff member's personnel file. HRD explained "There is a template form for verbal and written ..." indicating what type of disciplinary action was taken, education, verbal or written. Inquired if RN4 received any disciplinary action and if it was documented in her personnel file, HRD confirmed " ...she does not have ...no documentation of education done or anything." HRD was not aware of grievances, complaints, or concerns regarding RN4.

On 04/22/22 at 08:49 AM interview with DON and Administrator, inquired what the facility process is for staff members who have complaints or grievances against them, DON stated "We would do on the spot education ..." explain the concerns and provide an apology, provide verbal warning, three written warnings, then suspension and

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F 585	Continued From page 40 termination. DON stated Human Resources (HR) should know right away. Requested DON to provide documentation that RN4 received education, training, verbal warnings or written warnings for incidents and grievances related to RN4. DON did not provide the documentation for the incident on 01/31/22 or 02/01/22. On 04/22/22 at 4:10 PM during the exit conference, DON stated RN4 received education and/or training for the incident on 01/31/22 or 02/01/22. Requested DON provide the documentation and fax it by the end of the day. On 04/25/22, documentation was not faxed to the State Agency.	F 585		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		5/20/22

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F 609	Continued From page 41 §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 interviews and record reviews, the facility failed to conduct an investigation of an alleged violation of mistreatment by staff and failed to report the alleged violation the to the State Survey Agency and/or Adult Protective Services. Findings include: Cross Reference to F610 Investigate/Prevent/Correct Alleged Violation. The facility failed to conduct a thorough investigation of an alleged incident of mistreatment. R75 is a 74-year-old male who was admitted to the facility on 03/16/22 on hospice services with diagnosis that include Chronic Obstructive Pulmonary Disease (COPD), depression, palliative care, chronic respiratory failure with hypoxia, malnutrition, emphysema, and Post Traumatic Stress Disorder (PTSD) with chronic pain to the neck and both lower extremities. On 04/20/22 at 10:58 AM, conducted a review of R72's EMR. The resident's admission Minimum Data Set (MDS) with an Assessment reference Date (ARD) of 03/22/22, documented in Section O. 0100. Special Treatments, Procedures, and	F 609	1. On 05/16/22 R75 was supported that pain medications will be administered positively and supportively. An investigation was completed and RN4 was suspended on 04/20/22 and terminated on 04/25/22 by the Director of Nursing/designee. 2. On 05/16/22 all residents were surveyed by the Social Services Manager to ensure that all residents were being treated with respect and dignity. No mistreatment. All staff were in serviced on 05/18/22 the requirement to report and investigate all allegations of abuse, neglect, exploitation and mistreatment by the Director of Nursing/designee. Allegations of mistreatment to be reported to the State Agency (DOH) and Adult Protective Services. 3. On 04/22/22, 05/18/22 all staff were in services on the Abuse and Neglect P/P and the requirements to protect the resident, investigate and to report any alleged violations by the Director of Nursing/designee. All new hire staff will be in serviced at orientation and annually thereafter by the Director of Nursing/designee. 4. The Administrator/designee will audit	

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F 609	Continued From page 42 Patterns documented the R72 was receiving hospice services as a resident and Section V. A19 identified pain as a care area. Review of the care plan documented an intervention for pain is for staff to "administer pain medications per order ..." for complaint of abdominal pain 6-7 on a scale of 10 (10 indicates severe pain) managed by as needed medications. Review of R72's Physician Orders documented orders for Acetaminophen 650 mg and Fentanyl patch 72 hours for pain management. Review of the resident's hospice Interdisciplinary Team (IDT) notes documented an incident where R72 became upset with a facility nurse when she made comments about his request for more pain medication and was rude to him. R72 also reported being unhappy at the facility (due to this incident) and feels uncomfortable at the facility. R72 stated "I don't deserve to be treated like that". The notes documented that it is important for R72 to be treated with respect, he did not feel like the facility understood that and requested to be transferred out of the facility. On 04/20/22 at 10:35 AM, an interview was conducted with the Social Service Manager (SSM). SSM identified staff's mistreatment of the resident as a form of abuse that may have had a negative psychosocial affect on a hospice resident transitioning. SSM confirmed that the incident was not handled as a grievance, a formal investigation was not conducted, and a report was not made to the State Survey Agency or APS regarding the incident. SSM stated that the nurse was counseled and received training regarding this incident. Through deduction, SSM identified Registered Nurse (RN)4 as the alleged violator due to previous and similar complaints made by other residents. Requested to review	F 609	each month to ensure that all alleged violations are investigated and reported to the QA Committee. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee. 05/20/22.	

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F 609	Continued From page 43 documentation of the training/counseling the nurse received and a copy of the content of the training that was provided to the nurse. Documentation was not provided to this surveyor as requested. On 04/22/22 at 08:49 AM, conducted an interview with the Director of Nursing (DON) and the Administrator. Informed the DON and administrator of the incident with a staff nurse and R72. The DON stated the staff nurse received training and education regarding the incident. Requested for the DON to provide documentation of the training/counseling the nurse received and the content of the training provided to the nurse. At 01:30 PM, received a printed email thread that stated the nurse had received education on compassionate care and bedside manner. A request was made for the content of the training materials provided and it was not received. During the exit conference at 04:10 PM, DON was provided the the opportunity to fax documentation by the end of the day (04/22/22), documentation was not provided to this surveyor by the end of the day. On 04/25/22, there was no documentation from the facility sent via fax.	F 609		
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,	F 610		5/20/22

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F 610	Continued From page 44 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 interviews and record reviews, the facility failed to conduct an investigation of an allegation of mistreatment of a resident by a direct care staff. Findings include: Cross Reference to F609 Reporting of Alleged Violations. The facility did not ensure an allegation of mistreatment was reported to the State Agency and Adult Protective Services. R75 is a 74-year-old male who was admitted to the facility on 03/16/22 on hospice services. Hospice Interdisciplinary Team (IDT) notes documents R75 expressed he became upset when Registered Nurse (RN)4 made rude comments in response to his request for pain medication. R72 stated "He doesn't deserve to be treated like that" and wanted to transfer to another facility. On 04/20/22 at 10:35 AM, an interview was conducted with the Social Service Manager (SSM). SSM identified staff's mistreatment of the resident as a form of abuse that had a negative psychosocial effect on a hospice resident	F 610	1. On 05/16/22 R75 was supported that pain medications will be administered positively and supportively. An investigation was completed and RN4 was suspended on 04/20/22 and terminated on 04/25/22 by the Director of Nursing/designee. 2. On 05/16/22 all residents were surveyed by the Social Services Manager to ensure that all residents were being treated with respect and dignity. No mistreatment. All staff were in serviced on 05/18/22 the requirement to report and investigate all allegations of abuse, neglect, exploitation and mistreatment by the Director of Nursing/designee. Allegations of mistreatment to be reported to the State Agency (DOH) and Adult Protective Services. 3. On 04/22/22, 05/18/22 all staff were in services on the Abuse and Neglect P/P and the requirements to protect the resident, investigate and to report any alleged violations by the Director of Nursing/designee. All new hire staff will be in serviced at orientation and annually thereafter by the Director of	

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F 610	Continued From page 45 transitioning. Mentally, the resident should be feeling cared for and it is important while transitioning in hospice. Inquired whether this allegation was investigated, SSM confirmed an investigation of the alleged violation was not done.	F 610	Nursing/designee. 4. The Administrator/designee will audit each month to ensure that all alleged violations are investigated and reported to the QA Committee. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee. 05/20/22.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-	F 623		5/20/22

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(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part

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F 623	Continued From page 47 C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff member, the facility failed to ensure a copy of a resident's discharge notice was sent to the Office of the State Long-Term Ombudsman. Findings include: Resident (R)56 was discharged from the facility on 04/05/22 to an adult foster home (AFH).	F 623	1. On 05/18/22 the Social Services Coordinator sent the discharge notification date of transfer, reason for discharge/transfer, social service information, equipment needed, physician follow-up summary and a summary of stay for R56 to the Office of the State Long-Term Ombudsman. 2. On 05/18/22 all discharges were	

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F 623	Continued From page 48 There was no documentation this was a resident-initiated discharge. On 04/22/22 at 11:18 AM an interview was conducted with the facility's Social Services Coordinator (SSC). Requested a copy of the discharge notification to the Office of the State Long-Term Ombudsman. The SSC provided a copy of R56's "Discharge/Transfer Notice", further requested confirmation (i.e. fax transmittal receipt) that the form was sent to the Ombudsman. SSC was agreeable to provide documentation. Upon exit of the facility on 04/22/22 at 04:45 PM, the documentation was not provided.	F 623	audited by the Social Services Coordinator and discharge notifications were sent to the State Long-Term Ombudsman. 3. On 05/17/22 the Social Services staff were in serviced on the requirement to send discharge notifications to the State Long-Term Ombudsman, Discharge Notice P/P. All new hire staff will be in serviced at orientation and annually thereafter by the Director of Nursing/designee. 4. The Social Services Manager will audit each month that discharge notices are sent to the Office of the State Long-Term Ombudsman and reported to the QA Committee. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee. 05/20/22.	
F 656 SS=E	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	F 656		5/20/22

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F 656	Continued From page 49 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 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview with staff members, the facility failed to develop comprehensive person-centered care plans for five (Residents 45, 51, 58, 77, and 67) of the 20 residents included in the active sample. Findings include: 1) On 04/18/22, 04/19/22, and 04/20/22 observed while seated in a wheelchair, Resident	F 656	1. On 04/20/22 □ 04/21/22 the MDS Coordinator reviewed and updated the comprehensive care plans for: " R67 for use of a raised foot rests. " R58□s functional status including the resident□s abilities and needs for assistance for eating, walking, personal hygiene, toilet use and transferring between surfaces. " R77□s dietary interventions to limit	

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F 656	Continued From page 50 (R)67's foot rests were raised (approximately 30 degrees) with a square padded cushion placed under the lower leg (knee to ankle). R67 also observed with a clip alarm attached. On 04/20/22 at 07:55 AM record review found no documentation for the use of raised foot rests and padding. A review of a significant change Minimum Data Set (MDS) with an assessment reference date of 03/18/22 notes in Section G, Balance During Transitions and Walking, R67 is not steady when moving from a seated to standing position, requiring staff to stabilize her. R67 was not coded for use of physical restraint. A review of R67's care plan found she is at risk for falls due to impaired cognition secondary to dementia and does not call for help. The goal was for resident to be free of fall through the next review date. On 04/21/22 at 12:43 PM concurrent record review and interview was done with the Minimum Data Set Coordinator (MDSC). Inquired why the facility is using raised foot rests for R67. MDSC confirmed the use of raised foots rests were not care planned and was unable to determine why the facility is using raised foot rests. MDSC reported R67 is 103 years old and can no longer stand. Concurrent observation of the resident's wheelchair was done and R67 acknowledged how raised foot rests could be perceived as a physical restraint, preventing the resident from standing. 2) On 04/18/22 at 09:50 AM, conducted an interview with R58's Family Member (FM)9. During the interview, inquired regarding R58's	F 656	intake of Vitamin K and with foods high in Vitamin K such as broccoli, cabbage, collard greens, spinach, turnip greens Brussel sprouts and cranberry products (this was completed with the Dietitian. " R45□s prevention of constipation. " R51□s prevention of falls (supervision when resident is out of bed). 2. On 04/22/22 the MDS Coordinator reviewed all of the resident care plans to ensure that the comprehensive care plans were complete and person-centered. 3. On 04/19/22 the MDS Coordinators and Interdisciplinary Team were in serviced on the requirements for a comprehensive person-centered care plan. All new hire staff will be in serviced at orientation and annually thereafter by the Director of Nursing/designee. 4. The MDS Coordinator will audit each month that each comprehensive care plan is complete and person-centered and report to the QA Committee. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee. 05/20/22.	

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fractured wrist that was reported to the State Agency as an injury of unknown injury. FM9 stated R58 sustained the injury when staff transferred the resident incorrectly and not because of a fall. R58 was observed to have a cast on her left wrist.

On 04/18/22 at 02:30 PM, conducted a record review of R58's Electronic Health Record (EHR). R58 was admitted to the facility on 02/24/22 with diagnosis that includes heart failure, Dementia, heart disease, and Diabetes Mellitus type 2. Review of R58's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/02/22, Section G. Functional Status (how the resident moves between surfaces including to or from: bed, chair, wheelchair, standing position) documented R58 is totally dependent on staff for transfers and requires staff to provide full performance assistance. Review of the R58's care plan documented the facility did not include the resident's functional performance which identifies the resident's abilities and needs for assistance for eating, walking, personal hygiene, toilet use, and transferring between surfaces.

On 04/20/22 requested a copy of R58's care plan from the MDSC. MDSC provided a copy of R58's care plan which included the resident's functional status/abilities and differed from the care plan this surveyor saw while reviewing the resident's EHR. Upon further review, MDSC realized and added it to the care plan before providing a copy to this surveyor.

3) On 04/19/22 at 01:28 PM, conducted a review of R77's EHR. Review of the resident's physician orders documented R77 is administered Warfarin

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Sodium Tablets 7.5 mg daily due to a stroke and the presence of a mechanical aortic valve. Review of R77's care plan documented the interventions implemented for the resident's use of anticoagulant therapy which did not include dietary interventions to limit intake of vitamin K and cranberry products. According to the Nursing 2022 Drug Handbook by Wolters Kluwer documented drug-food interactions of Warfarin and vitamin K and cranberry products. Cranberry juice increase the risk of severe bleeding and vitamin K impairs the anticoagulant properties of the medication. Cranberry products and vitamin K interfere with the efficacy of Warfarin and could cause serious potential harm to R77.

On 04/20/22 at 01:40 PM, conducted a concurrent interview and record review with the Dietician (D)1. Inquired if R77's intake of vitamin K or Cranberry products were being monitored. D1 confirmed R77's intake of vitamin K and cranberry products were not a part of the resident's dietary order or care plan. D1 also stated that she was unaware of the potential adverse effects that vitamin K and cranberry products have on anticoagulant therapy, how much vitamin K is safe for the resident to consume, and how much is in the resident's meals.

On 04/20/22 at 02:00 PM, review of the facility's policy and procedure, High Risk Medications-Anticoagulants (reviewed/revised on 11/01/21) documented a resident's plan of care shall include interventions to minimize risk of adverse consequences and identified limiting the intake of foods high in vitamin K: broccoli, cabbage, collard greens, spinach, turnip greens, and brussel sprouts and to avoid cranberry juice and

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cranberry products.

4) Cross Reference to F684. The facility failed to develop a care plan for a resident's bowel regimen which resulted in pain and fecal impaction.

R45 is a 63-year-old female admitted on 11/19/21 for skilled nursing services following a left third toe amputation and a right below-the-knee amputation, with admitting diagnoses that include resolved sepsis, acute respiratory failure, insulin-dependent diabetes, asthma, congestive heart failure (CHF), and chronic kidney disease. Upon admission and until the beginning of April 2022, R45 was not ambulatory as she waited for her amputation site to heal so that her prosthetic could be safely worn.

On 04/18/22 at 09:37 AM, an interview was done with R45 in her room. R45 stated that she prefers to stay in her room every day where it is quiet, as opposed to getting up in the wheelchair and leaving her room. She also stated that as a result of pain associated with her existing medical conditions and physical therapy, she was admitted on oxycodone for her moderate to severe pain (a medication known to cause constipation). In addition, due to her CHF, water retention, and history of respiratory failure, R45 was admitted on a fluid restriction. During the interview, R45 described an incident "a few weeks ago" where she became so constipated that even after administering suppositories and two enemas, staff had to manually remove her stool. R45 stated the experience was so traumatic, she never wanted to go through that again and continues to feel very anxious about it.

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When asked about her pain management, R45 stated that the oxycodone definitely helps but she is hesitant on taking it because she does not want to become constipated. R45 explained that the facility only offers her acetaminophen as an alternative, "but ...[acetaminophen] doesn't work for me, it doesn't do anything." R45 stated she has requested Naproxen several times, as well as an over-the-counter pain-relieving patch that has worked well for her in the past, but she has been told, "Oh, we don't have that."

On 04/21/22 at 12:50 PM, a review was done of R45's electronic health record (EHR). A review of her progress notes noted that beginning on 03/22/22, nursing staff consistently began charting on R45's complaints of constipation, documenting both a change and an increase in medications given for constipation. A review of R45's comprehensive care plan noted that despite being at an increased risk for constipation upon admission, no care plan had been developed to prevent constipation. In addition, after identifying R45's constipation as a problem in March 2022, no care plan had been developed to address it.

A review of R45's CP for pain noted the following four interventions:
"Administer pain medications per order, if non-medication interventions are ineffective"
"Encourage times of rest and relaxation between care activities"
"Evaluate pain"
"Utilize non-medication interventions for pain relief"

On 04/21/22 at 02:16 PM, an interview was done

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with the Minimum Data Set Coordinator (MDSC) in his office. After reviewing R45's admission assessment, the MDSC acknowledged that R45 had been admitted on a fluid restriction, non-ambulatory, and on a pain medication known to cause constipation, placing her at an increased risk for constipation. The MDSC agreed that this should have been identified and care planned upon admission to help prevent constipation, but also staff should have added it to her care plan once R45 began to experience problems with it.

On 04/21/22 at 03:35 PM, an interview was done with Registered Nurse (RN)11 in the Pikake Dining Room. RN11 confirmed that acetaminophen is the only floor-stock analgesic available and stated that anything else would require a physician order.

5) R51 is a 90-year-old male admitted on 06/15/21 following a fracture of his right thigh with admitting diagnoses that include dementia, senile degeneration of the brain, high blood pressure, and generalized muscle weakness, with a history of falls.

On 04/19/22 at 10:09 AM, observations were made in the Pikake dining room. R51 was observed sitting at a table alone, with no activity in front of him. The TV in the dining room was on, but R51 was not interested in it. R51 was observed moving his right foot outside of the right footrest on his high-backed wheelchair and placing his left foot in front of the left footrest, then he stood up unsteadily. No chair/clip alarms were activated upon R51's standing. Observed 10 residents in the dining room at the time, with no licensed or certified staff present. As R51 attempted to step around the footrests of his

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F 656	Continued From page 56 wheelchair, the unit secretary happened to look up from her desk and got up to assist R51, but by then R51 had lost his balance and plopped back into his wheelchair. On 04/19/22 at 10:08 AM, during a record review of R51's EHR, the following was noted as part of his CP for Falls: "Provide activities when resident is awake- refer to activity care plan." "Provide close supervision when resident is out of bed." "Utilize devices as appropriate to ensure safety (i.e. [sic] bed mats, sensor alarms, etc.) ..." As part of his CP for Activities, the following was noted: "Ensure resident receives media tuning to his liking ..."	F 656		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and	F 661		5/20/22

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F 661	Continued From page 57 over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff member, the facility failed to ensure a discharge summary was completed for a resident (Resident 56) that was discharged to an adult foster home. Findings include: On 04/22/22 at 07:36 AM and 09:56 AM a record review found Resident (R)56 was admitted to the facility on 08/28/21 and discharged on 04/05/22 to an adult foster home (AFH). There was no documentation of a discharge summary. Further review noted there was no documentation that R56 requested to be discharged. The Social Worker (SW) note for 03/22/22 documents care conference with resident, hospice nurse and social worker regarding the plan to discharge from hospice in April and to look for a foster home. Requested the Social Services Coordinator (SSC) provide documentation of R56's discharge summary. On 04/22/22 at 10:55 AM, the SW provided the requested documentation. A review of the "Transfer/Discharge Summary - Post Discharge Plan of Care" noted the form was	F 661	1. On 05/18/22 the Social Services Coordinator updated the transfer discharge summary on R56. 2. On 05/19/22 the Social Services Coordinator/Manager reviewed all other discharges to ensure that the Transfer/Discharge Summary □ Post Discharge Plan of Care was complete with date of transfer, reason for transfer/discharge, social services information, equipment needed, need for follow-up with physician and a summary of stay. 3. On 05/18/22 the Interdisciplinary Team was in serviced on the discharge summary requirements. All new hire staff will be in serviced at orientation and annually thereafter by the Director of Nursing/designee. 4. The Social Services Manager will audit each month to ensure that all transfer discharge summaries are complete and report to the QA Committee. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent	

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F 661	Continued From page 58 incomplete. Documentation missing include, date of transfer, reason for transfer/discharge, social services information, equipment needed, need for follow up with physician, and a summary of stay. On 04/22/22 at 11:18 AM an interview was conducted with the SSC in the conference room. SSC reported R56 was receiving hospice services and graduated. The hospice SW informed the facility that R56 would be discharged from hospice in April. Inquired whether this was a facility-initiated discharge or resident-initiated discharge as the reason for discharge was blank. SSC reported R56 and his friend was agreeable to the discharge to an AFH with hospice services and there was an option to stay in facility. SSC was unable to confirm whether the discharge was facility or resident initiated.	F 661	substantial compliance has been achieved as determined by the committee. 05/20/22.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition. Resident (R)183 is unable to feed himself/herself and is dependent on staff for assistance with meals. R183 had to wait approximately an hour after his/her lunch was served for staff to assist the resident with the meal.	F 677	1. On 05/18/22 the Director of Nursing reviewed the timing of the meal cart and ensured that the resident was assisted with his meal when the meal tray was delivered to the R183. 2. On 05/18/22 the Director of Nursing reviewed the timing of the meal carts of other residents and ensured that residents were assisted with their meals when the meal tray is delivered.	5/20/22

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PALOLO CHINESE HOME	2459 10TH AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 59 Findings include: Interview with R42 on 04/18/22 at 09:44 AM, the resident stated that he/she was concerned about R183 (R42's roommate) waiting for an hour or more before staff assist R183 with meals. R42 recalled watching the time and stated that R183 had to wait approximately 1 hour and 15 minutes after lunch was served before staff came into the room to assist R183 with the meal. On 04/18/22 at 11:55 AM, entered a unit and observed a resident eating lunch in the main dining room, entered R183's room and observed the resident's uneaten lunch tray on the resident's bedside table (parallel to the resident's bed). R183 stated that he/she was hungry but had to wait for staff then held up both arms, showing this surveyor that R183 had cast on both wrists. R183 showed and informed this surveyor the fingers on her left had was swollen and purple from bruising. R183 stated that she had pain in both wrists and could not eat independently. At 12:38 PM, observed R183's lunch tray on the bedside table, parallel to the resident's bed, exactly as the previous observation, uneaten and covered. The resident's touch pad to call for staff was located on the lunch tray out of R183's reach. At 12:41 PM, staff were collecting other residents' finished lunch trays, placed them on a rack and pushed the trays off the unit. At 12:48 PM, Certified Nurse Aide (CNA)73 entered R183's room and proceeded to assist the resident with lunch. On 04/18/22 at 01:15 AM, inquired with CNA73 regarding the length of time R183 has to wait for	F 677	3. On 05/18/22 the Interdisciplinary Team was in serviced on the requirement that residents receive necessary services to maintain good nutrition. All new hire staff will be in serviced at orientation and annually thereafter by the Director of Nursing/designee. 4. The Director of Nursing/designee will audit each month the timing of the meal cart and those residents are assisted with their meals when the trays arrive to the resident and report to the QA Committee each quarter. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee. 05/20/22.	

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F 677	Continued From page 60 assistance with meals. CNA73 confirmed that R183 is one of the last residents to receive assistance with lunch, and often receives meals later than other residents. On 04/19/22 at 01:01 PM, conducted a review of R183's Electronic Medical Record (EMR) that documented R183 was admitted on 04/11/22 after falling and sustaining fractures to the right and left radius (one of two bones that make up the forearm), a fractured mandible (lower jawbone), a lip laceration (cut), and noticeable bruising to the neck and face. A progress note written on 04/11/22 at 09:35 PM documented, R183 required 1-person total assist for feeding. At the time of the record review, R183's admission Minimum Data Set (MDS) had not been completed due to being newly admitted.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews with staff member, the based on a comprehensive assessment and care plan, the facility failed to provide an ongoing activity	F 679	1. On 05/18/22 the Activity Manager assessed the activity care plan of R50 and educated the activity and nursing staff of R50 and R67 activity care plan□s	5/20/22

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F 679	Continued From page 61 program which engaged residents and met their interest to support their psychosocial well-being for 2 (Resident 67 and 50) of 3 residents sampled for activities. Findings include: 1) Resident (R)50 was admitted to the facility on 03/14/17. Diagnosis includes but not limited to vascular dementia with behavioral disturbance. On 04/18/22 an initial tour of the unit observed R50 seated in the dining room. On 04/18/22 at 11:52 AM, R50 had eaten her lunch and was observed in the dining room. The resident was seated in a wheelchair which was positioned to face the television. The station was set at SBS, a Korean station with the volume turned off. Observation from 11:52 AM to 11:55 AM, observed R50 seated in a wheelchair in the dining/activity room. R50 was repetitively calling out, "help...itchy..itchy". At 11:55 AM, staff member scratched R50's back. When staff member left, R50 continued to call out, "please help me, itchy, itchy, help Mom". On 04/19/22 at 08:24 AM, the resident's door was closed and she was in bed, moaning. Subsequent observation at 08:48 AM, R50 was awake and laying in bed and in the afternoon she was asleep. On 04/20/22 at 09:30 AM, R50 was observed in bed asleep. There was no observation of music playing or television in her room. R50 remained in her room. On 04/19/22 a Certified Nurse Aide commented R50 was tired and on 04/20/22, the Registered Nurse (RN)1 reported R50 threw up the night before.	F 679	intervention. The Activity Manager/Coordinator observed the activities and ensured that the activity interventions were implemented and documented. 2. On 05/18/22 the Activity Manager/Coordinator reviewed the other resident□s care plan and observed the activities and ensured that the activity interventions were engaging and meet each resident□s psychosocial wellbeing. 3. On 05/18/22 the Interdisciplinary Team was in serviced by the Director of Nursing on the requirement for an activity program that support the interest and psychosocial wellbeing of each resident. All new hire staff will be in serviced at orientation and annually thereafter by the Director of Nursing/designee. 4. The Activity Manager will audit/observe each month that residents are engaged in activities that meet each resident□s psychosocial wellbeing. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee. 05/20/22.	

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F 679	Continued From page 62	F 679		

Record review done on 04/20/22 at 08:35 AM of R50's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 03/04/22. Administration of the Brief Interview for Mental Status, R50 yielded a score of 2 (severe cognitive impairment). Review of significant change MDS with an ARD of 12/03/21 notes in Section F. Preferences for Customary Routine and Activities, Interview for Activity Preferences, R50 identified the following activities as very important, listening to music you like, doing things with groups of people, engage in favorite activities, and going outside when the weather is good.

A review of R50's care plan notes goal to attend and participate in daily activities of interest with assistance. Interventions include: assist with playing in-room TV (Music program/Japanese Channel) and radio (classical/Oldies 40's, 50's, 60's/Japanese/Hawaiian/local music); encourage family visits; invite to daily groups for games, exercise, and current events; and offer outdoor stroll 2-3x/week to get fresh air and change the scenery. R50 also noted with visual and hearing deficits without glasses or hearing aides.

A review of the Certified Nurse Aide tasks section from January through April 2022 notes resident's participation in BINGO four times (03/08/22, 03/12/22, 03/15/22, and 03/22/2). Resident also noted to participate in karaoke four times (03/10,22, 03/24/22, 03/31/22 and 04/07/22) and exercise seven times (01/18/22, 01/19/22, 01/23/22, 01/28/22, 02/02/22, 02/03/22, and 02/09/22).

A review of the progress notes found an entry by activities on 04/06/22 noting, R50 is out of bed for meals and activities regularly, mostly a passive

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F 679	Continued From page 63	F 679		

observer. Also documented R50 noted to participate in exercise, singing, Pokeno/BINGO, and outdoor strolls and continues to listen to music/TV background noise when in room and dining room.

On 04/22/22 at 10:56 AM an interview was done with the Minimum Data Set Coordinator (MDSC) as the Activities Manager was out for the day and the Activity Coordinator (AC) could not be found on the units (the Director of Nursing requested staff to assist in locating the AC, AC was not located prior to exit of the survey team). MDSC provided a print out of R50's activities from 04/13/22 through 04/21/22. Only two activities were checked for R67, listening to music and watching television. The other activities listed in the resident's care plan was not checked. The MDSC reported R50's activities are self-directed, questioned how is activity self-directed when the resident has severe cognitive impairment.

2) R67 was admitted to the facility on 08/09/19. Diagnoses includes but not limited to Alzheimer's disease, unspecified and senile degeneration of brain, not elsewhere classified.

On 04/18/22 on initial tour of the unit, R67 was observed seated alone at the dining room table. On 04/18/22 at 10:13 AM to 11:00 AM observed R67 seated at a table in the dining room. R67 was pulling napkins from the holder, folding the napkins, and hiding them. At 11:16 AM, R67 received assistance with her lunch. During lunch, the television was turned on, it was set on a Korean channel (SBS) and there was no sound. Observation at 04:05 PM, R67 was asleep in bed.

On 04/19/22 at 08:22 AM observed R67 in dining

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F 679	Continued From page 64	F 679		

room receiving assistance with breakfast. The television was turned, set to the morning news. R67 was observed not watching the program, just sitting. At 01:49 PM and 02:37 PM, R67 was observed asleep in bed.

On 04/20/22 at 09:04 AM R67 was seated in the dining room. She was placed in front of the television and had her head in her hands and her eyes were closed. At 01:55 PM, R67 was observed asleep in bed.

A record review was done on 04/20/22 at 07:55 AM. A review of a significant change MDS with an ARD of 03/18/22 documents R67 is rarely/never understood and rarely/never understands others. R67's cognition was scored as severely impaired. Review of Section F. Interview for Daily Preferences notes having family or a close friend involved in discussion about your care was rated as very important. Choosing what to wear; taking care of personal belongings; choosing between a tub bath, shower, bed bath or sponge bath; having snacks available between meals; choosing your bedtime; ability to use the phone in private; and having a place to lock her things in were all rated as not very important. Interview for Activity Preferences notes going outside was rated as somewhat important. The following activities having books, newspapers, and magazines to read; listening to music you like; being around animals; keeping up with the news; doing favorite activities; and participating in religious services or practices were rated as not very important. Doing things with groups of people was rated as not important at all.

A review of R67's care plan for impaired cognition

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F 679	Continued From page 65 includes intervention to engage the resident in simple, structured activities that avoid overly demanding tasks. R67 prefers playing mahjong with other residents in another unit. Also, noted resident wants to read Chinese magazines before breakfast. The care plan includes goal for resident to be able to engage in daily activities of choice and to encourage out from room and assist to groups. The interventions include, assist resident in in-room self-directed activities such as turning on TV and radio (R67 likes to watch Asian drama and listening to Chinese/instrumental music); assist with in-person visits by family; encourage and provide outdoor activities 2-3x per week for fresh air and change of scenery; invite and assist to scheduled activities; provide Chinese reading material for self-directed activities large print); and use Chinese translation sheets or Chinese speaking staff to converse with her. On 04/22/22 at 10:56 AM an interview was done with the Minimum Data Set Coordinator (MDSC) as the Activities Manager was out for the day and the Activity Coordinator (AC) could not be found on the units (the Director of Nursing requested staff to assist in locating the AC, AC was not located prior to exit of the survey team). Reviewed R67's current care plan with MDSC. MDSC also provided a print out of R67's activity participation for 04/09/22 through 04/21/22. Activity for listening to music and watching television daily were the primary activities checked for participation. MDSC reported R67 has been participating in activities, mostly watching television and listening to music.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		5/20/22

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F 684	Continued From page 66 § 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 interviews and record review, the facility failed to identify, care plan, and manage an elevated risk of constipation for one Resident (R) in the sample. As a result of this deficient practice, R45 experienced stool impaction that had to be manually removed, causing her pain, distress, and embarrassment. This deficient practice has the potential to affect all the residents at the facility at risk of constipation. Findings include: Cross Reference to F656 Care Plan. The facility failed to develop a comprehensive care plan to address resident's risks for constipation related to the use of pain medications (opiods), fluid restriction, and lack of mobility. Resident (R)45 is a 63-year-old female admitted on 11/19/21 for skilled nursing services following a left third toe amputation and a right below-the-knee amputation, with admitting diagnoses that include resolved sepsis, acute respiratory failure, insulin-dependent diabetes, asthma, congestive heart failure (CHF), and chronic kidney disease. Upon admission and until the beginning of April 2022, R45 was not	F 684	1. On 04/21/22 the MDS Coordinator reviewed and updated the comprehensive care plans for R45□s prevention of constipation. 2. On 04/22/22 the MDS Coordinator reviewed all of the resident care plans to ensure that the comprehensive care plans were complete and person-centered. 3. On 04/29/22 the MDS Coordinators and Interdisciplinary Team were in serviced on the requirements for a comprehensive person-centered care plan. All new hire staff will be in serviced at orientation and annually thereafter by the Director of Nursing/designee. 4. The MDS Coordinator will audit each month that each comprehensive care plan is complete and person-centered and report to the QA Committee. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee. 05/20/22.	

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F 684	Continued From page 67	F 684		

ambulatory as she waited for her amputation site to heal so that her prosthetic could be safely worn.

On 04/18/22 at 09:37 AM, an interview was done with R45 in her room. R45 stated that she prefers to stay in her room every day where it is quiet, as opposed to getting up to the wheelchair and leaving her room. She also stated that as a result of pain associated with her existing medical conditions and physical therapy, she was admitted on oxycodone for moderate to severe pain (a medication known to cause constipation). In addition, due to her CHF, water retention, and history of respiratory failure, R45 was admitted on a fluid restriction. During the interview, R45 described an incident "a few weeks ago" where she became so constipated that even after administering suppositories and two enemas, staff had to manually remove her stool. R45 stated the experience was so traumatic, she never wanted to go through that again and continues to feel very anxious about it.

On 04/21/22 at 12:50 PM, a review was done of R45's electronic health record (EHR). A review of her progress notes noted that beginning on 03/22/22, nursing staff began charting on R45's complaints of constipation, documenting both a change and an increase in medications given for constipation. A review of R45's comprehensive care plan noted that despite being at an increased risk for constipation upon admission, no care plan had been developed to prevent constipation. In addition, after identifying R45's constipation as a problem in March 2022, no care plan had been developed to address it.

On 04/21/22 at 02:16 PM, an interview was done

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F 684	Continued From page 68 with the Minimum Data Set Coordinator (MDSC) in his office. After reviewing R45's admission assessment, the MDSC acknowledged that R45 had been admitted on fluid restriction, non-ambulatory, and on a pain medication known to cause constipation, placing her at an increased risk for constipation. The MDSC agreed that this should have been identified and care planned upon admission to help prevent constipation, but also staff should have added it to her care plan once R45 began to experience problems with it.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interviews, and a review of the facility's policy and procedures, the facility failed to identify environmental hazards and individual resident risk of an accident after Resident (R)283 was observed ambulating unsupervised outside of the facility without without staff knowledge. Findings include: Resident (R)283 was admitted to the facility on 03/23/22 for short term course of physical and occupational therapy to improve functional status. Diagnosis include but not limited to acute	F 689	1. On 04/18/22 R283 was assessed for risk for elopement by the Director of Nursing. R283 was placed on 04/18/22 supervision. R283 was care planned for walks outside with the nursing/activity staff each day with limited assistance. 2. On 05/18/22 residents were assessed for environmental hazards such with risk of falls while ambulating by the MDS Coordinator. 3. On 05/18/22 the Interdisciplinary Team was in serviced by the Director of Nursing on the requirement that each staff is responsible to identify any	5/20/22

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F 689	Continued From page 69 respiratory failure with hypoxia, unspecified anemia, alcoholic cirrhosis of liver with ascites, uncomplicated alcohol dependence, spondylosis without myelopathy or radiculopathy lumbar region, myocardial infarction type 2, hypomagnesemia, acute on chronic diastolic (congestive) heart failure, and hypertensive heart disease with heart failure. A review of R283's admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 03/29/22 documented R283 with a score of 15 [cognitively intact] when the Brief Interview for Mental Status (BIMS) was administered. In Section G0110. Activities of Daily Living (ADL) Assistance F. Locomotion off unit (how resident moves to and returns from off-unit locations), R283 required limited assistance with one person physical assistance. In G0300. Balance During Transitions and Walking B. Walking (wish assistive device if used) and C. Turning around facing the opposite direction while walking documented R283 not steady and only able to stabilize with human assistance. On 04/18/22 at 04:19 PM observed R283 walk out of his room using a walker and turn to the right. R283 stopped at the end of the hallway and looked left to the closest exit door to his room. R283 then turned around and walked back to his room. On 04/18/22 at 04:31 PM observed R283 ambulating outside of the facility with his walker with no staff present. He was wearing rubber slippers and yellow-nonskid socks. He was walking in the lane of the parking lot outside of the Victoria Ward Hall. Using his walker, R283 walked over a large grate in the road and	F 689	environmental hazards that may place the resident at risk for injury. All new hire staff will be in serviced at orientation and annually thereafter by the Director of Nursing/designee. 4. The Director of Nursing/designee will audit each month that staff/self identify environmental hazards that may pose a risk for resident injury and report to the QA Committee. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee. 05/20/22.	

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F 689	Continued From page 70	F 689		

proceeded to walk on the road near the parking lot behind Farm Hall. R283 then turned onto the sidewalk, passed the Administration Office and continued to walk on the sidewalk until he reached the end of the parking lot in front of Lani Ward Booth Hall. At 04:34 PM observed staff run out of Lani Ward Booth Hall and approach R283.

On 04/19/22 at 02:10 PM interview with R283 stated he just wanted to go outside and take a long walk, " ...they told me I need to tell someone if I want to go outside, and someone will take me."

On 04/19/22 at 03:30 PM reviewed the facility's policy and procedures (P&P) on "Elopements and Wandering Residents" with a review/revised date of 11/01/21. The P&P defines wandering as a " ...random or repetitive locomotion that may be goal-directed or non-goal directed or aimless" and defines elopement, "occurs when a resident leaves the premises or a safe area without authorization and/or necessary supervision to do so." Guidelines included in the P&P document "1. The facility is equipped with door locks/alarms to help avoid elopements. 2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. 3. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks ...4. a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and through their stay by the interdisciplinary care plan team..."

On 04/19/22 at 03:44 PM interview and

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concurrent review of R283 Electronic Health Record (EHR) with Clerk (C)1 stated she did not see a wandering/elopement risk assessment for R283 in his EHR. C1 stated since the incident on 04/18/22, nursing staff are checking R283 frequently and documenting in an elopement risk log.

On 04/19/22 at 03:58 PM review of R283's progress notes documented the incident as well as an unwitnessed fall prior to the incident. On 04/16/22 staff documented an unwitnessed fall reported by resident, "Resident reported that he slid off the bed and fell on his butt on the fall mat located on his beside during NOC [Night Shift] at 4 am today. Resident said he did not use the call light and did not ask for help, he did not report to any staff during NOC shift as well, he just stood up using his walker and went back to bed." On 04/18/22, staff documented "Res [R283] with risk for elopement today. Res was found by social worker wandering by Lani booth. Res stated that he feels like he is stuck in his room and snuck off the unit without telling the staff. Res was educated that if want to step out for fresh air, res is to notify staff and be supervised around the vicinity of Harry Wong." On 04/19/22 staff documented "Continue elopement risk log. Continue frequent visual checks. Continue bed in locked lowest position. Continue fall precautions."

On 04/20/22 at 11:15 AM reviewed R283's care plan documents "Resident has Pain and Gait/Balance instability r/t [related to] to lumbar spondylosis and calf tenderness" and documented R283 for risk of falls.

On 04/20/22 at 12:57 PM interview with Social Services Manager (SSM), reported two staff

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members found R283 outside and were sitting with R283 when SSM found him. Inquired how R283 left the building, SSM stated he was not sure and stated there are two exits at the main entrance near the nurse's station and another exit in Pikake Unit closer to R283's room. Inquired about the sound alert at the exit doors, SSM stated "It has that sound it is constant I am thinking the staff was busy, oblivious on what was going on and people go in and out of that door... That is the first time that has happened, usually if they wanted some outdoor strolling, they would notify their aide or nurse. SSM did not know what the bell noise on the door was for." SSM reported he spoke with R283 after the incident and learned R283 wanted to go outside and take a walk because he was frustrated at a staff member and wanted fresh air. SSM confirmed a wandering/elopement risk assessment was not completed for R283 and stated, "When a resident is admitted there is an elopement assessment."

On 04/20/22 at 01:27 PM interview with Minimum Data Set Coordinator (MDSC), confirmed a wandering/elopement risk assessment was not completed and further explained "I saw one on point click care but I don't see that we use it, all the residents don't get an elopement risk assessment. If they do elope there is a process for that. My role is to determine if this is a significant change. Update the care plan, work with social services what we need to do to help prevent it. They let me know he went outside. He did not leave the facility." MDSC did not consider the incident as elopement because R283 did not leave the facility and did not consider the incident as wandering. Concurrent review of R283's care plan, MDSC confirmed the care plan was not updated to include the risks and hazards for

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elopement, wandering, or going outside unsupervised and "activity staff to offer resident supervised outdoor strolls" was added to care plan on 04/19/22. MDSC did not respond when inquired if it is safe for R283 to be outside in the road and where cars park on the side of Victoria Ward Hall.

On 04/20/22 at 01:51 PM interview with Registered Nurse (RN)18, confirmed R283 did not have a wandering/elopement risk assessment upon admission and stated she "hasn't done any, don't think we have ..." and stated an hourly elopement log is currently being done for R283.

On 04/20/22 at 01:56 PM interview with admission RN19, stated a wandering/elopement risk assessment should be done at admission. RN19 confirmed a wandering/elopement risk assessment was not completed for R283 on admission. Concurrent review of the facility admission checklist, wandering/elopement risk is not included in admission assessments and RN19 confirmed she follows the checklist.

On 04/21/22 at 12:35 PM interviewed Director of Nursing (DON). Inquired with DON if an wandering/elopement risk assessment was completed for R283, DON explained the nurse's document in "COMS-Clinical Admission Evaluation" under Mood/Behavior MD3. Wanders at night, if the nurses documents "no" further questions will not be prompted. Also, in the social services admission intake, under psychosocial assessment wandering is listed as a previous or current behavior expressed or displaced. R283 was not documented for wandering as a behavior displayed. DON stated the incident on 04/18/22 was not wandering or elopement, "...BIMS 15,

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knows what to do, his intention was to get fresh air" and DON explained he was not confused so did not consider wandering. Concurrent review of the facility's P&P, DON explained wandering is random local motion that may be goal directed ...elopement means leaves the premises or a safe are without authorization to leave ...or any supervision to do so. He was still here in our premises." Inquired if it is safe for R283 to be outside in the road and where cars park on the side of Victoria Ward Hall, DON responded "He know he understand he is not confused, he pretty much understood he is able to look out if something coming through ..."

On 04/22/22 at 10:03 AM interview with RN16, stated nursing staff are no longer calling the incident on 04/18/22 elopement because they were told it was not elopement, " ...it was not elopement hearsay around the staff ..." RN16 explained the incident was " ...not elopement because he was not trying to actively leave the facility but may be wandering because he was walking around." Inquired if resident was a fall risk and had a fall recently if it is safe for the resident to go on a walk unsupervised, RN16 stated " ...in any situation I would like to have staff ..." with residents.

On 04/22/22 at 10:08 AM, follow up interview and concurrent review of R283's "COMS Fall Risk Evaluation" dated 03/23/22 with admission RN19, RN19 stated R283 scored an 8, " ...8 is a higher end of fall risk and monitor very closely for falls ...he has a walker if walking outside should be supervised when ...by himself ...fall assessment noted that he has medications ...causes dizziness ...it would not be safe outside by himself."

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F 726	Continued From page 75	F 726		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services 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)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure nurse competency in medication administration for two residents in the sample (Residents 83 and 39). This deficient practice	F 726	1. On 05/18/22 RN 3 was educated by the Director of Nursing that it is their responsibility to inform the resident of medications being administered and the	5/20/22

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F 726	Continued From page 76 placed the residents at risk for decreased quality of care, denied one resident (Resident 83) of her right to be informed, and has the potential to affect all the residents at the facility. Findings include: 1) R83 is an alert and oriented 75-year-old female admitted to the facility on 04/06/22 following fractures in her right thigh and left forearm. Admitting diagnoses also include high blood pressure, anemia, and constipation. On 04/20/22 at 08:47 AM, during medication administration observations with RN3 on the Pikake Unit, observed RN3 preparing to administer medications to R83. Of the five medications RN3 prepared, one was Polyethylene Glycol (a laxative used for constipation), and another was Senna-Docusate Sodium (a combination of a laxative and a stool softener). The Polyethylene Glycol is a medication which is mixed into liquid for administration. At 08:51 AM, as RN3 approached R83 with her medications, R83 refused the Polyethylene Glycol as soon as she saw the cup. RN3 asked, "You don't want it?" R83 responded, "That's the laxative, no I don't need that, I already went [had a bowel movement] this morning, and yesterday, and the day before, and the day before." RN3 placed the cup of liquid on the side and handed R83 a medication cup with the other four medications in it. R83 asked "What's in here?" RN3 responded, "Which one?" R83 pointed to each tablet in the cup, one by one, asking what they were. R83 asked RN3 twice what the Senna-Docusate Sodium tablets were, both times RN3 responded, "That's your stool softener."	F 726	resident having the right to refuse medications. RN 3 was educated on the requirement of when administering insulin via a prefilled injector that the needle be kept under the skin for a full count of 6 seconds. 2. On 05/18/22 the Director of Nursing in serviced each nurse of informing the resident of medications being administered and the right of a resident to refuse medications; and holding the needle of a prefilled insulin pen under the skin for at least 6 seconds to ensure that the full dose is injected. 3. On 05/18/22 the Director of Nursing in serviced the nursing staff of informing the resident of medications being administered and the right of a resident to refuse medications; and holding the needle of a prefilled insulin pen under the skin for at least 6 seconds to ensure that the full dose is injected. All new hire staff will be in serviced at orientation and annually thereafter by the Director of Nursing/designee. 4. The Director of Nursing will audit each month that residents are being informed of medications being administered and residents having the right to refuse medications; and that insulin administered via a prefilled syringe is being properly administered and report to the QA Committee. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee. 05/20/22.	

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At 08:59 AM, after exiting the room, questioned RN3 what the facility policy was regarding informed consent for medications. RN3 stated there is no policy on letting residents know what they are taking while administering medications, "we already tell them on admission what they are taking, we only explain again if they are taking a new med [medication], or unless they ask." Questioned RN3 why she misidentified the laxative-stool softener twice, especially after R83 had already refused one laxative. RN3 responded, "Oh, that's my bad, I didn't tell her there was a laxative in it too."

2) On 04/20/22 at 08:36 AM, medication administration observations were done with Registered Nurse (RN)3 in the Pikake Unit. At 08:43 AM, observed RN3 administer one of Resident (R)39's insulin medications via a pre-filled injector pen. Once injected, observed RN3 hold the needle under R39's skin for 3-4 seconds. At 08:46 AM, questioned RN3 about how long the needle should be held under the skin, RN3 stated "6-10 seconds, was that not 10 seconds?" Informed RN3 it was not 10 seconds.

A review of the insulin pre-filled injector pen's package insert for Instructions for Use, noted the following:

"Step H. Injecting the Dose o Insert needle into your skin in the stomach (abdomen), thigh or upper arm ...Press down on the center of the dose button to inject until 0 mg lines up with the pointer ...Keep the dose button pressed down and make sure that you keep the needle under the skin for a full count of 6 seconds to make sure the full dose is injected."

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F 732 SS=D	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 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	F 732		5/20/22

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F 732	Continued From page 79 by: Based on observations and interviews, the facility failed to ensure nurse staffing information including, facility name, current date, total number, and actual hours worked by licensed and unlicensed staff directly responsible for resident care per shift was posted in a prominent place readily accessible to residents and visitors for one of four facility units. Findings include: On 04/20/22 at 01:15 PM, while conducting observations on Weinberg Unit, this surveyor did not observe staff information posted in a prominent place which is readily accessible to residents and visitors for this unit. Staffing information was not posted on the bulletin board visible at the entrance of the unit, (on the side of the nursing station); or the bulletin board on the wall prior to entering the hallway where residents' rooms are located; in the residents' dining room/main room; or at the Weinberg nurse's station. Asked Registered Nurse (RN)56 and Certified Nurse Aide (CNA)61 where the staff posting for the Weinberg unit was located. RN56 and CNA61 both looked around the nurse's station and unit and confirmed the staffing information for the Weinberg Unit was not posted on the unit. CNA61 stated that the only staff information with how many nurses and aides were working was located on the Pikake unit. Both RN56 and CNA61 confirmed visitors of residents on Weinberg unit enter directly on the Weinberg unit and do not pass through the Pikake unit where the information is posted.	F 732	1. On 04/20/22 the Director of Nursing posted the nurse staff data. RN56 and CNA 61 were educated that the nurse staff data is to be posted each day. 2. On 04/20/22 the Director of Nursing checked to ensure that the nurse staff data was posted on a daily basis and that the nursing staff were educated on this requirement. 3. On 05/18/22 the Director of Nursing in serviced all nursing staff (clerks) of the requirement to post daily staffing data each morning on Weinberg Hall I and Pikake units. All new hire staff will be in serviced at orientation and annually thereafter by the Director of Nursing/designee. 4. The Director of Nursing will audit each month to ensure that the nurse staffing data is posted each day and report to the QA Committee. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee. 05/20/22.	
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		5/20/22

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F 755	Continued From page 80 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff member, and review of the policy and procedures, the facility failed to maintain an accurate reconciliation and accounting for controlled medication to properly identify loss or	F 755	1. On 05/18/22 the Director of Nursing reviewed and ensured the documentation of the missing narcotic count documentation. The nurses were educated on 05/18/22. On 05/18/22 the	

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F 755	Continued From page 81 diversion. Findings include: 1) On 04/21/22 at 10:10 AM observation of the medication cart was done with Registered Nurse (RN)1. RN1 reported at the end of each shift, two nurses will count the narcotics in the medication cart, and sign to confirm the accuracy of the count. RN1 provided documentation of the audit record for the medication cart. Review of the record found missing documentation for 04/01/22 (NOC shift), 04/09/22 (day shift), and 04/19/22 (day shift). RN1 confirmed the missing documentation. On 04/21/22, the facility provided the policy and procedure for "Controlled Substances". A review of the policy and procedure notes "controlled substances are subject to special handling, storage, disposal, and record keeping at the nursing care center." The procedure includes "at each shift change, a physical inventory of controlled medications, as defined by state regulation, is conducted by two licensed clinicians and is documented on an audit record." 2) On 04/22/22 at 11:01 AM, an inspection was done of the medication room in one of the units with Registered Nurse (RN)3. At 11:17 AM, while attempting to reconcile refrigerated controlled medications with the narcotic log, it was revealed that Resident (R)284's blister pack of Dronabinol 2.5 mg capsules had one capsule missing. The narcotic record that came with the medication from the pharmacy indicated that there should be 27 capsules remaining in the blister pack. Confirmed with RN3 that the blister pack	F 755	Director of Nursing reconciled the narcotics with the narcotic logs for R15 Lorazepam pouch and R22 Lorazepam vials/pouch. The discontinued medications were disposed. 2. On 05/18/22 the Director of Nursing audited all the narcotics and logs to ensure each were reconciled. That the narcotic count was completed, accurate and documented. Discontinued medications were disposed. 3. On 05/18/22 the Director of Nursing in serviced the staff on the reconcile, account and document the use of controlled medications. That discontinued medications must be disposed. All new hire staff will be in serviced at orientation and annually thereafter by the Director of Nursing/designee. 4. The Director of Nursing will audit for a complete, accurate and documented reconcile of controlled medications and report to the QA Committee each quarter. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee. 05/20/22.	

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F 755	Continued From page 82	F 755		

contained 26 capsules. As the Charge Nurse for the Unit, RN3 could not explain the discrepancy. At 11:19 AM, RN16 entered the medication room, noted that Surveyor had a photocopy of the narcotic record, and stated "oh yeah, that was me, I forgot to sign it out, I gave it this morning."

At 11:20 AM, while still attempting to reconcile refrigerated controlled medications with the narcotic log, it was observed that the refrigerated narcotic lock box had 8 loose vials of Lorazepam in the bottom of the box. Two resident pouches of Lorazepam vials were also contained in the box.

R15's Lorazepam pouch was sealed closed with 2 (two) vials in the pouch. The narcotic record that came with the medication from the pharmacy indicated that there should have been 3 (three) vials in the pouch.

R22's Lorazepam pouch was open with 2 vials in the pouch. Both Surveyor and RN3 could not locate the narcotic record that came with the medication from the pharmacy. RN16, who was still present in the medication room, stated she believed R22's Lorazepam order had been discontinued. RN3 checked the electronic health record (EHR) and confirmed that R22's Lorazepam was discontinued on 04/13/22. The narcotic record for R22's medication was located in an accordion file that contained documentation of completed medications. RN3 stated that the policy is to pull the medication when it is discontinued, reconcile the remaining inventory with the narcotic record, then two RNs witness the disposal of the remaining inventory and attest to that by signing the narcotic record. Only then should the narcotic record be filed as complete.

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F 755	Continued From page 83 RN3 could not explain why the policy was not followed. When located, the narcotic record for R22's Lorazepam indicated that there should have been 9 vials remaining. RN17, who was serving as the Staff Educator, entered the medication room at 11:22 AM. When the discrepancies were shared with her, RN17 acknowledged that each shift (i.e., three times a day), two nurses should be reconciling all controlled medications with the narcotic log and attesting to its accuracy. RN17 agreed that the discrepancies found indicated a system failure of reconciling the controlled medications, with RNs consistently attesting to inventory counts that were inaccurate.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical	F 756		5/20/22

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F 756	Continued From page 84 director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that irregularities reported by the pharmacist in the monthly drug/medication regimen review (MRR) were acted upon appropriately, or in a timely manner, as evidenced by an as needed (prn) psychotropic medication order that had no specified end date, or a rationale for extending the prn order past 14 days for 2 of 5 residents reviewed for unnecessary medication. Findings include: Cross to F758. The facility did not assure the continued need of a prn psychotropic medication exceeding 14 days was medically necessary. Resident (R)45 is a 63-year-old female admitted on 11/19/21 for skilled nursing services following	F 756	1. On 05/18/22 the Director of Nursing reviewed R45□s Trazadone order and 05/18/22. For R51□s Lorazepam order was reviewed and 05/18/22. The Interdisciplinary Team/nurses/clerks were educated on the procedure of and requirement of the pharmacist monthly review for needed medications. 2. On 05/18/22 the Director of Nursing audited all of the MRRs to ensure that each were reviewed and acted upon. 3. On 05/18/22, the Director of Nursing in serviced the Interdisciplinary team, nurses and clerks on the procedure of reviewing, completing and following up on MRRs. All new hire staff will be in serviced at orientation and annually thereafter by the Director of Nursing/designee.	

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F 756	Continued From page 85 a left third toe amputation and a right below-the-knee amputation, with admitting diagnoses that also include resolved sepsis, acute respiratory failure, insulin-dependent diabetes, asthma, congestive heart failure, and chronic kidney disease. On 04/21/22 at 12:54 PM, during a review of R45's electronic health record (EHR), it was noted that R45 had an order of Trazodone (a psychotropic medication) prescribed for insomnia on 03/10/22. On 03/23/22, an Medication Regimen Review (MRR) was done by the Pharmacist with the following recommendation: "This resident is currently receiving the PRN [as needed] psychotropic medication (trazodone) ...Please provide a specific stop date or time period (e.g. [sic] six months) AND a clinical rationale to continue PRN psychotropic medication past 14 days ..." On 04/04/22, the trazodone was re-ordered, as a prn with an "indefinite" stop date. A review of the progress notes uncovered no documentation of why the order was being kept as needed, nor why it was being extended past 14 days. On 04/22/22 at 09:30 AM, an interview was done with the Director of Nursing (DON) and the Administrator in the Chapel. The DON stated that she is responsible for processing the MRRs from the Pharmacy and ensuring that they are addressed. The DON stated that when an MRR is addressed, normally she/the DON would make a note on the MRR in the binder. Per the Administrator, the expectation is that MRRs should be addressed/responded to within one week. The DON added that the Charge Nurses	F 756	4. The Director of Nursing will audit each month that each MRR is reviewed and acted upon and report to the QA Committee each quarter. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee. 05/20/22.	

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F 756	Continued From page 86	F 756		

should also place a copy of the MRR(s) in the Doctor's folder but acknowledged that the DON is ultimately responsible to follow-up. The DON admitted that she was still catching up on the MRR recommendations following the departure of the previous DON.

2) Cross Reference to F758. The facility failed to ensure a gradual dose reduction was done for a resident on multiple psychotropic medications.

R51 is a 90-year-old male admitted on 06/15/21 following a fracture of his right thigh with admitting diagnoses that include dementia, senile degeneration of the brain, high blood pressure, and generalized muscle weakness.

On 04/19/22 at 10:08 AM, during a record review of R51's EHR, it was noted that R51 was taking the following psychotropic medications: Lorazepam for anxiety and restlessness, Quetiapine for agitation, Trazodone for difficulty sleeping, and Fluoxetine for depression.

On 02/28/22, an MRR was done by the Pharmacist with the following recommendation as a result:

This resident has been on the psychotropic fluoxetine ...Please evaluate the current dose and consider a gradual taper to ensure this resident is using the lowest possible effective/optimal dose ..."

On 03/24/22, an MRR was done by the Pharmacist with the following recommendation as a result:

This resident has been on the psychotropic

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F 756	Continued From page 87 trazodone ...Please evaluate the current dose and consider a gradual taper to ensure this resident is using the lowest possible effective/optimal dose ..." A review of the EHR uncovered no documentation that the gradual dose reduction recommendations had been considered or addressed. On 04/22/22 at 09:30 AM, an interview was done with the Director of Nursing (DON) and the Administrator in the Chapel. The DON stated that she is responsible for processing the MRRs from the Pharmacy and ensuring that they are addressed. The DON stated that when an MRR is addressed, normally she/the DON would make a note on the MRR in the binder. Per the Administrator, the expectation is that MRRs should be addressed/responded to within one week. The DON added that the Charge Nurses should also place a copy of the MRR(s) in the Doctor's folder but acknowledged that the DON is ultimately responsible to follow-up. The DON admitted that she was still catching up on the MRR recommendations following the departure of the previous DON.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 758		5/20/22

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F 758	Continued From page 88 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	F 758		

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F 758	Continued From page 89 This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to monitor the medication regimen for one resident (R) in the sample and ensure that she did not have any "PRN [as needed]" orders for psychotropic drugs (any drug that affects brain activities associated with mental processes and behavior) for longer than fourteen days. For another resident, the facility failed to address the gradual dose reduction (GDR) recommendations for 2 of his 4 psychotropic medications. As a result of this deficient practice, both residents did not have their medication regimen effectively monitored, placing them at risk for adverse effects related to unnecessary medication. This deficient practice has the potential to affect all the residents at the facility taking psychotropic medications. Findings include: 1) Cross Reference to F756 Drug Regimen Review. The facility failed to ensure follow up on the pharmacist's suggestion to provide a medical rationale for exceeding a 14 day use of a prn psychotropic medication was done. Resident (R)45 is a 63-year-old female admitted on 11/19/21 for skilled nursing services following a left third toe amputation and a right below-the-knee amputation, with admitting diagnoses that include resolved sepsis, acute respiratory failure, insulin-dependent diabetes, asthma, congestive heart failure, and chronic kidney disease. On 04/21/22 at 12:54 PM, during a review of R45's electronic health record (EHR), it was	F 758	1. On 05/18/22 the Director of Nursing reviewed R45□s Trazadone order and 05/18/22 for R51□s Lorazepam order was reviewed and updated. The Interdisciplinary Team/nurses/clerks were educated on the procedure of and requirement of the pharmacist monthly review for needed medications, need for medical rationale for PRN psychotropic medications exceeding 14 days use and the requirements for gradual dose reductions with the use of psychotropic medications. 2. On 05/18/22 the Director of Nursing audited all of the psychotropic medication use to ensure that each were medically reviewed for dose reduction and continued PRN use. 3. On 05/18/22 the Director of Nursing in serviced the Interdisciplinary team, nurses and clerks on the procedure of reviewing, completing and following up on MRRs. And that the psychotropic medications are medically reviewed for dose reduction and continued PRN use. All new hire staff will be in serviced at orientation and annually thereafter by the Director of Nursing/designee. 4. The Director of Nursing will audit each month that each psychotropic medication use is medically reviewed, continued PRN use or gradual dose reduction is documented and report to the QA Committee each quarter. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has	

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F 758	Continued From page 90 noted that R45 had an as needed Trazodone (a psychotropic medication) prescribed for insomnia on 03/10/22. On 03/23/22, a drug/medication regimen review (MRR) was done by the Pharmacist with the following recommendation as a result: "This resident is currently receiving the PRN [as needed] psychotropic medication (trazodone) ...Please provide a specific stop date or time period (e.g. [sic] six months) AND a clinical rationale to continue PRN psychotropic medication past 14 days ..." On 04/04/22, the trazodone was re-ordered, remaining as needed, with an "indefinite" stop date. A review of the EHR uncovered no documentation of why the order was being kept as needed, nor why it was being extended past 14 days. 2) Cross Reference to F756 Drug Regimen Review. The facility failed to follow up on the pharmacist's suggestion to consider a gradual dose reduction for the use of psychotropic medication was assessed. R51 is a 90-year-old male admitted on 06/15/21 following a fracture of his right thigh with admitting diagnoses that include dementia, senile degeneration of the brain, high blood pressure, and generalized muscle weakness. On 04/19/22 at 10:08 AM, during a record review of R51's EHR, it was noted that R51 was taking the following psychotropic medications: Lorazepam for anxiety and restlessness, Quetiapine for agitation, Trazodone for difficulty sleeping, and Fluoxetine for depression.	F 758	been achieved as determined by the committee. 05/20/22.	

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F 758	Continued From page 91 On 02/28/22, an MRR was done by the Pharmacist with the following recommendation: This resident has been on the psychotropic fluoxetine ...Please evaluate the current dose and consider a gradual taper to ensure this resident is using the lowest possible effective/optimal dose ..." On 03/24/22, an MRR was done by the Pharmacist with the following recommendation as a result: This resident has been on the psychotropic trazodone ...Please evaluate the current dose and consider a gradual taper to ensure this resident is using the lowest possible effective/optimal dose ..." A review of the EHR uncovered no documentation that the gradual dose reduction recommendations had been considered or addressed. On 04/22/22 at 09:30 AM, an interview was done with the Director of Nursing (DON) and the Administrator in the Chapel. The DON stated that she is responsible for processing the MRRs from the Pharmacy and ensuring that they are addressed. The DON stated that when an MRR is addressed, normally she/the DON would make a note on the MRR in the binder. Per the Administrator, the expectation is that MRRs should be addressed/responded to within one week. The DON added that the Charge Nurses should also place a copy of the MRR(s) in the Doctor's folder but acknowledged that the DON is ultimately responsible to follow-up. The DON	F 758		

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F 758	Continued From page 92 admitted that she was still catching up on the MRR recommendations following the departure of the previous DON.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff members, and review of the facility's policy and procedures, the facility failed to ensure drugs were securely stored in locked compartments and medications were labeled in accordance with	F 761	1. On 05/18/22 RN1 was educated on the requirement to keep the medication cart locked by the Director of Nursing. RN1 was educated on the requirement that all medications must be labeled with	5/20/22

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F 761	Continued From page 93 professional standards (name of resident, prescribed dose, and expiration dates. Findings include: 1) On 04/21/22 at 09:50 AM observed a male visitor standing next to an unlocked medication cart (the lock button was popped out). A nurse was not at the cart and there were no staff members around. The visitor was texting on his telephone. Approximately two minutes later, Registered Nurse (RN)1 returned with two bagfuls of medication. Upon return, RN1 locked the cart. Inquired what was going on, RN1 responded she was preparing for Resident (R)283's discharge and the visitor was the resident's son. RN1 left with the resident and his son. Upon return at 10:09 AM, the observation of the unlocked cart was shared with RN1, RN1 did not comment. 2) On 04/21/22 at 10:10 AM observation of medication cart was done with RN1. Observed an insulin pen, Victoza labeled with an open date of 04/07/22 and discard date of 05/19/22. Queried RN1 when should the insulin pen be discarded. RN1 responded to discard after 30 days. RN1 confirmed the insulin pen was mislabeled, discard date was over 30 days. The bottom drawer of the medication cart, observed a plastic bag full of medications. RN1 reported these medications were brought from home and belonged to R134 who was admitted on 04/20/22. There was an inhaler, Trelegy in the bag. This was not labeled with the resident's name and RN1 reported that she administered the medication to R134 this morning. The inhaler dose counter was at five, the inhaler was not	F 761	the resident□s name and prescription, to check for the expiration dates and to dispose and not use expired medications. Residents are administered medications in a positive and supportive way, informed of medications being administered and observed taking it. 2. On 05/18/22 the Director of Nursing ensured that all medication carts were locked and all unlabeled and expired medications were discarded. Residents are administered medications in a positive and supportive way, informed of medications being administered and observed taking it. 3. On 05/18/22 the nurses were educated on the requirement to keep the medication cart locked by the Director of Nursing. RNs were educated on the requirement that all medications must be labeled with the resident□s name and prescription, to check for the expiration dates and to dispose and not use expired medications. Residents are administered medications in a positive and supportive way, informed of medications being administered and observed taking it. All new hired staff will be in serviced at orientation and annually thereafter by the Director of Nursing/designee. 4. The Director of Nursing, each month will audit all medications to ensure that medications are properly labeled, not expired, are administered medications in a positive and supportive way. Residents are informed of medications being administered and observed taking it. The Director of Nursing will report to the QA Committee each quarter. Each area will	

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F 761	Continued From page 94 labeled with the resident's name, date of first use, and discard date. RN1 reported the inhaler should be discarded 30 days after first use. RN1 found an inhaler from the pharmaceutical contractor for R134 in the bottom drawer. The inhaler was not opened and labeled with the resident's name and prescription. On 04/22/22 at 10:28 AM a telephone interview was conducted with the facility's contracted Pharmacist. The Pharmacist reported Victoza should be discarded 30 days after initial use. The Pharmacist also reported Trelegy inhaler should be discarded six weeks after removing from the wrapper. A review of the facility's policy and procedure for "Medication Storage - Storage of Medication" notes insulin products should be labeled with the date the insulin vial and pen was first used. 3) On 04/21/22 at 03:35 PM, observed an unlocked and unattended medication cart in the dining room of one of the Units. Approximately three minutes later, observed Registered Nurse (RN)11 return to the medication cart and lock it. Interviewed RN11 at 03:39 PM in front of the medication cart, RN11 confirmed that she forgot to lock the medication cart before leaving the area and apologized for the mistake. On 04/21/22 at 04:30 PM, a review of the facility's Medication Storage policy, last reviewed/revised on 11/01/21, revealed the following: "1. a. All drugs and biologicals will be stored in locked compartments ..."	F 761	be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee. 05/20/22.	

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F 761	Continued From page 95	F 761		

4) On 04/18/22 at 04:18 PM observed an unsupervised and unlocked medication cart in the hallway. At 04:19 PM R283 was observed to come out of his room using a walker and walk pass the unsupervised and unlocked medication cart. At 04:21 observed RN5 return to the unlocked medication cart. Inquired with RN5 regarding the unlocked medication cart, RN5 stated " ...it is not supposed to be unlocked."

5) Cross Reference to F550. The facility failed to ensure R49 was treated with respect and dignity.

Cross Reference to F585. The facility failed to document any corrective action was take as a result of R49's grievance.

On 04/19/22 at 01:15 PM interview with R49 reported on either 01/31/22 or 02/01/22 during the night shift she requested for her cough medication and pain medication during the night shift and was not aware RN4 set her medication on the over bed tray. R49 asked again for her pain medication, RN4 came to her room picked up the medications left on her overbed tray, slammed them down and told R49 to open her eyes they are right in front of her. R49 stated she has difficulty seeing especially with her left eye. R49 noted she is a retired nurse and that RN4 should not leave her medication on her without witnessing her take it, especially since one of the medications is a controlled substance, oxycodone, "I know narcotics aren't supposed to be left, that is absolutely a no no ....if someone snatched it I don't benefit from it, the other nurses watch me take my meds [medication(s)]."

On 02/02/22 R49 submitted a grievance report. A review of the grievance report, RN4 documents

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F 761	Continued From page 96 she left the resident's room with medication (cough medication 30 cc (cubic centimeter) in med (medication) cup and two oxycodone pain pills in another 30 cc med cup) "in front of resident." On 04/21/22 at 10:02 AM interview with R16, stated when administering medication, the nurse " ...needs to watch the resident take it, so need to be in front of them ...unless you see it happen you don't know they took it." On 04/21/22 at 12:50 PM interview and concurrent review RN4's written report and explanation dated 02/05/22 with Director of Nursing (DON), "You are not supposed to be leaving medication in front of her. Not supposed to leave any medication, oxycodone you don't leave ..."	F 761		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to support, and honor the food preferences of one resident (R) in the sample. As a result of this deficient practice, R45 experienced anxiety	F 806	1. On 03/22/22 the Dietitian and the Food Service Manager added the resident□s daily breakfast preference to be served prunes on the meal ticket and	5/20/22

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F 806	Continued From page 97 and was placed at risk of constipation. This deficient practice has the potential to impact all the residents at the facility. Findings include: Cross Reference to F684. The facility failed to identify a resident's risk for constipation and failed to develop a care plan to include interventions to prevent constipation including the resident's preference for prunes at breakfast. On 04/18/22 at 09:37 AM, an interview was done with R45 in her room. R45 stated that although she has spoken to the registered dietician (RD) regarding her request for prunes every day with breakfast to help prevent constipation, and the resident's request is documented on her breakfast meal ticket, she does not always get prunes with her breakfast. R45 explained that "only once in the past week did I get prunes, every other time my CNA [certified nurse aide] had to call the kitchen and pick it up." R45 went on to describe an incident which occurred "a few weeks ago" where she became so constipated that even after two enemas, staff had to manually remove her stool. R45 stated the experience was so traumatic, she never wanted to go through that again and feels very anxious about it, so one of the ways she feels more in control is to eat prunes every day. On 04/21/22 at 12:51 PM, a review of R45's electronic health record (EHR) was done. During a review of R45's comprehensive care plan (CP), it was confirmed that "Prunes at breakfast daily" had been added to her CP on 03/22/22. On 04/22/22 at 08:51 AM, an interview was done	F 806	verified on 04/21/22. 2. On 05/16/22 the Dietitian and the Food Service Manager reviewed other resident preferences and checked that each was added to the meal ticket. 3. On 05/19/22 the Interdisciplinary Team were in serviced on the requirements for resident food preferences to be honored. Dietitian and Food Service Manager to ensure that each is added to the meal ticket and served. All new hire staff will be in serviced at orientation and annually thereafter by the Director of Nursing/designee. 4. The Dietitian will audit each month that each resident□s food preferences are served as requested unless contraindicated and report to the QA Committee. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee. 05/20/22.	

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F 806	Continued From page 98 with the Administrator and Director of Nursing (DON) in the Chapel. When asked how residents' food preferences are assessed, documented, and honored, the DON stated that food preferences are assessed upon admission, documented in the Dietary admission assessment, and the information is passed to the kitchen who places the preferences on the residents' meal tickets. The Administrator added that the information should also be in the residents' CP, and that staff who pass meal trays should be checking the CP to ensure they are aware of residents' preferences. On 04/22/22 at 12:40 PM, during a review of R45's meal ticket information, it was confirmed that the kitchen has documented "Standing Orders" for R45 to have "Fortified Oatmeal ...Fresh Papaya ...Prunes 1 oz [ounce] ..." with breakfast daily.	F 806		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews with residents and staff members, the administration failed to ensure appropriate action was taken in response to residents' grievances related to a staff member's treatment of residents. This deficient practice affected five cognitive residents (Residents 72, 49, 42, 75, and	F 835	1. On 04/20/22 the Administrator suspended RN4 and she was terminated on 04/25/22. 2. On 05/18/22, the Administrator reviewed all resident complaints and grievances for required action and follow-up especially those involving	5/20/22

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F 835	Continued From page 99 45) that were in the sample with capacity to report their concerns. This failure has the potential to affect all the residents receiving care from Registered Nurse (RN)4. This deficient practice has potential to affect residents' ability to effectively attain or maintain their highest practicable physical, mental, and psychosocial well-being. Findings include: Cross Reference to F550. The facility failed to assure residents were treated with respect and dignity to maintain their psychosocial well-being. Cross Reference to F585. The facility failed to investigate grievance and make prompt efforts to resolve the grievances. Observation of an interaction between Registered Nurse (RN)4 and Resident (R)52 on 04/19/22 at 03:50 PM (cross reference to F550), a review of the facility's grievance log, and interviews with residents and staff members, it was identified there were concerns related to RN4's treatment of residents. On 04/21/22 a request was made to review RN4's personnel files. On 04/21/22 at 09:14 AM a review of RN4's personnel file was done. RN4 started employment on 06/01/21. There was no documentation of grievances or personnel/disciplinary actions taken. Also, there was no documentation that an evaluation of nurse competency was done following initial hire. On 04/21/22 at 02:52 PM the Director of Human Resources (DHR) was interviewed in the chapel. Inquired whether human resources (HR) keeps	F 835	personnel performances. 3. On 05/16/22 the CEO will review all complaints and grievances with the Administrator to ensure that each are properly investigated, appropriate action taken and documented including education, training, coaching and disciplinary action with staff performances. All staff was educated on the Grievance and Complaint P/P by the Director of Nursing on 05/18/22. All new hire staff will be in serviced at orientation and annually thereafter by the Director of Nursing/designee. 4. The CEO will audit the grievances and complaints each month and report to the QA Committee each quarter. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee. 05/20/22.	

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record of grievances that were filed for staff members. DHR responded when a resident grievance is submitted and there is a disciplinary action taken, the documentation is placed in the employee's personnel file. DHR reported usually the Director of Nursing (DON) or Administrator will do the write up and indicate what disciplinary action was taken, verbal or written warning. DHR further reported the sequence prior to termination is usually verbal, written, and final warning. However, termination is based on the severity of the infraction. If the infraction is severe the facility will terminate the employee without going through the sequencing. DHR stated if HR is included in the process they will advise the supervisor(s).

DHR reported when education is provided to an employee, the complaint is documented to include the nature of the complaint, what type of disciplinary action was taken, and it is signed and dated by supervisor and a witness. DHR confirmed there is no documentation of a grievance history for RN4 and there is no documentation of personnel/disciplinary actions (education, verbal, or written) was taken. DHR reported the facility has a form to complete to document any employee incidents and confirmed there is no documentation for RN4.

Inquired whether DHR was aware of any incident involving RN4, DHR reported not having knowledge. Further queried whether DHR was aware of recent incident involving RN4. DHR replied being notified on 04/20/22 at 04:00/04:30 PM of the incident on 04/19/22.

On 04/21/22 at 03:18 PM DHR provided a copy of the "Employee/Supervisor Meeting" that the

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facility utilizes to document performance issues with employees. The form includes reason for meeting (violation of house rules, violation of policy, work performance, and other), disciplinary action taken, a section to include narrative (summarize the incident, expected corrective action and details of prior incidents), and signature of employee, manager, second manger and Chief Operating Officer or Chief Executive Officer.

On 04/22/22 at 08:49 AM an interview was conducted with the Administrator and the Director of Nursing (DON). The grievances filed regarding RN4's conduct were shared with the Administrator and DON. Surveyors also shared residents' reports regarding RN4. DON reported that there were previous incidents that were addressed by the previous DON and Social Worker. DON was aware of the grievance regarding end of life care for Resident (R72). DON stated the previous DON and Social Services Manager (SSM) met with RN4 regarding this incident and provided education with warning. DON was also aware of RN4 leaving medication unattended on R49's overbed tray. DON recalls the previous DON investigated this incident and RN4 was apologetic. Inquired whether nursing would notify HR, DON replied HR should be made aware right away, they were supposed to be notified. Further queried whether the facility has documentation of grievance and the education RN4 was provided. DON was agreeable to go through previous DON's documents and emails.

The DON stated they met with RN4 several times and this is her "last leg", RN4 has been suspended. DON was aware of previous

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incidents and allowed the previous DON to addresses concerns. DON further reported when they would meet with RN4, she would cry, apologize, and state she would never do it again. DON stated they gave RN4 a chance and sometimes staff doesn't get along with certain residents. RN4 was provided an opportunity to improve and was transferred to another unit.

Inquired how often are nurse competency performed. The DON reported after hire, then three months and annually. It is usually done in June every year. Based on RN4's employment, DON reported a competency would have been performed in September 2021, three months after employment. Requested to review RN4's competency report. DON agreed to check previous DON's records.

On 04/22/22 at 01:30 PM, RN17 provided documentation. A review found documentation of a meeting dated 02/16/22 at approximately 02:30 PM with previous DON, SSM, and RN4. The purpose of the meeting was to provide education on how to better exhibit bedside manner and compassion with residents and how to better interact with family members through clear communication and active listening. Cultural differences were also discussed (no details) and RN4 was provided with feedback that she may be perceived "as coming off as rude when she engages with residents and families in a way where she is moving too fast or speaking quickly and assertively, though she may not recognize it." RN4 verbalized understanding, stating, "I am sorry, I do not intentionally come off as being rude or not showing compassion to families, I apologize if that's how residents and families see me as, I will do my best to be more calm and

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F 835	Continued From page 103 lower down my voice when I speak with our resident and families." The document was signed by the SSM. The facility also provided an email dated 02/18/22 at 04:28 PM from the SSM to the current DON and previous DON. The grievance form was submitted by a hospice contract staff (attachment of the grievance was not provided). An email from present DON dated 02/18/22 at 06:08 PM, responds to the previous DON email acknowledging she would like to be present for RN4's education. An email from the previous DON to SSM and Administrator dated 02/18/22 at 08:37 PM documents the following: "Given the number of complaints from staff, residents, and families - I believe something more than just education needs to be done this time. [SSM's name] has already talked to [RN4] a couple of times. What are your thoughts?" There was no documentation of subsequent emails responding to the previous DON's query. The survey team requested the facility provide documentation of the administration's participation or oversight regarding RN4's performance, written warning, all education that was provided, and the monitoring of RN4 after receiving warning and education. The team also requested documentation of RN4's competency assessment. At the exit conference on 04/22/22, the facility was provided the opportunity to fax the aforementioned documents to the State Agency by the end of 04/22/22. On 04/25/22, the facility had not sent documentation to the State Agency.	F 835		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		5/20/22

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F 880	Continued From page 104 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections 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,	F 880		

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F 880	Continued From page 105 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §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, record review, and interview with staff members, the facility failed to maintain infection prevention strategies for Resident (R)40 on oxygen therapy. Findings include: Resident (R)40 was admitted to the facility on 02/11/22. Diagnosis includes but not limited to chronic respiratory failure with hypoxia, unspecified chronic obstructive pulmonary disease, unspecified uncomplicated asthma,	F 880	1. On 04/22/22 the Director of Nursing initial and dated the R40□s oxygen tubing. RN40 was educated on the infection control requirement to add a label with date, time and initial when the oxygen tubing is changed. 2. On 05/17/22 the Director of Nursing audited all other oxygen tubings and ensured that each was changed on time with the proper labeling. 3. On 05/18/22 the Director of Nursing in serviced all of the nursing staff on the	

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F 880	Continued From page 106 dependence on supplemental oxygen and thyrotoxicosis unspecified without thyrotoxic crisis of storm. A review of R40's admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 02/17/22 found R40 with a score of 15 [cognitively intact] when the Brief Interview for Mental Status (BIMS) was administered. On 04/18/22 at 11:11 AM interview with R40 stated she has a " ...respiratory infection right now because my lungs are very weak and very fragile. I have half a lung." R40 reported her cannula and oxygen tubing need to be changed out frequently because water gets trapped into the tubing and it feels like she is drowning. R40's husband brought multiple 50 feet (ft) oxygen tubing from home and cut it into 25 ft, " ...it fits perfectly we put tape." Observed rolls of green tubing next to R40 on the shelf and a long green tube connected to cannula with tape and oxygen concentrator. The tubing was not dated when it was last changed. R40 confirmed there was no date on the tubing indicating when it was last changed and confirmed the green tubing was from her home. On 04/20/22 at 09:12 AM observed R40 with a long clear tube in place of the long green tube observed on 04/18/22. R40 stated her doctor discontinued the dehumidifier and the nurse helped her change the oxygen tube yesterday. The facility provided the 25 ft clear tube and R40 confirmed the nurse did not date when it was last changed. On 04/20/22 at 11:04 AM interview and concurrent observation with Registered Nurse	F 880	requirement to properly label the oxygen tubing with each change. Oxygen tubings are changed each week or when soiled. All new hire staff will be in serviced at orientation and annually thereafter by the Director of Nursing/designee. 4. The Director of Nursing will audit each month that the oxygen tubings are properly changed and labeled and report to the QA Committee each quarter. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee. 05/20/22.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	04/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOLO CHINESE HOME	2459 10TH AVENUE HONOLULU, HI 96816

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F 880	Continued From page 107 (RN)18, stated oxygen tubes are usually changed " ...every Sunday at night shift, we use a sticker to date and initial person who changed and stick it on tube." Concurrent observation of R40's oxygen tube, RN18 confirmed there was no label or date. RN18 pointed to a bright orange sticker which read, "O2 (Oxygen) TUBING CHANGED" with direction "WRAP AROUND O2 TUBING" "Date ...Time ...By ..." and explained this is what should be used. Review of the facility's policy and procedures on "Oxygen Concentrator" with a reviewed/revised date of 11/01/21, documented " ...5. Care of the Concentrator: c. Nurse responsibilities: i. Change oxygen tubing and mask/cannula weekly as needed if it becomes soiled or contaminated."	F 880		

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E 000	Initial Comments A recertification survey was conducted by the Office of Healthcare Assurance (OHCA) from April 19, 2022 through April 22, 2022. The facility was found to be in substantial compliance with Appendix Z, Emergency Preparedness, §42 CFR 483.73 for Long Term Care facilities.	E 000		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING **BU - BUILDING 1** B. WING _____	**04/22/2022**

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PALOLO CHINESE HOME	**2459 10TH AVENUE** **HONOLULU, HI 96816**

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K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: K-293 Exit Signage Wong Building This STANDARD is not met as evidenced by: Based on record review and staff interview with staff members, the facility failed to produce documentation for a monthly 30 second test for the battery backed up exit signs in the facility in accordance with NFPA 101, 2012 edition, and section 7.9.9.1.1 (1). This deficiency could affect all residents, staff, and visitors during an emergency requiring evacuation during a power outage. Findings include: During record review on 4/22/22 at approximately 11:30 am revealed that the facility failed to provide documentation for the monthly exit sign test. These findings were verified at the exit conference with the facility manager and Administrator on 4/22/22 at 1:30 pm.	K 293	1. On 4/25/22 & 4/26/22, a 30-second test was conducted on all emergency exit sign lighting by Maintenance staff. 2. On 5/18/22, Support Services Director reviewed and updated the documentation requirements for the monthly emergency exit sign lighting testing requirements. 3. On 5/18/22, Support Services Director educated the Maintenance staff on the testing requirements for emergency lighting and policy updates. 4. Support Services Director or designee will report testing requirement results at the QA Committee meeting quarterly.	5/19/22
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second	K 918		5/19/22

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	125059	A. BUILDING **BU - BUILDING 1** B. WING _____	**04/22/2022**

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PALOLO CHINESE HOME	**2459 10TH AVENUE** **HONOLULU, HI 96816**

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K 918	Continued From page 1 criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: K-918 Electrical Systems-Essential Electric System Maintenance and Testing This STANDARD is not met as evidenced by: Wong Building Based on record review and staff interview with staff members, the facility failed to produce documentation for an annual testing of diesel fuel in accordance with NFPA 99 Healthcare Facilities	K 918	1. On 4/29/22, the required annual generator diesel fuel test was conducted during regular scheduled maintenance service. 2. On 5/16/22, Support Services Director reviewed and updated the annual testing requirements for the generator. 3. On 5/18/22, Support Services Director	

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	125059	A. BUILDING **BU - BUILDING 1** B. WING _____	**04/22/2022**

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K 918	Continued From page 2 Code, 2012 edition, section 6.5.4, and NFPA 110 Standard for Emergency and Standby Power Systems, 2010 edition, section 8.3.8. This deficiency could affect all residents, staff, and visitors during an interruption of grid power due to the lack of an annual diesel fuel test to ensure proper operation of the standby power system. Findings include: During record review on 4/22/22 at approximately 11:45 am, revealed that the facility failed to provide documentation for the annual diesel fuel test. These findings were verified at the exit conference with the facility manager and Administrator on 4/22/22 at 1:30 pm.	K 918	educated the Maintenance staff on the annual testing requirements for the generators. 4. Support Services Director or designee will report the annual results of the diesel fuel test to the QA Committee quarterly.	

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	125059	A. BUILDING **02 - BUILDING 2** B. WING _____	**04/22/2022**

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K 291 SS=D	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 Weinberg Building 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 testing in accordance with NFPA 101, Life Safety Code, 2012 edition, section 7.9.3.1.1. This deficiency could affect all residents, staff, and visitors during an emergency requiring evacuation from the facility. Findings include: During record review on 4/22/22 at approximately 12:30 pm, revealed that the facility failed to conduct an annual 90 minute exit light function test. The light provides lighting for the exit stairway serving all occupants of the building. These findings were verified at the exit conference with the facility manager and Administrator on 4/22/22 at 1:30 pm.	K 291	1. On 5/15/22, a 90-minute emergency lighting test was conducted on all emergency lights to verify proper operation. 2. On 5/16/22, Support Services Director reviewed and updated the annual testing requirements for emergency lighting. 3. On 5/18/22, Support Services Director educated the Maintenance staff on the testing requirements for emergency lighting and policy updates. 4. Support Services Director or designee will report testing requirement results at the QA Committee meeting quarterly.	5/19/22
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)	K 293		5/19/22

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	125059	A. BUILDING **02 - BUILDING 2** B. WING _____	**04/22/2022**

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K 293	Continued From page 1 This REQUIREMENT is not met as evidenced by: K-293 Exit Signage Weinberg Building This STANDARD is not met as evidenced by: Based on record review and staff interview with staff members, the facility failed to produce documentation for a monthly 30 second test for the battery backed up exit signs in the facility in accordance with NFPA 101, 2012 edition, and section 7.9.9.1.1 (1). This deficiency could affect all residents, staff, and visitors during an emergency requiring evacuation during a power outage. Findings include: During record review on 4/22/22 at approximately 11:30 am revealed that the facility failed to provide documentation for the monthly exit sign test. These findings were verified at the exit conference with the facility manager and Administrator on 4/22/22 at 1:30 pm.	K 293	1. On 4/25/22 & 4/26/22, a 30-second test was conducted on all emergency exit sign lighting by Maintenance staff. 2. On 5/18/22, Support Services Director reviewed and updated the documentation requirements for the monthly emergency exit sign lighting testing requirements. 3. On 5/18/22, Support Services Director educated the Maintenance staff on the testing requirements for emergency lighting and policy updates. 4. Support Services Director or designee will report testing requirement results at the QA Committee meeting quarterly.	
K 531 SS=D	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key	K 531		5/19/22

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	125059	A. BUILDING **02 - BUILDING 2** B. WING _____	**04/22/2022**

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K 531	Continued From page 2 recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: K-531 Elevators Weinberg Building This STANDARD is not met as evidenced by: Based on record review and staff interview with staff members, the facility failed to produce documentation for monthly tests for the facility's elevators in accordance with NFPA 101, Life Safety Code, 2012 edition, section 9.4.6.2. This deficiency could affect all residents, staff, and visitors during a fire due to the lack of monthly tests to ensure proper fire fighter operations. Findings include: During record review on 4/22/22 at approximately 11:45 am revealed that the facility failed to provide documentation for the monthly fire fighter emergency operations elevator inspection and testing. These findings were verified at the exit conference with the facility manager and Administrator on 4/22/22 at 1:30 pm.	K 531	1. On 5/18/22, the Firefighter□s Service function was tested for proper function. 2. On 5/18/22, Support Services Director reviewed and updated the testing requirements for the firefighter□s monthly service testing. 3. On 5/18/22, Support Services Director educated the Maintenance staff on the testing requirements for the elevator□s firefighter service testing requirements. 4. Support Services Director or designee will report the monthly testing requirement results at the QA Committee meeting quarterly.	
K 761 SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience	K 761		5/19/22

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K 761	Continued From page 3 that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: K-761 Maintenance, Inspection and testing-Doors This STANDARD is not met as evidenced by: Based on record review and staff interview with staff members, the facility failed to produce documentation for an annual inspection for the fire doors in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 edition, sections 5.2, and 5.2.3. This deficiency could affect all residents, staff, and visitors during a fire due to the lack of an annual inspection to ensure proper protection from fire and smoke extension within the facility. Findings include: During record review on 4/22/22 at approximately 11:30 am revealed that the facility failed to provide documentation for the annual fire door inspection. These findings were verified at the exit conference with the facility manager and Administrator on 4/22/22 at 1:30 pm.	K 761	1.All fire doors at the facility will be inspected for compliance by an outside 3rd party certified vendor hired by the company by 6/30/22. 2.Any identified fire door deficiencies will be corrected by 7/31/22. 3.Upon completion of the fire door inspection by the 3rd party certified vendor the Support Services Director or designee will review and update the annual inspection requirements for all fire doors. 4.Upon completion of the fire door inspection by the certified vendor the Support Services Director or designee will educate the Maintenance staff on the annual inspection requirements for fire doors. 5.Support Services Director or designee will report the annual audit results at the QA Committee meeting.	

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E 000	Initial Comments THIS FACILITY MET THE LIFE SAFETY REQUIREMENTS OF APPENDIX "Z"; IN ACCORDANCE WITH CFR 483.73, REQUIREMENT FOR LONG-TERM CARE (LTC) FACILITIES	E 000		

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