STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	125021		09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAUAI VETERANS MEMORIAL HOSPITAL	4643 WAIMEA CANYON DRIVE WAIMEA, HI 96796

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F 000	INITIAL COMMENTS	F 000		
	A recertification survey was conducted by the Office of Health Care Assurance on 08/30/22 - 09/02/22. The facility was found not to be in substantial compliance with 42 CFR §483, Subpart B. One facility-reported incident (ACTS #9268) was investigated during the survey, and found to be unsubstantiated. Highest S/S = E. Survey Dates: 08/30/22 - 09/02/22 Survey Census: 19 Sample Size: 17			
F 568 SS=D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on interview with family member and staff member, the facility failed to assure quarterly bank statements were provided in writing to the resident's representative. Findings include:	F 568		

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

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

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F 568	Continued From page 1 On 08/31/22 at 02:30 PM an interview was conducted with Resident (R)12's family member. Family member stated R12 has a personal fund account with the facility. Family member reported they do not receive quarterly account statements. On 09/01/22 at 09:27 AM an interview was conducted with the Accountant. The Accountant confirmed R12 has two accounts with the facility, personal fund account and a bank account. The personal fund account is cash account held by the facility for accessibility and quarterly statements are sent to the residents and/or resident representatives upon request. The Accountant reported R12's family has not reached out to request quarterly petty cash statements. The Accountant provided a copy of R12's personal funds account, this statement was addressed to R12's family member. As requested by resident or resident representative, the facility will open a bank account for residents at a commercial bank. These accounts are opened on behalf of the resident and statements are sent to the facility. On 09/01/22 at 10:40 AM the Accountant provided a copy of R12's commercial bank statement for March through June 2022 for review. The bank statement was addressed to R12 and mailed to the facility. Inquired whether the bank statements are sent to resident's power of attorney (POA) or representative, Accountant responded statements do not go to the POA or representative. The Accountant further reported the statements are delivered to the residents as mail and the accounting department doesn't always receive a copy of the statement.	F 568		

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F 568	Continued From page 2 Review of the policy and procedure titled, Resident Cash Funds (Policy No.: 600-105-5) with effective date of 10/15/20 notes the facility has three types of account, interest-bearing account, personal account, and temporary holding account. In parentheses for interest-bearing account and personal account, it was documented "Quarterly reconciliation of account." However, the procedure does not include providing quarterly statements for any of the accounts to a resident or resident representative.	F 568		
F 574 SS=E	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective	F 574		

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F 574	Continued From page 3 services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation,	F 574		

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F 574	Continued From page 4 misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on interview with resident council representatives, the facility did not assure residents are aware of the contact information for the State Long Term Care Ombudsman and not aware of how to contact the State Survey Agency to file a complaint. Findings include: On 08/31/22 at 09:30 AM an interview was conducted with six resident council representatives. Residents were asked if they are aware of where the Ombudsman's information is posted. Resident (R)13 was aware of the Ombudsman's name but not sure where to find the contact information. Resident (R)15 responded it is probably posted on the bulletin board. The representatives were asked if they were aware they can contact the State Survey Agency to file a complaint. The representatives could not confirm knowledge of contacting the State Survey Agency to file a complaint.	F 574		
F 577 SS=E	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	F 577		

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F 577	Continued From page 5 (ii) Receive information from agencies acting as 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 interview with resident council representatives, the facility did not ensure residents were aware of the right to examine the results of the most recent survey conducted by the State surveyors. Findings include: On 08/31/22 at 09:30 AM an interview was conducted with six resident council representatives. The representatives were asked if they are aware that the State Survey Agency report is available for review. None of the representatives were aware a State Survey Agency report is available to review and they did not know where it is located.	F 577		

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F 584	Continued From page 6	F 584		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to	F 584		

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F 584	Continued From page 7 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 ensure a safe, clean, homelike environment for the residents at the facility, as evidenced by half of Resident (R)13's room being used for storage, and residents being taken to use the toilet and shower in the Isolation/Compassionate Care Room, a room which was also filled with storage. As a result of this deficient practice, the residents were placed at risk for avoidable decline and injuries. This deficient practice has the potential to affect all the residents at the facility. Findings include: 1) On 08/30/22 at 10:36 AM observed Resident (R)13 does not have a roommate. R13's bed was placed close to the wall with a nightstand and chair next to her bed. The other half of the room was filled with seven wheelchairs, a mechanical lift and other equipment (bolsters) stacked on the nightstand. On 08/30/22 at 12:47 PM R13 was observed sitting in her room. Inquired about the stored equipment in her room. R13 explained the facility had to use a room for a resident so all the items in that room were brought to her room. R13 commented that this is a "warehouse" and would prefer items not be stored in her room. On 08/30/22 at 02:12 PM observed a staff member enter R13's room to get a wheelchair. R13 was sitting in her room and staff member did not acknowledge R13 upon entering her room.	F 584		

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F 584	Continued From page 8 On 08/31/22 at 08:55 AM observed R13 was not in her room and a staff member entered her room to return a wheelchair. 2) On 09/01/22 at 08:40 AM, observed Certified Nurse Aide (CNA)1 walking a resident out of the Isolation/Compassionate Care Room (ICCR) at the end of the hall. Observation of the inside of the room noted it was filled with storage items such as wheelchairs, a bed, walkers, wedges, and nightstands, with many items piled on top of each other. A narrow path had been created between the storage that led from the room entrance to the bathroom. When asked about using the room, CNA1 stated that "sometimes" they will take residents to the bathroom in the ICCR because it was closer to the activity room than their own rooms. An interview with CNA6 at the same time revealed that the shower in the ICCR was used to shower all the residents in the back half of the hall. While the residents from the front half of the hall were taken to the shower room through the double doors at the beginning of the Unit. On 09/02/22 at 11:07 AM, an interview was done with the Infection Preventionist (IP) in Conference Room C. When asked about the storage in the ICCR, the IP stated that those items were stored there because there was nowhere else to put them. When the ICCR needed to be used as a Compassionate Care Room, some storage would be moved into the resident's room, who would then occupy the vacated space in the ICCR (as was the case for R13's room, whose roommate was moved into the ICCR). When asked what the facility would do if they needed to clear out the ICCR to be used as an isolation room, the IP stated that they would need to find another place	F 584		

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F 584	Continued From page 9 to put the storage. When asked to clarify where that would be, the IP confirmed that a space had not been identified yet.	F 584		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to conduct a comprehensive assessment of functional capacity within fourteen (14) days of identifying a significant change in physical condition for one resident (R) in the sample. Although R4 was identified with a serious, potentially life-threatening infection that required extended intravenous (IV) antibiotic therapy, placement of a central line (IV access into a large central vein near the heart), and an upgrade of her status to a skilled nursing level of care, the facility failed to assess the impact the infection and its intervention(s) had on R4's functional needs. As a result of this deficient practice, the facility placed R4 at an increased risk for avoidable declines and injuries. This deficient practice has the potential to affect all residents in	F 637		

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F 637	Continued From page 10 the facility with a significant change in condition. Findings include: Resident (R)4 is a 94-year-old female admitted for long-term care on 03/29/22, then upgraded to a skilled nursing (SNF) level of care on 08/03/22. Her current diagnoses include dementia, diabetes, peripheral vascular disease, insomnia, and osteomyelitis (bone infection) of her right foot. Review of R4's electronic health record (EHR) noted that what began as a blister-like lesion on her right great toe in April 2022 has now progressed to osteomyelitis and gangrene (dead tissue due to a lack of blood flow or a serious bacterial infection) of her right big toe and hallux metatarsal phalangeal (MTP) joint, or her big toe joint. On 08/30/22 at 03:15 PM, an interview was done with the Director of Nursing (DON) at the Nurses' Station (NS). Questioned why R4 was listed with an admission date of 08/03/22 in the Electronic Health Record (EHR). The DON stated that R4 was discharged and re-admitted into the EHR system on 08/03/22 as a result of her change in status from long-term care (LTC) to SNF, and a new diagnosis of acute osteomyelitis. On 08/31/22 at 01:05 PM, a review of R4's EHR noted that there were two Minimum Data Set (MDS) assessments completed. One was an Admission Assessment with an Assessment Reference Date (ARD) of 04/10/22, and the second was a Quarterly Review Assessment with an ARD of 07/03/22. Despite her change of condition identified on 08/03/22, no assessments were found since 07/03/22.	F 637		

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F 637	Continued From page 11 On 09/01/22 at 07:48 AM during an interview with the DON in her office, the DON stated that she was the person responsible for transmitting the completed MDS assessments. At 02:30 PM, the DON was interviewed at the NS. After a discussion regarding R4's increased transfer, mobility, dietary, and wound healing needs, the DON agreed that a significant change in condition assessment had been warranted and should have been done following R4's osteomyelitis diagnosis.	F 637		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to recognize the need for closer monitoring and additional interventions to manage a significant change in physical condition for one resident (R) in the sample. Although R4 was identified with a serious, potentially life-threatening wound infection that required extended intravenous (IV) antibiotic therapy, placement of a central line (IV access into a large central vein near the heart), and an upgrade of her status to a skilled nursing level of care, the facility failed to assess the impact the infection had on her functional needs, or to refer	F 684		

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F 684	Continued From page 12 her to the appropriate specialists for her condition. As a result of this deficient practice, the facility placed R4 at an increased risk for avoidable declines and injuries. This deficient practice has the potential to affect all residents in the facility with worsening wounds. Findings include: Cross-reference to F637 Comprehensive Assessment after Significant Change. The facility failed to conduct a comprehensive assessment of functional capacity within fourteen (14) days of identifying a significant change in physical condition for Resident (R)4. Cross-reference to F692 Nutrition/Hydration Status Maintenance. The facility failed to provide care and services to prevent significant weight loss or to identify the need for closer monitoring and timely interventions for R4. R4 is a 94-year-old female admitted for long-term care on 03/29/22, then upgraded to a skilled nursing (SNF) level of care on 08/03/22. Her current diagnoses include dementia, diabetes, peripheral vascular disease, insomnia, and osteomyelitis (bone infection) of her right foot. Review of R4's electronic health record (EHR) noted that what began as a blister-like lesion on her right great toe in April 2022 had progressed to osteomyelitis and gangrene (dead tissue due to a lack of blood flow or a serious bacterial infection) of her right big toe and hallux metatarsal phalangeal (MTP) joint, or her big toe joint. On 08/31/22 at 12:55 PM, further review of R4's EHR noted that despite extensive documentation beginning in May 2022 about the worsening	F 684		

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F 684	Continued From page 13 wound(s) on her right foot, prolonged wound infection(s), and peripheral vascular disease, no referrals were found to have been made to a wound specialist, an infection disease specialist, or a vascular disease specialist. On 09/01/22 at 10:26 AM, observations were done of Certified Nurse Aide (CNA)3 and CNA6 transferring R4 from her geriatric chair (Geri-Chair) to her bed. With the Geri-Chair in the fully upright position, it was observed that R4's feet dangled approximately four (4) inches above the ground. Both CNAs attempted to waken R4 as she slept sitting up, with no success. Observed CNA3 and CNA6 each use one arm to hook under one of R4's armpits and use their remaining free hand to grab the back of R4's elastic-waist pants. They then proceeded to lift R4 from the Geri-Chair to the bed with no assistance from her. After R4 was safely in the bed, an interview was done with both CNAs at the bedside. When asked why a mechanical lift was not used, both CNAs stated that R4 is a "2-man assist for transfer because she can bear weight on her good [left] foot and assist with the transfer when she is not sleepy." When it was pointed out that R4 was very sleepy and could not even lift a hand to assist with the transfer, nor could she bear weight on her good foot when her feet did not touch the floor, CNA3 explained that is why they transferred her the way they did. On 09/01/22 at 10:38 AM, an interview was done with Registered Nurse (RN)1 outside of R4's room. After describing the transfer that was just observed, RN1 agreed that when R4 is sleepy, as she has been lately, the safer option for both resident and staff would be to transfer her utilizing a mechanical lift. RN1 stated that all staff should	F 684		

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F 684	Continued From page 14 be using their own judgement to ensure transfers are safe and that an order is not needed for mechanical lifts. On 09/01/22 at 02:30 PM, the DON was interviewed at the NS. After a discussion regarding R4's increased transfer, mobility, dietary, and wound healing needs, the DON agreed that R4's functional needs had to be reassessed. On 09/02/22 at 09:13 AM, an interview was done in Conference Room C with the Chief Quality Officer (CQO). The CQO confirmed that although R4's condition had been followed by two different Podiatrists (a medical professional devoted to the treatment of disorders of the foot, ankle, and related structures of the leg), and reviewed by the facility's Chief Medical Officer, no referrals or orders had been made for a wound specialist, an infection disease specialist, or a vascular disease specialist.	F 684		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident	F 692		

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F 692	Continued From page 15 preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide care and services to prevent significant weight loss or to identify the need for closer monitoring and timely interventions for one Resident (R)4, as evidenced by a weight loss of 5.571% in one month. As a result of this deficient practice, the facility placed this resident at risk for avoidable declines and injuries. This deficient practice has the potential to affect all residents at the facility. Findings include: Resident (R)4 is a 94-year-old female admitted for long-term care on 03/29/22, then upgraded to a skilled nursing (SNF) level of care on 08/03/22. Her current diagnoses include dementia, diabetes, peripheral vascular disease, insomnia, and osteomyelitis (bone infection) of her right foot. Review of R4's electronic health record (EHR) noted that what began as a blister-like lesion on her right great toe in April 2022 has now progressed to osteomyelitis and gangrene (dead tissue due to a lack of blood flow or a serious bacterial infection) of her right big toe and hallux metatarsal phalangeal (MTP) joint, or her big toe joint. On 08/31/22 at 12:55 PM, further review of R4's	F 692		

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F 692	Continued From page 16 EHR revealed that on 07/25/22, R4 was documented as weighing 104.1 pounds. One month later, on 08/29/22, R4 was documented as weighing 98.3 pound, reflecting a 5.571% weight loss. On 08/31/22 at 02:06 PM, a phone interview was done with R4's family representative (FR). FR shared that R4 had initially gained weight when she was admitted to the facility and told her that she enjoyed the food. As time passed, with the development of the right foot wounds, FR stated that R4 has not seemed to be eating as much and has been sleepier than usual. FR expressed that she is concerned about R4 losing weight, stating that R4 is not even interested in her favorite foods that FR brings from home. When she asks the facility about R4 losing weight, FR stated that she is told that R4's weight "is stable." On 09/01/22 at 03:20 PM, additional review of R4's EHR was done. The following was noted regarding her nutritional assessments and interventions: Nutrition Evaluation done on 04/10/22 documented a regular diet, thin liquids, weight stable with an "Average Meal Consumption Per Day: 75-100%." Nutrition Evaluation done on 07/07/22 documented a chopped diet with thin liquids, "overall beneficial weight gain," with an "Average Meal Consumption Per Day: 50-74%." No changes were made to R4's nutritional plan at that time. No nutrition/dietary referrals, notes, or assessments found between 07/07/22 and 08/12/22, despite a change in condition identified on 08/03/22.	F 692		

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F 692	Continued From page 17 Nutrition Note done on 08/12/22 documented the following: "Discussion of wounds with Interdisciplinary Team on 08/11/22 ... Nutritional concerns d/t [due to] resident with wounds. High protein needs d/t ulcer to promote wound healing. Resident with recent decline in oral intake ... Per RN [Registered Nurse] notes on 08/08 - [08/]09, poor oral intake AEB [as evidenced by] ate only 25% of her meals, ate only 3 bites and 100ml of her fluids for breakfast, stated, "I wanna die, I don't wanna eat" ..." The interventions implemented were to add eight (8) ounces of a nutritional shake three times a day with meals, and a recommendation "to continue encouragement and cueing at meal times [sic]." Nutrition Consultation done on 08/16/22 documented the following: "Consult: Weight Difference ...Resident continue with poor oral intake AEB RN Notes (08/12 - 08/15) detailing meal intakes are 25% or less, refusal of supplement, poor appetite, requirement of much encouragement to eat and drink ...Resident on regular, bite sized, thin liquids ...Continue to encourage oral intake. Will continue to monitor." Further review found no indication on the frequency of the monitoring that would be done, no calculation of caloric, hydration, or protein needs, and no changes in interventions ordered. It was also noted that there was no dietary/nutrition referrals, notes, or assessments between 08/16/22 and 09/01/22, a period during which R4 lost 5.5 pounds, or 5.298% of her body weight. On 09/02/22 at 09:13 AM, an interview was done in Conference Room C with the Chief Quality Officer (CQO). The CQO reported that R4 had	F 692		

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F 692	Continued From page 18 been assessed by the Registered Dietician (RD) the previous day and moved to the Medical-Surgical Unit so that she could receive Total Parenteral Nutrition (TPN), a method of feeding done by IV, bypassing the gastrointestinal tract, and providing most of the nutrients the body needs. After concurrent record review of R4's EHR, the CQO agreed that the RD referral and review of R4's weight and dietary intake was delayed.	F 692		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to designate a Registered Nurse (RN) to serve as the Director of Nursing (DON) on a full-time basis. Specifically, the staff member identified to the State Agency (SA) as the Director of Nursing was not clearly identified in the Organization Chart, position title, Facility Assessment or Job Description as the DON. In addition, the staff member also served as the	F 727		

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F 727	Continued From page 19 Minimum Data Set Coordinator (MDSC), also known as the Resident Assessment Instrument (RAI) Coordinator, thereby making her unable to focus her attention on the DON role for 35 or more hours a week. Findings include: On 08/30/22 at 09:48 AM, an entrance conference was conducted with a staff member who was identified to the State Agency (SA) as the Director of Nursing (DON) in Conference Room C. Upon questioning regarding her role as the DON, the staff member confirmed that she was full-time and stated that her "title" was "Head Nurse." A copy of her Job Description was requested. On 08/30/22 at 01:08 PM, a review of the Job Description for Registered Professional Nurse V [RPN V] (Nursing Facility (SNF/ICF) Head Nurse) with position number 20860 was done. The DON confirmed that the Job Description and position number belonged to her. The review revealed the following: I.C. "Position may be subject to rotating shifts and may be floated to other nursing units." I.D "Position reports to the Asst. [Assistant] Director of Nursing..." II.A.3.a. "Prepares draft of annual budget and submits draft to the DON and/or Assistant Administrator ..." A concurrent review of the Facility Assessment revealed the following:	F 727		

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F 727	Continued From page 20 3.2 "Staffing Plan - LTC [long-term care] ... Other Positions/Indirect Care... LTC Nurse Manager/RAI Coordinator ... RN = 1 ..." On 08/30/22 at 02:15 PM, a review of the facility's Nursing, Recreational, & Respiratory Therapy Services Position Organization Chart, last updated 12/31/21, revealed position number 20860 was listed under the position title Nurse Manager RPN V, along with four other staff members of the organization also listed as Nurse Manager RPN V(s). All Nurse Managers were listed under the "Asst Director of Nursing," who fell under the "Regional Chief Nurse Executive," who was overseen by the "Regional Chief Executive Officer." On 09/01/22 at 07:48 AM during an interview with the DON in her office, she confirmed that she is also the MDSC (or RAI Coordinator).	F 727		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §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.	F 755		

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F 755	Continued From page 21 §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 interview and record review, the facility failed to ensure pharmacy services included a thorough process to assure accurate reconciliation and accounting for all controlled medications in order to promptly identify loss or potential diversion. Findings include: On 09/01/22 at 08:52 AM, a medication cart inspection was done. During a review of the Daily Medication Count logs for the narcotic drawer and narcotic E-Kit (Emergency Kit) for August 2022, it was noted that there were fourteen (14) empty spaces or empty spaces with a dash on the narcotic drawer log, and nineteen (19) on the narcotic E-Kit log, where either the incoming or the outgoing Nurse had not initialed off to attest that the counts were correct. On 09/01/22 at 09:32 AM, an interview and	F 755		

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F 755	Continued From page 22 concurrent review of the Count logs was done with the Director of Nursing (DON) at the Nurses' Station. The DON confirmed that two Nurses should be initialing off each shift on the logs to attest that the narcotic inventories were reconciled. The DON stated that the empty spaces with a dash "is nothing, that doesn't count," and acknowledged that there is no way to confirm if the narcotic count was done without two Nurses attesting to it each shift.	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff	F 757		

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F 757	Continued From page 23 member, the facility failed to ensure insulin and high blood pressure medications were provided with adequate monitoring for 2 (Residents 21 and 2) of 5 residents sampled for medication review. Medications were not administered in accordance with physician orders. Findings include: 1) Resident (R)21 was readmitted to the facility on 07/10/22. Diagnoses include but not limited to, diabetes mellitus, type 2; diabetes mellitus, type 2 causing chronic kidney disease; and vascular dementia. Record review found physician order for NovoLog (insulin), 5 units every evening, give 5-10 minutes before the evening meal, if finger stick blood sugar (FSBS) is greater than 150 mg/dL; insulin degludec, 50 units daily; and blood glucose monitoring. Review of the medication administration record (MAR) from 08/12/22 to 08/31/22 found the NovoLog was not administered as ordered. There were four entries of blood sugars taken in the morning, no evidence blood sugar was tested before the evening meal, then NovoLog was administered when blood sugar levels were below 150 mg/dL. On 08/14/22 at 06:55 AM, R21's blood sugar was 114 mg/dL. There was no documentation of test results for FSBS before evening meal and NovoLog was administered at 05:00 PM. On 08/24/22 blood sugar was tested at 06:19AM (112 mg/dL) and NovoLog was administered at 05:05 PM. On 08/25/22 blood sugar was tested at 06:19 AM (84 mg/dL) and NovoLog was administered at 04:51 PM. On 08/31/22 blood sugar was tested at 06:54 AM (88	F 757		

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F 757	Continued From page 24 mg/dL) and NovoLog was administered at 06:01 PM. There was one entry which documented on 08/18/22 NovoLog was administered before blood sugar was tested. The NovoLog was administered at 04:25 PM and the blood sugar was tested at 06:23 PM (252 mg/dL). On 09/02/22 at 09:32 AM concurrent record review and interview was conducted with the Charge Nurse (CN)3. The MAR was reviewed with CN3. Inquired why NovoLog was administered without blood sugar testing in the evening. CN3 reviewed the entries and replied, the nurse may have forgotten to take the blood sugar or forgotten to document the results. Further queried why are there results for blood sugar testing twice a day on some days and only once a day on others. CN3 stated per physician's orders, R21's blood sugars are to be taken twice a day. A review of the MAR with CN3 found blood sugar testing was done only once a day on the following days: 08/12/22 at 04:30 PM, 08/14/22 at 06:55 AM, 08/15/22 at 04:40 PM, 08/18/22 at 06:23 PM, 08/21/22 at 04:27 PM, 08/24/22 at 06:19 AM, 08/25/22 at 06:19 AM, 08/26/22 at 06:13 AM, and 08/31/22 at 06:54 AM. CN3 commented the nurse may have forgotten to document the results. 2) R2 was admitted to the facility on 05/26/15. Diagnoses include but not limited to hypertension, vascular dementia, edema, and Type 2 diabetes mellitus. A review of R2's physician orders include lisinopril, 10 mg. daily, hold if SBP (systolic blood pressure) is less than 110. A review of the MAR	F 757		

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F 757	Continued From page 25 found an entry for 08/27/22 at 08:17 AM documenting the SBP was 103. There was no documentation the lisinopril was held. On 09/02/22 at 09:32 AM, concurrent record review and interview was done with CN3. CN3 confirmed there was no documentation that the medication was held due to SBP not meeting the parameters for administration.	F 757		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §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 observation, and interview, the facility failed to store, label, and serve food in accordance with professional standards for food service safety. Residents (R) risk serious complications from foodborne illness as a result	F 812		

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(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 812	Continued From page 26 of their compromised health status. Unsafe and/or unsanitary food handling practices represent a potential source of pathogen exposure for all residents at the facility. Findings include: 1) On 08/30/22 at 09:50 AM an initial tour of the kitchen was done with Kitchen Staff (KS)1. Observations found the three-door refrigerator contained a plastic container of balsamic vinegar dressing and a plastic container of miso labeled with a used by date of 08/23/22. In the reach-in refrigerator there was a container of chickpeas that was not labeled to identify the food item and the use by date. The reach-in freezer found a plastic bag of frozen food that was not labeled. Inquired what was in the plastic bag, KS1 replied she did not know and threw out the food item. Upon entering the walk-in freezer, observed frozen red liquid on the floor close to the door jam with frozen red liquid trailing down an empty plastic container. Asked KS1 what is that? KS1 responded it is probably frozen blood and further states this is the area where raw hamburger is stored. Also observed a box on the floor of the walk-in freezer. KS1 confirmed this was a box of frozen chicken that was just delivered. 2) On 08/31/22 at 09:50 AM a confidential resident interview was conducted. The resident reported the dishware (plates, bowls, cups) are oftentimes chipped. The resident reported that this is not sanitary. On 09/01/22 at 08:15 AM observed breakfast meal, there were three plates (white in the center with grey trimming) with chips on the perimeter.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	125021		09/02/2022

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F 812	Continued From page 27 At 08:20 AM, concurrent observation and interview was done with Certified Nurse Aide (CNA)5 as she was clearing the tables. Inquired whether she noticed if there were chips in the ceramic dishware. CNA5 stated she has not noticed, however, confirmed there was a chip in the plate. On 09/01/22 at 12:55 PM concurrent observation of the dishware was done with the Kitchen Manager. Observation found five white plates with fluted edges with chips on the rim. The Kitchen Manager reported the chipped plates allow particles to permeate the plates and is not a good infection control practice. The Kitchen Manager stated she will go through the dishware and check for chips. 3) On 08/30/22 at 11:02 AM, observations were done in Resident (R)8's room as the Certified Nurse Aide (CNA)2 prepared to feed him his lunch. Observed CNA2 stir R8's pureed rice with a spoon, then stick her right index finger in it, wipe the finger on his napkin, and continued to stir. When asked about sticking her ungloved finger in his food, CNA2 explained that she was ensuring the food was cool enough to feed to the resident. As she explained what she was doing, CNA2 demonstrated the process by sticking her right index finger into R8's pureed main dish twice, in between stirring it with a spoon. When asked about hand hygiene, CNA2 explained that she washed her hands with soap and water before she left to pick up R8's lunch tray, then used an alcohol-based hand rub when she returned with the food, before she began feeding him.	F 812		