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ALOHA NURSING & REHAB CENTRE	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744

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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. A facility reported incident (FRI) #9646 from the Aspen Complaints/Incidents Tracking System (ACTS) was also investigated and found to be substantiated. Survey Dates: September 6 to September 9, 2022. Survey Census: 84. Sample Size: 21.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the	F 578		

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

Electronically Signed

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facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interview and review of policy, the facility failed to follow up on Advanced Health Care Directive (AHCD) for one resident (R)7 of the four residents sampled. As a result of this deficiency, there was a potential of R7 not being given the right to update their AHCD to reflect their current wishes for medical treatment.

Findings include:

Record review of R7's electronic health record (EHR) showed R7 was admitted on 01/05/21 with a diagnosis of Chronic Obstructive Pulmonary Disease, Respiratory Failure, Atrial Fibrillation, Obstructive Sleep Apnea, Diabetes Mellitus, Chronic Kidney Disease . Minimum Data Summary (MDS) with an Assessment Reference

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Date (ARD) of 06/05/22 showed a Brief Interview for Mental Status (BIMS) Score of 15 which indicated that R7 was cognitively functioning at a high level. There were two notes from Social Services regarding AHCD. The first note was on 01/12/21 which read, "Offered Physician's Orders for Life-Sustaining Treatment (POLST) and AHCD to resident's sister..." Second note on 12/02/21 read, "Mailed...AHCD questionnaires to res' [resident's] sister..."

During an interview on 09/06/22 at 2:00 PM, Social Services Manager (SS Mgr) acknowledged that there was no follow up documentation on R7's AHCD. SS Mgr also said that they needed to work on their AHCD follow up process and documentation.

Review of facility policy on Advance Directives read the following: "Policy: It is the policy of this facility to establish, implement, and maintain written policies and procedures for advance directive. This facility recognizes the right of an adult to make decisions regarding his/her medical care, including the right to accept or refuse treatment. The facility supports a resident's right to execute Advance Directives, including a Living Will, a Durable Power of Attorney for Health Care and a Legal Surrogate for Health Care. The facility does not condition care or discriminate against an individual based upon whether or not he/she has an Advance Directive. Procedure: 1. Upon admission, the Social Services Department or designee will: Provide information on Advance Directives if the resident and/or representative is receptive. Ask the resident or responsible party if he/she has an Advance Directive. Receive the document(s) and photocopy one (1) copy for the chart. Indicate if there is an Advance Directive on

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F 578	Continued From page 3 the Minimum Data Set form and on the facility's Admission Agreement. Review Advance Directives upon admission. 2. If the resident did not execute an Advance Directive and does not seem capable of having one executed: A family member or concerned individual who is familiar with the resident may indicate a willingness to act as the legal surrogate for health care. He/she will be asked to sign the Non-Designated Surrogate Declaration... The legal surrogate will be able to make health care decisions as outlined in the Hawaii Revised Statutes, Chapter 327E."	F 578		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		

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recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to appropriately develop and implement the care plans (CP) for three residents (R), R75, R33, and R23, out of a sample of 21 residents. The deficient practices included:
1. Staff failed to implement the identified care needs for R75 that resulted in a facility-acquired stage 2 pressure ulcer (PU), and the facility also failed to develop a person centered CP with interventions to heal and/or prevent the worsening of R75's PU.
2. The facility failed to identify and develop an individual care need for R33, and
3. The facility failed to follow and implement the identified care needs for R23.
As a result, R75 suffered harm by developing an avoidable PU and R33 and R23 are not able to achieve their highest practicable quality of life.
This has the potential to affect all residents in the

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F 656	Continued From page 5 facility. Findings include: 1) Cross Reference to F657 Care Plan Revision and F686 Pressure Ulcers On 09/07/22 at 08:21 AM, conducted an interview with R75 and R75's Family Member (FM)5 on 09/07/22 at 08:21 AM. R75 reported that she did not have a pressure injury when she initially came into the facility. She needed staff's help to turn from side to side, but staff left her laying on her back while she was in bed and because she was on her back all the time she developed "a sore on her bottom." FM5 stated that when he would come to visit, R75 was always on her back and confirmed R75 needed staff to help R75 move from side to side and with repositioning due to R75's hip fracture. Inquired if R75 and FM5 recalled if staff may have used pillows or a wedge to alleviate the pressure and both confirmed neither were used. R75 stated that prior to the "sore", the only time she was not laying on her back was when she got up to go to the bathroom because she had not gotten used to "going" in the briefs she wore. On 09/09/22 at 09:20 AM, conducted a record review of R75's electronic health record (EHR) that documented the resident was admitted on 08/05/22 with diagnosis that included a fractured right femur and generalized muscle weakness. Review of R75's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/10/22 documented in Section G. Functional Status for Bed Mobility (how resident moves to and from lying position, turns side to	F 656		

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side, and positions body while in bed or alternate sleep furniture) R75 requires two or more person to physically assist. Section M. Skin Conditions (M0150) identified R75 was at Risk of Pressure Ulcer/Injuries and (M0210) she did not have any unhealed pressure ulcers or skin injuries. In Section V, Care Area Assessment (CAA) Summary, documented Pressure Ulcer was triggered as a care area.

Review of R75's care plan (CP) documented a focus on skin for the potential for pressure ulcer due to immobility was developed with an intervention to encourage turning and repositioning every 2 hours and during rounds, as needed (initiated on 08/11/22).

Review of R75's progress notes documented on 08/15/22 at 09:56 AM, an incident note for a new pressure wound discovered on 08/15/22. The wound was documented as being on the upper inner buttock injury measures 0.8 cm (centimeter) by 0.9 cm by 0.1 cm and the left inner buttock skin injury is 0.2 cm by 0.2 cm, skin injury with scant amount of serosanguineous (contains both blood and the liquid part of blood (serum). The progress note identified the lack of off-loading (turning and relieving constant pressure on an area which could include the use of pillow and wedges) as one of the root causes for the development of the stage 2 PU.

After the stage 2 facility-acquired pressure ulcer (PU) was identified by staff, R75's person-centered comprehensive care plan was not updated to include R75's stage 2 facility-acquired PU with interventions to promote healing and the prevention of worsening of the PU to ensure that R75 will attain her highest

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F 656	Continued From page 7 practicable quality of life. On 09/09/22 at 11:14 AM, conducted a concurrent record review of R75's EHR and interview with the Director of Nursing (DON). DON reviewed staff's documentation for the task of turning R75. After reviewing the times staff documented R75 was turned, the DON confirmed staff did not implement R75's care plan for turning every two hours. DON stated the care plan should have stated that staff should turn or attempt to turn R75 instead of encouraging the resident to turn and reposition because R75 cannot turn alone and required staff assistance with the task. DON confirmed R75 did not have a stage 2 PU on admission, the care plan initially developed for pressure ulcers could have contained more person-centered interventions to further ensure R75 did not develop a PU, and after R75 developed the PU, the care plan was not revised to include the facility-acquired PU and interventions to assure the resident's quality of life is attained and the resident received services and care provided that meets the professional standard of care and should have been. 2) On 09/07/22 at 11:16 AM, review of the EHR revealed that R33 was admitted on 11/15/21 with a diagnosis of End Stage Renal Disease, Renal Dialysis, Diabetes Mellitus, Peripheral Vascular Disease, Heart Failure, Atrial Fibrillation, Cardiomyopathy, Hyperlipidemia. The Dialysis Communication Record on 09/05/22 showed that R33 was given Epogen (a medication to stimulate the bone marrow to make red blood cells) 2800 units at the dialysis center. A review of the most recent comprehensive care plan showed interventions related to dialysis but did not have any interventions to monitor for possible adverse	F 656		

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F 656	Continued From page 8 reaction to Epogen. During staff interview on 09/07/22 at 1:20 PM, Minimum Data Set Coordinator (MDS)5 acknowledged that there was no monitoring for possible adverse reaction to the Epogen medication that R33 receives during dialysis. MDS5 stated that they would review this further. Review of facility policy "Comprehensive Care Plans - Planning, Development, Implementation and Review" with revision date 12/15/21, read the following, "Policy, Our facility's Care Planning/interdisciplinary Team is responsible for the planning, development, implementation and review of an individualized comprehensive care plan for each resident. Policy Interpretation and Implementation, 1. A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment (MDS), 2. The care plan is based on the resident's comprehensive assessment and is developed, implemented and revised by a Care Planning/Interdisciplinary Team ... 4. The care planning process will include an assessment of the resident's strengths and needs..." On 09/12/22 at 9:37 AM, reviewed the Epogen prescribing information (PI) on the website, https://www.amgenesas.com/epogen, and it contained a warning that stated: "WARNING: ESAs [erythropoietin stimulating agents] INCREASE THE RISK OF DEATH, MYOCARDIAL INFARCTION [heart attack], STROKE, VENOUS THROMBOEMBOLISM [blood clots], THROMBOSIS [clotting] OF VASCULAR ACCESS AND TUMOR PROGRESSION OR RECURRENCE [cancer]..."	F 656		

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3) On 09/07/22 at 08:19 AM, R23 was observed sitting up in a wheelchair outside of her room. Both of R23's arms were stiffly held to her chest, bent at the elbows. A hand towel was rolled up and she held it in her left hand. No splints were noted to be on her arms.

On 09/07/22 at 09:00 AM, R23 was lying in bed on her right side, no splints were noted on her arms.

On 09/08/22 at 09:56 AM, R23 was observed to be lying in bed with rolled hand towels in both hands. No splints were noted to be worn on her arms. Certified Nurse Assistant (CNA)7 was asked if R23 wears a splint on her arms and he stated that R23 doesn't wear a splint and she only hand towel rolls in her hands.

On 09/08/22 at 12:12 PM, R23 was being assisted with lunch by staff in the dining room. R23 sat up in her wheelchair with hand towel rolls in both of her hands and no splints to her arms.

On 09/09/22 at 06:46 AM, R23's electronic health record (EHR) was reviewed. R23's "Admission Record" revealed that R23 is a 78 year old resident admitted on 12/02/2015 for hemiplegia (paralysis of one side of the body) after having a stroke. Review of R23's care plan revealed the following "Interventions" initiated on 01/12/22 for the activities of daily living (ADL) focus: "Apply LEFT hand and elbow splint while in bed," "Apply LEFT hand palm guard at all times except during hygiene and ROM [range of motion]," "Apply LEFT soft elbow extension orthosis [splint] 6-8 hours a day; ON at 10:00am and off at 6pm."

On 09/09/22 at 09:14 AM, observed R23 lying in

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F 656	Continued From page 10 bed on her right side, no splint noted on her left arm and hand. Nurse Assistant (NA)10 stated that R23 wears the left hand and arm splint while she is sitting up in her wheelchair. A follow up observation was done at 10:00 AM. R23 was sitting up in her wheelchair outside of her room with a blue splint applied to her left lower arm extending down to her hand.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		

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F 657	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure a comprehensive care plan was revised for two residents(R), R75 and R80, out of a sample of 21 residents to correctly reflect a physician's order. This deficient practice prevents them from achieving their highest practicable quality of life and has the potential to affect all residents in the facility. Findings include: 1) Cross Reference to F656 Care Plan Development/Implementation and F686 Pressure Ulcers On 09/07/22 at 08:21 AM, during an interview with R75 and R75's Family Member (FM)5, I was informed the resident developed a stage-2 pressure ulcer (PU) while in the facility. R75 stated she developed the "sore on her bottom" because she laid on her back all the time and staff did not turn her side to side to relieve the pressure from the area the PU had developed. On 09/09/22 at 09:20 AM, conducted a record review of R75's Electronic Medical Record (EMR) that documented the resident was admitted on 08/05/22 with diagnosis that included a fractured right femur and generalized muscle weakness. Review of R75's progress notes documented a note (written on 08/15/22 at 09:56 AM) of staff initially reporting/documenting that R75 had developed a facility acquired stage-2 pressure ulcer. Review of R75's person-centered comprehensive	F 657		

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F 657	Continued From page 12 care plan (CP) documented R75's care plan was not revised to include the facility-acquired PU and interventions to assure the resident's quality of life is attained and the resident received services and care is provided which meets the professional standard of care. During a concurrent record review and interview on 09/09/22 at 11:14 AM, the Director of Nursing (DON) confirmed R75's care plan was not revised to include the facility-acquired PU and interventions to assure the resident's quality of life is attained and that the resident received services and care provided which meets the professional standard of care and should have been. 2) On 09/07/22 at 1:41 PM, conducted a review of R80's electronic health record (EHR). Review of the physician orders documented an order for GT (gastrostomy tube) water flush, 120 milliliters (ml) four times a day for hydration and GT patency, which is a total of 480 ml of water per day. Review of the comprehensive care plan documented a care plan for the resident's GT. The care plan documented R80's GT is no longer used for nutrition/hydration with an intervention to flush the GT with 200 ml of water every 6 hours, which is a total of 800 ml of water per day. There was a difference of 320 ml of water from the intervention (800 ml) of the care plan and the physician's order (480 ml). On 09/09/22 at 11:15 AM, conducted a concurrent record review and interview with the Director of Nursing (DON) of R80's care plan and physician orders. The DON confirmed the care plan was not updated to reflect the physician's updated order and that it should have been revised by staff to reflect the current treatment for	F 657		

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F 657	Continued From page 13 R80.	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to prevent a new pressure ulcer for resident (R), R75, from developing. F75's care plan to prevent pressure ulcers was not consistently implemented by staff, thus R75 developed an avoidable stage 2 pressure ulcer (PU). Also, a person-centered comprehensive care plan was not developed for the treatment of the facility acquired stage 2 PU after it was identified by staff. As a result of this deficiency, all residents with difficulty with mobility and need assistance from staff to turn are at risk of developing an avoidable pressure ulcer. Finding includes: Cross Reference to F656 Care Plan Implementation and F657 Care Plan Revision	F 686		

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F 686	Continued From page 14 On 09/07/22 at 08:21 AM, conducted an interview with R75 and R75's Family Member (FM)5. She needed staff's help to turn from side to side, but staff left her laying on her back while she was in bed and because she was on her back all the time she developed "a sore on her bottom." FM5 stated that when he would come to visit, R75 was always on her back and confirmed R75 needed staff to help R75 move from side to side and with repositioning due to R75's hip fracture. Inquired if R75 and FM5 recalled if R75 reported that she did not have a pressure injury when she initially came into the facility. Also inquired if R75 may have used pillows or a wedge to alleviate the pressure and both confirmed neither were used. R75 stated that prior to the "sore", the only time she was not laying on her back was when she got up to go to the bathroom because she had not gotten used to "going" in the briefs she wore. On 09/09/22 at 09:20 AM, conducted a record review of R75's electronic health record (EHR) that documented the resident was admitted on 08/05/22 with diagnosis that included a fractured right femur and generalized muscle weakness. Review of R75's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/10/22 documented in Section G. Functional Status for Bed Mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture) R75 requires two or more person to physically assist. Section M. Skin Conditions (M0150) identified R75 was at Risk of Pressure Ulcer/Injuries and (M0210) she did not have any unhealed pressure ulcers or skin injuries. In Section V, Care Area Assessment (CAA)	F 686		

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Summary, documented Pressure Ulcer was triggered as a care area.

Review of R75's care plan (CP) documented a focus on skin for the potential for pressure ulcer due to immobility was developed with an intervention to encourage turning and repositioning every 2 hours and during rounds, as needed (initiated on 08/11/22).

Review of R75's progress notes documented on 08/15/22 at 09:56 AM, an incident note for a new pressure wound discovered on 08/15/22. The wound was documented as being on the upper inner buttock injury measures 0.8 cm (centimeter) by 0.9 cm by 0.1 cm and the left inner buttock skin injury is 0.2 cm by 0.2 cm, skin injury with scant amount of serosanguineous (contains both blood and the liquid part of blood (serum). The progress note identified the lack of off-loading (turning and relieving constant pressure on an area which could include the use of pillow and wedges) as one of the root causes for the development of the stage 2 PU.

Review of the Skin/Wound Evaluation form documented the evaluation was completed on 08/18/22, three (3) days after the stage 2 PU was initially identified.

After the stage 2 facility-acquired PU was identified by staff, R75's person-centered comprehensive care plan was not updated to include R75's stage 2 facility-acquired PU with interventions to promote healing and the prevention of worsening of the PU to ensure will attain her highest practicable quality of life.

On 09/09/22 at 11:14 AM, conducted a

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F 686	Continued From page 16 concurrent record review of R75's EHR and interview with the Director of Nursing (DON). DON confirmed R75 did not have a stage 2 PU on admission, the care plan initially developed for pressure ulcers could have contained more person-centered interventions to further ensure R75 did not develop a PU. Also, after R75 developed the PU, the care plan was not revised to include the facility-acquired PU and interventions staff should implement to assure the resident's quality of life is attained and the services and care that needs to be provided that meets the professional standard of care, and should have been.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and	F 688		

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interviews, the facility failed to implement a restorative nursing treatment program utilizing a splint for one resident, R23, in a sample of one, to treat R23's left arm contracture (a permanent shortening of the muscle or joint due to reduced use). This deficient practice leaves R23 with continued contractures of her left arm and hand resulting in the possible pain and skin breakdown. This potentially can affect all residents in the facility who progressively cannot maintain function of their extremities and need a splint to prevent contractures.

Finding includes:

On 09/07/22 at 08:19 AM, R23 was observed sitting up in a wheelchair outside of her room. Both of R23's arms were held tightly to her chest, bent at the elbows. A hand towel was rolled up and she held it in her left hand. No splints were noted to be on her arms.

On 09/07/22 at 09:00 AM, R23 was lying in bed on her right side, no splints were noted on her arms.

On 09/08/22 at 09:56 AM, R23 was observed to be lying in bed with rolled hand towels in both hands. No splints were noted to be worn on her arms. Certified Nurse Assistant (CNA)7 was asked if R23 wears a splint on her arms and he stated that R23 doesn't wear a splint and she only hand towel rolls in her hands.

On 09/08/22 at 12:12 PM, R23 was being assisted with lunch by staff in the dining room. R23 sat up in her wheelchair with hand towel rolls in both of her hands and no splints to her arms.

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F 688	Continued From page 18 On 09/09/22 at 06:46 AM, R23's electronic health record (EHR) was reviewed. R23's "Admission Record" revealed that R23 is a 78 year old resident admitted on 12/02/2015 for hemiplegia (paralysis of one side of the body) after having a stroke. Reviewed R23's annual Minimum Data Set (MDS) assessment dated 06/27/22. "Section G - Functional Status" revealed for R23's self-performance, she was totally dependent on staff for dressing. R23's quarterly MDS assessment dated 10/01/21 revealed that R23 needed "extensive assistance" for dressing, meaning that she was involved in the activity. "Section O - Special Treatments, Procedures, and Programs" for R23's annual assessment on 06/27/22 revealed under "O0500. Restorative Nursing Programs," zero days recorded for the number of days the restorative program was performed for "C. Splint or brace assistance." The quarterly assessment for 10/01/21 also recorded zero days performed for "C. Splint or brace assistance," but the annual assessment for 07/21/20 recorded five days of the last seven calendar days were performed for "C. Splint or brace assistance." Review of R23's care plan revealed the following "Interventions" initiated on 01/12/22 for the activities of daily living (ADL) focus: "Apply LEFT hand and elbow splint while in bed," "Apply LEFT hand palm guard at all times except during hygiene and ROM [range of motion]," "Apply LEFT soft elbow extension orthosis [splint] 6-8 hours a day; ON at 10:00am and off at 6pm." The treatment administration record (TAR) for the month of September revealed that on 09/07/22 and 09/08/22, the treatments were signed off by staff for: "Nursing/CNA to don left Upper Extremity Wrist Hand Orthosis & Soft Elbow	F 688		

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Extension 6-8 hrs/day [hours per day] as tolerated. Monitor skin for redness/breakdown and inform nurse. One time a day for Contractures" at 08:00 AM and "Nursing/CNA to remove Left Upper Extremity Wrist Hand Orthosis & Soft Elbow Extension after 6-8 hrs/day of wear as tolerated. Monitor skin for redness/breakdown and inform nurse. in the afternoon at 4:00 PM." The physician's orders were also reviewed and revealed a revision date of 08/08/22 for both treatments. The progress notes were reviewed from 03/03/22 to 09/08/22 and there was no documentation about R23's left arm splint, why R23's splint was not applied, R23's tolerance to the splint or any assessment to indicate if there was a decline or improvement of her left arm and hand mobility. (Cross reference to F656)

On 09/09/22 at 08:21 AM, MDS5 was interviewed. MDS5 stated that R23 has had the order for the left arm and hand splint "for a while" and that no days are recorded for her left arm/hand splint application on the MDS for 06/27/22 and 10/01/21 because the facility does not have a formal restorative nursing program. The staff member responsible for this program left "a couple of years ago" and the position had not been filled. Currently, there is no staff member responsible for the tracking and recording of the restorative nursing program which involves the application of splints or the performance of passive/active range of motion done by the direct patient care staff to prevent contractures in their residents.

On 09/09/22 at 09:14 AM, observed R23 lying in bed on her right side, no splint noted on her left arm and hand. Nurse Assistant (NA)10 stated that R23 wears the left arm/hand splint while she

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F 688	Continued From page 20 is sitting up in her wheelchair. A follow up observation was done at 10:00 AM. R23 was sitting up in her wheelchair outside of her room with a blue splint applied to her left lower arm extending down to her hand.	F 688		
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, staff interview, and review of policy, the facility failed to identify a broken/cracked electrical outlet cover in a resident's room on the nursing unit. As a result of this deficiency there was a potential for an electrical accident hazard that could affect all residents in the building. Finding includes: On 09/06/22 at 09:00 AM during an observation in one of the rooms of a nursing unit, an electrical outlet cover was noted to be broken/cracked. A dime size piece of the outlet cover was missing/broken off and the electrical wiring inside the wall was visible. Maintenance staff (Maint)1 was interviewed on 09/08/22 at 3:00 PM and acknowledged that the broken/cracked electrical outlet cover was an	F 689		

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F 689	Continued From page 21 electrical accident hazard and stated that they have already replaced the cover. Maint1 also stated that the facility needed to work on a procedure in the future for identifying these types of hazards. On 09/09/22 at 10:00 AM, review of facility policy on "Physical Environment: Electrical Equipment" revised on 09/31/20, read the following: "Policy, the facility will maintain all mechanical, electrical, and patient care equipment in safe operating condition. Policy Explanation and Compliance Guidelines: 1. The Facilities Manager or Designee shall maintain schedules for routine inspection and maintenance or all mechanical, electrical and patient care equipment, 2. Frequency of inspection and maintenance shall be in accordance with the facility's Electrical Safety policy, current Life Safety Code requirements, and manufacturer recommendations, 3. Equipment that is malfunctioning or exhibits safety hazards, such as frayed wires of plugs, shall be removed from use..."	F 689		
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	F 761		

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F 761	Continued From page 22 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, and record reviews, the facility failed to ensure safe and secure storage of medications to minimize loss or diversion, and failed to ensure safe medication administration to residents, which could subsequently cause harm. A label for a narcotic medication did not specify the correct medication dispensing information, a medication cart on a nursing unit was not appropriately locked, and a medication cart on a nursing unit was stocked with expired medications. These deficient practices has the potential to affect all residents. Findings include: 1) On 09/08/22 at 08:20 AM, conducted an observation of nursing staff (NS)19 administer medication to Resident (R)47. NS19 administered four (4) tablets of Oxycodone HCl 5 mg (milligram) tablet for moderate to severe pain. On 09/08/22 at 09:38 AM, reviewed the medications NS19 administered to R47 with the	F 761		

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physician's medication orders for the resident. Review of the physician orders documented as the following:

- Oxycodone HCl 20 mg, give 1 (one) table by mouth every 8 hours as needed for moderate to severe back pain (ordered 08/08/22)
- Oxycodone HCl 5 mg, give 1 (one) table by mouth every 8 hours as needed for moderate to severe back pain (ordered 08/29/22)

Reviewed the medication that was stored in the medication cart and administered to R47 and confirmed R47 was administered four (4) tablets of Oxycodone HCl 5 mg for a total of 20 mg.

At 09/08/22 at 10:14 AM, conducted a concurrent record review of R47's electronic health record (EHR) and interview with the Director of Nursing (DON). The DON reviewed the discrepancy between the physician orders and could not provide an answer. The DON contacted the pharmacy and stated a mix-up occurred due to the facility changing to a new EHR system. The DON also confirmed the physician's order should have aligned with the medications dispensed by the pharmacy but it did not.

2) On 09/06/22 at 12:20 PM, observed a medication cart on one of four nursing units was not locked and left unattended by a nurse or appropriate staff. Registered Nurse (RN)43 was in the dining area assisting a resident with lunch. Observed several staff and a visitor that could have potentially accessed the unlocked medication cart. At 12:39 PM, RN43 returned to the medication cart, realized the medication cart was unlocked, and stated to state agency (SA), "I bet you noticed it (unlocked medication cart) as

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soon as you walked onto the unit." RN43 confirmed the medication cart should have been locked as other facility staff and visitors could have accessed medications stored in the cart.

3) On 09/08/22 at 09:14 AM, a concurrent observation and interview with Registered Nurse (RN)2 was done during a medication cart check. The top drawer contained a nine ounce sized white plastic cup filled to the rim with multiple Iron Sulfate (medication for treatment of low red blood cell count) 325 mg (milligram) tablets in separately packaged blister packs. The expiration date printed on the blister pack was "02/22." RN2 confirmed that the expiration date was "02/22" and stated that the medication should not have been in the medication cart because the medication could be inadvertently administered to residents. The Infection Preventionist (IP) RN also verified the medication and expiration date and stated the same.

On 09/10/22 at 10:00 AM, a record review of the specific nursing unit's resident's medication administration records (MAR) was done. Five of the 26 residents (R18, R37, R58, R65, and R79) receive "Ferrous [iron] Sulfate Tablet 325 (65 Fe [iron]) MG" to treat anemia or low red blood cell count.

On 09/10/22 at 12:08 PM, an interview was done with the Administrator. She stated that the nursing units are supposed to perform a check of their medication carts.

On 09/14/22 at 4:10 PM, a follow up interview with the Administrator and Director of Nurses (DON) through email was done. The DON stated through the Administrator's reply email that it was

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F 761	Continued From page 25 the responsibility of the floor nurse to perform routine checks of their assigned medication cart to ensure proper labeling and that no expired medications exist. The nurse also replenishes house stock medications as needed. The unit manager does periodic medication cart audits to ensure compliance to their "Medications: Storage" policy. On 09/14/22 at 4:15 PM, the facility's "Medications: Storage" policy attached to the reply email from the Administrator was reviewed. "8. Removal of Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist. Floor Nurses also routinely inspect the medication carts, medication rooms and other storage locations for removal of discontinued, expired, defective, or deteriorated medications with worn, illegible, unlabeled and/or cracked, soiled or unsecured containers..."	F 761		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as	F 803		

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F 803	Continued From page 26 input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure that Resident(R)71, out of a sample of six residents, received the correct nutritional texture as ordered. This deficient practice has the potential to not provide the dietary needs and preferences of residents who have their meals prepared by the kitchen. Findings include: On 09/06/22 at 10:40 AM, conducted an interview with Resident (R)71 and R71's Family Member (FM)4. R71 and FM 4 reported the resident's diet texture changed to fine chopped and for two (2) weeks, the resident received the wrong texture. They stated sometimes the resident would receive puree or regular chopped texture so she would send the trays back to the kitchen and had to wait for staff to deliver the correct texture. On 09/08/22 at 10:45 AM, conducted a review of R71's electronic health record (EHR). R71 was admitted on 07/05/22 with diagnosis that include dysphagia, oropharyngeal phase (swallowing	F 803		

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F 803	Continued From page 27 problems that occurs in the mouth and/or throat). R71's orders documented a diet order for a fine chopped texture. Two sepearte Diet Requisition's were sent to the kitchen on 08/23/22 (no time on form) and 08/30/22, which documented to change R71's texture to fine chopped. On 09/08/22 at 11:15 AM, conducted concurrent observations and an interview with the Director of Nutritional Services (DNS) and the Supervisor of Nutritional Services (SNS). SNS stated that once diet orders are received, they are either handed to kitchen staff or placed in a plastic bin (in the kitchen area) and the changes and it is inputted into the kitchen's computer system and filed by the resident's name. SNS logged onto the kitchen's computer system and searched for R71's history of diet orders. Review of R71's history documented a diet change was input on 08/23/22 at 11:59 AM, R71's consistency was changed to chopped. However, R71's diet texture order was for fine chopped not chopped. SNS confirmed the wrong texture was input into the system and explained why the resident had received the wrong texture on multiple occasions. Inquired how the facility ensures the correct diet changes are documented in the system. DNS and SNS confirmed the current process used to change diet orders does not ensure all changes have been implemented and does not double check that changes made are correct. DNS and SNS also confirmed the kitchens system of filing past diet requisitions is unorganized with no method to ensure past diet requisitions are accounted for and/or could be referred to if there are any issues with changes.	F 803		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

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F 812	Continued From page 28 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the proper storage for food related items and properly labeling the contents of a container. As a result of this deficiency, there is an increase in the potential for food-borne illness and the potential for error in texture. Findings include: On 09/08/22 at 10:58 AM, during the second inspection of the facility's kitchen with Kitchen Staff (KS)1, this surveyor observed a clear plastic container filled with a white-powdered item with a scooper stored in it. Inquired with KS1 about the contents of the plastic container and was informed it was a container of thickener. KS1 confirmed the container should have been	F 812		

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F 812	Continued From page 29 labeled and dated and the scooper should not have been stored in the container.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections 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;	F 880		

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F 880	Continued From page 30 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §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 observations, record review, interviews, and facility policy review, the facility failed to consistently implement measures to prevent the potential spread of infection. Specifically, the facility failed to ensure staff consistently implemented standard and transmission-based precautions, including	F 880		

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F 880	Continued From page 31	F 880		

handwashing, used of dedicated equipment, and/or proper use of personal protective equipment (PPE) for four Residents(R) (R12, R54, R139, and R140) of six sampled residents reviewed for infection control. This deficient practice encourages the development and transmission of communicable diseases and infections and has the potential to affect all residents in the facility.

Findings include:

1) Review of a facility policy titled, "Infection Control-Coronavirus (COVID-19) Infectious Disease Threat Isolation-Categories of Transmission-Based Precautions," dated 01/25/2022, revealed, "When transmission-based precautions are in effect, non-critical resident-care equipment items such as a stethoscope, sphygmomanometer [blood pressure cuff], or digital thermometer will be dedicated to a single resident (or cohort of residents) when possible." The policy also indicated, "If re-use of items is necessary, then the items will be cleaned and disinfected according to current guidelines before use with another resident."

Review of an "Admission Record" revealed R12 had diagnoses including essential hypertension, anemia, type 2 diabetes mellitus, and muscle weakness.

Review of an "Admission Record" revealed the facility admitted R139 on 08/22/2022 with a diagnosis of COVID-19.

During an observation on 09/06/2022 at 12:01 PM, there was isolation signage and personal

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protective equipment (PPE) set up outside of R12's room.

During an observation on 09/08/2022 at 09:17 AM, Certified Nursing Assistant (CNA)1 entered R12's room without wearing a gown or gloves. CNA1 exited the room with a set of vital signs equipment and handed it to Registered Nurse (RN)1, who was in R139's room, which was also an isolation room.

During an interview on 09/08/2022 at 09:21 AM, RN1 stated the vital signs equipment should be dedicated to an isolation room but was brought over from the other room because R12 and R139 were previously roommates.

During an interview on 09/08/2022 at 09:34 AM, CNA1 stated she had not sanitized the equipment because it was inside the closet in R12's room.

During an interview on 09/09/2022 at 10:03 AM, the Infection Preventionist (IP) stated when a resident was COVID positive, they should have designated equipment, which should stay in one room. The IP stated equipment should not be taken to other rooms, but if the equipment was needed in another room, it should have been sanitized in between.

During an interview on 09/09/2022 at 10:27 AM, the Director of Nursing (DON) stated equipment should be wiped down between residents, but that in this situation, each resident should have had dedicated equipment.

During an interview on 09/09/2022 at 11:38 AM, the Administrator stated that any time a piece of equipment was used on one resident, it should be

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sanitized after. The Administrator stated there was dedicated equipment that should have stayed in the room for the duration of COVID isolation.

2) Review of an "Admission Record" revealed the facility admitted R54 on 07/20/2022 with diagnoses including pneumonia, acute kidney failure, and essential hypertension.

During an observation on 09/09/2022 at 9:19 AM, RN3 entered R139's room. At 09:30 AM, RN3 exited the room with a cart that had a cup of water and medication in pudding on top of the cart. The water and pudding with medications were not covered. RN3 entered R54's room and gave the medication/pudding and water to R54.

During an interview on 09/09/2022 at 09:46 AM, RN3 stated that R54 started on isolation the previous night. RN3 stated she had the medication on the cart in R139's room because she did not want to leave it in the hallway. RN3 stated she wiped the handles on the cart when she was finished in R139's room.

During an interview on 09/09/2022 at 10:03 AM, the Infection Preventionist (IP) stated medication should not have been brought between rooms.

During an interview on 09/09/2022 at 10:27 AM, the DON stated that taking medication from one room to the next was very concerning.

During an interview on 09/09/2022 at 11:38 AM, the Administrator stated she expected medication to be prepared for one resident at a time and delivered directly to that resident.

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F 880	Continued From page 34 3) Review of a facility policy titled, "Infection Control-Coronavirus (COVID-19) Infectious Disease Threat Isolation-Categories of Transmission-Based Precautions," dated 01/25/2022, revealed, "When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution. The signage informs the staff of the type of CDC [Centers for Disease Control and Prevention] precaution(s), instructions for use of PPE [personal protective equipment], and/or instructions to see a nurse before entering the room." Review of a facility policy titled, "Infection Control-Enhanced Barrier Precautions," dated 07/13/2022, revealed, "Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves." 3.a) Review of an "Admission Record" revealed the facility admitted R140 on 08/15/2022 with diagnoses including urinary tract infection, Escherichia coli, and retention of urine. During an observation on 09/09/2022 at 09:23 AM, there was no signage related to isolation precautions or the need for PPE on the door to R140's room. During an interview on 09/09/2022 at 09:46 AM, RN3 stated R140 was on enhanced barrier precautions because the resident was catheterized intermittently. RN3 stated there	F 880		

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should have been a sign outside the room, just like the signs for other types of isolation. She stated she thought there was a sign outside of R140's room.

During an interview on 09/09/2022 at 09:22 AM, CNA1 stated she was not sure what personal protective equipment to wear in R140's room, so she wore a gown, just in case.

During an interview on 09/09/2022 at 10:03 AM, the IP stated she had not gotten around to posting a sign outside of R140's room.

3.b) Review of an "Admission Record" revealed the facility admitted R54 on 07/20/2022 with diagnoses including pneumonia, acute kidney failure, and essential hypertension.

During an interview on 09/09/2022 at 08:19 AM, the IP stated there was an additional resident on isolation that began that day and identified the resident as R54. The IP stated the facility moved all isolation residents to the end of the hallway so they could have dedicated staff.

During an observation on 09/09/2022 at 09:26 AM, there was no signage outside R54's room regarding the need for personal protective equipment (PPE) to be donned prior to entering the room.

During an interview on 09/09/2022 at 09:46 AM, RN3 stated that R54 was started on isolation the previous night. She indicated she was not sure why there was no signage outside of R54's room.

During an observation on 09/09/2022 at 09:59 AM, the IP placed isolation signage outside of

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F 880	Continued From page 36 R54's room. During an interview on 09/09/2022 at 10:27 AM, the DON stated the facility had started implementing an enhanced barrier program. She stated the staff had been instructed to don PPE when performing direct care for residents on advanced isolation precautions. The DON stated the facility had adequate signage and that a sign should have been placed outside of R54's room the previous night. During an interview on 09/09/2022 at 11:38 AM, the Administrator stated when there was an isolation room, a sign should be placed on the door instructing visitors to see the nurse before entering and a sign indicating which PPE was to be used. 4) Review of a facility policy titled, "Handwashing," dated 04/01/2022, revealed handwashing must be performed, "After handling items or work surfaces potentially contaminated with a resident's blood, excretions or secretions." On 09/07/2022 at 2:37 PM, Housekeeper (HK)1 was observed placing a bag of trash from a resident's room into the trash bag on the housekeeping cart. She did not wash or sanitize her hands after handing the trash, before proceeding with her duties. During an interview on 09/09/2022 at 10:03 AM, the IP stated she told housekeeping staff to sanitize their hands when they came out of a resident's room and in between taking out the garbage. During an interview on 09/09/2022 at 10:27 AM,	F 880		

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F 880	Continued From page 37 the DON stated housekeeping received training on hand hygiene and that HK1 should have sanitized her hands. During an interview on 09/09/2022 at 11:38 AM, the Administrator stated the expectation was for staff to sanitize their hands any time they removed gloves.	F 880		