STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125057	A. BUILDING _____ B. WING _____	07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULANA MALAMA	91-1360 KARAYAN STREET EWA BEACH, HI 96706

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F 000	INITIAL COMMENTS A re-certification survey was conducted by the Office of Healthcare Assurance (OHCA) on 07/15/22. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. The following Aspen Complaints/Incidents Tracking System (ACTS) were investigated: ACTS #9109 was substantiated and #9376 was not substantiated. Survey Dates: 07/12/22-07/15/22 Survey Census: 29 Sample Size: 12	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550		8/26/22

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

Electronically Signed | 08/12/2022

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F 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to promote quality of life for Resident (R)2 by ensuring he was treated with dignity and respect when a staff member provided personal care. This deficient practice has the potential to affect all residents in the facility who receive assistance with personal care. Findings Include: Cross tag with F609. The facility failed to immediately report allegation of abuse to the adult protective services (APS) or law enforcement in accordance with State Law R2 was admitted to the facility on 12/03/08. R2's	F 550	CNA 5's employment was terminated at the close of the investigation in September 2021. The facility failed to report the possible abuse to the State of Hawaii, Department of Human Services, Adult Protective Services (APS) in a timely manner. A report was filed with the State of Hawaii, Department of Health, Office of Health Care Assurance (OHCA) per requirements; however, the report was not sent to APS. After being notified of our error, a report was submitted to APS on July 19, 2022. On July 21, 2022, APS case managers visited the facility to	

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F 550	Continued From page 2 diagnoses included severe intellectual disabilities, unspecified abnormal involuntary movement, abnormal reflex, unspecified paraplegia, unspecified scoliosis, and unspecified hip disorder of ligament. Review of R2's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/22/22 documented R2's cognitive skills for daily decision making as severely impaired. On 09/28/21 the facility submitted a completed Event Report to the State Agency. The Event Report documented "On 09/22/21, at approximately 7 pm, it was reported by a witness [Registered Nurse (RN) 38] that... [Certified Nursing Assistant (CNA)5] ...was heard yelling at the resident, "This is why I get hurt, you bitch!" She was also heard yelling profanities...in the resident room and slapping the resident's inner thigh with excessive force...The witness immediately pulled ...[CNA5] ...aside and spoke to her about treatment of the resident [R2]." It was reported that CNA5 was frustrated with the resident because both of her wrists were hurting due to arthritis. On 07/14/22 at 10:05 AM interview with Registered Nurse (RN) 30 was done. RN30 stated she worked on 09/22/21 and was the oncoming night shift. RN30 did not witness the incident but was with the charge nurse when CNA5 stated she wanted to go home and reportedly asked RN38 to help change R2 because he made a bowel movement (BM) and was not cooperating. RN30 reported CNA5 felt disrespected by RN38 and explained RN38 told her she was inappropriate and unprofessional.	F 550	review the resident chart to determine their further actions. No other resident since that incident has had an event which could have been the result of potential abuse. The facility will comply as required to submit reports to the appropriate government agencies as necessary. Management and staff will be in-serviced on August 19, 2022, by the Social Services Director and Director of Nursing on the reporting requirements for events, including when it is necessary to report to OHCA and APS. The Administrator will be responsible for ensuring that the reports are sent to OHCA and APS in a timely manner as the Administrator is the last to review all reports prior to submission to appropriate agencies. All staff will be in-serviced by the Director of Nursing and Social Services Director on August 26, 2022 concerning Resident Rights and abuse prohibition and protocols. For those not able to attend, a handout and post-test will be given. Periodic, random audits will be done by the Director of Nursing, Assistant Director of Nursing and Social Services Director watching staff interactions with residents. This will be done weekly x 3 months, then bi-monthly x 3 months. Any discrepancies will be reported to the	

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F 550	Continued From page 3 RN30 reported CNA5 blamed R2 for her sore wrists. RN30 spoke with RN38 and RN38 reported she went to help CNA5 and witnessed CNA5 swear in front of the resident, was rough when changing the resident's diaper, and blamed the resident for her wrist injury in front of the resident. RN30 reported she was instructed by the charge nurse to check on R2 and to examine his skin for signs of physical abuse. RN30 stated she did not see any redness, bruising, or scratches and the resident did not appear to be in any discomfort. RN30 further described R2 usually cooperative when providing care but becomes anxious when there is more than one person in the room and can become uncooperative. RN30 stated "you have to be patient and talk to him nicely." RN30 described CNA5 as a "good" CNA but " ...can't say I agree with her methods. She can be a bit more rough." Inquired with RN30 the impact if a reasonable person was in a similar situation, RN30 stated " ...they [the resident] wouldn't feel very well. They would feel bad as if it was their fault." On 07/14/22 at 10:05 AM interview with CNA1 was done. CNA1 did not work on the day of the incident but has experience working with R2. CNA1 explained R2 is uncooperative if there is more than one person in the room providing care and " ...if I change him, I talk to him nice he will listen ...he will eventually calm down and participate." CNA1 further explained if R2 is rushed he won't listen and become uncooperative. CNA1 confirmed CNA5's technique can be rough when assisting residents but has not noticed residents in pain or hurt due to her technique. On 07/14/22 at 11:17 AM telephone interview with	F 550	quarterly QA/QI Committee meetings by the Social Services Director.	

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F 550	Continued From page 4	F 550		

RN38 was done. RN38 confirmed she witnessed the incident on 09/22/21. RN38 reported she assisted CNA5 in changing R2 after having a BM. RN38 reported CNA5 appeared to be frustrated that day and was rough when providing care, tossing R2 side to side aggressively than normal, slapping his thighs, grabbing and pulling him toward her, and reportedly said "This is why I get hurt, you bitch." RN38 reported CNA5 then said " ...he knows I am just playing with him, I raised him." RN38 described R2 as a "sweet boy" and " ...if you talk sweet to him and hold his hand ..." to distract him from scratching his buttocks, he usually cooperates.

On 07/14/22 at 01:36 PM interview with RN29 was done. RN29 stated she was working as a CNA on 09/22/21 but did not witness the incident. RN29 stated if you are patient and speak calmly when providing care to R2 he will listen to you. RN29 further stated if R2 made BM, holding his hand prevents him from touching his buttocks, " ...he loves holding hands."

On 07/15/22 at 10:26 AM interview with Director of Nursing (DON) was done. DON reported after the incident he interviewed CNA5 and during the interview CNA5 reportedly stated while changing R2's diaper "You have to be rough with him ...". DON reported CNA5 could not recall if she called R2 a derogatory term and slapped his thigh. Inquired with DON if staff members complained of CNA5's rough technique when providing care, DON stated it has been mentioned that CNA5 " ...would be a little rough repositioning or changing diapers ..." and he had verbal undocumented conversations with CNA5 about it. Inquired if CNA5's reported behavior on 09/22/21 was appropriate, DON stated it would be inappropriate

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F 550	Continued From page 5 to use profanities in front of a resident and/or at a resident. Review of the facility's employee conduct titled "APPENDIX I" dated April 2007 documents an employee must not use " ...abusive, profane, or obscene language, threatening, fighting or engaging in any act of physical aggression ...either by words or actions, directed at a residents, visitors, doctors, supervisor, member of the Facility ..." Review of the faculty's resident rights and responsibilities dated August 2007 documents under dignity "The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. "	F 550		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and	F 609		8/19/22

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F 609	Continued From page 6 adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of the facility's policy and procedures and staff interview, the facility failed to immediately report allegation of abuse to the adult protective services (APS) or law enforcement in accordance with State Law for Resident (R) 2. This deficient practice has the potential to affect all residents in the facility. Findings Include: Cross tag with F550. The facility failed to promote quality of life for Resident (R) 2 by ensuring he was treated with dignity and respect when a staff member provided personal care. On 09/28/21 the facility submitted a completed Event Report to the State Agency regarding an allegation of staff to resident abuse. The Event Report documented "On 09/22/21, at approximately 7 pm, it was reported by a witness that...[Certified Nursing Assistant (CNA) 5]...was heard yelling at the resident, "This is why I get hurt, you bitch!" She was also heard yelling profanities...in the resident room and slapping the resident's inner high with excessive force..." The	F 609	The facility failed to report the possible abuse to the State of Hawaii, Department of Human Services, Adult Protective Services (APS) in a timely manner. A report was filed with the State of Hawaii, Department of Health, Office of Health Care Assurance (OHCA) per requirements; however, the report was not sent to APS. After being notified of our error, a report was submitted to APS on July 19, 2022. On July 21, 2022, APS case managers visited the facility to review the resident chart to determine their further actions. No other resident since that incident has had an event which could have been the result of potential abuse. The facility will comply as required to submit reports to the appropriate government agencies as necessary. Management and staff will be in-serviced on August 19, 2022, by the Social Services Director and Director of Nursing	

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F 609	Continued From page 7 facility documented "Abuse cannot be ruled out..." A review of the facility's "Incident Report" and "Event Report" submitted by the facility found this allegation was not reported to APS. A review of the facility's policy and procedure for abuse and neglect entitled "Investigation of Alleged Violations Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source, Unusual Occurrences and Misappropriation of Resident Property", effective 09/2017, documents "The Administrator or his/her designee shall immediately notify by phone or by FAX, the following State agencies as required by State law through established procedures of the reported incident and findings within 24 hours after the discovery of the event..." The following State agencies listed included APS. On 07/13/22 at 02:20 PM interview and concurrent review of the facility's policy and procedure on abuse and neglect with Social Worker (SW) was done. SW confirmed the facility did not call AP'S or law enforcement and stated "...it is questionably whether we report to APS...I was told it was not necessarily an APS referral." Concurrent review of the facility's policy and procedure, SW stated "It reads we should go ahead and make the referral...I think it is safer to report to APS." On 07/15/22 at 10:26 AM interview with Director of Nursing (DON) was done. Inquired if the facility reported the incident to APS, DON stated "...we did question whether to report to APS..." DON could not confirm if APS was notified but confirmed the facility did not report the incident to law enforcement.	F 609	on the reporting requirements for events, including when it is necessary to report to OHCA and APS. The Administrator will be responsible for ensuring that the reports are sent to OHCA and APS in a timely manner as the Administrator is the last to review all reports prior to submission to appropriate agencies.	

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F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		8/19/22

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F 623	Continued From page 9 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

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F 623	Continued From page 10 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide proper notification of discharge/transfer to two resident/family representative(s) in the sample. Resident (R)18 and Resident 10 were discharged/transferred without they or their family representative(s) receiving written notification of their discharge/transfer, their right to appeal the discharge/transfer, or contact information for the Office of the State LTC [long-term care] Ombudsman (LTCO). In addition, the facility failed to send notification of the discharge/transfers to the LTCO. This deficient practice has the potential to affect all residents at the facility who are discharged or transferred. Findings include: Resident (R)18 is a 9-year-old female admitted to the facility on 09/01/20. During a review of her electronic health records (EHR) on 07/15/22 at	F 623	The Social Services Director reviewed residents 10 and 18 on July 18, 2022, and identified that the notice to the Ombudsman's Office about the discharges were not sent to the Ombudsman's Office on the date of the transfer or soon after. Additionally, written notices were not sent to the Responsible Parties for the residents. They were notified by phone prior to discharge, but not through written media. The facility was negligent in mailing the notice to the Responsible Parties and the Ombudsman's Office. The Social Services Director, in consultation with the Administrator, determined that mailing the notices to the Responsible Parties at this time may confuse them. All other residents had the potential to be affected as the Social Services Director	

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F 623	Continued From page 11 08:23 AM, it was noted that R18 was transferred and admitted to an acute care hospital on 05/29/22. There was no discharge/transfer notification or LTCO notification found in the EHR for this discharge/transfer. On 07/15/22 at 09:31 AM, an interview was done with the Health Information Associate (HIA) at the Nurses' Station. The HIA confirmed that she could find no documentation in R18's medical record that her family representative had received written notification of her transfer/discharge. The HIA stated that the normal procedure when a resident is transferred to the acute care hospital is that the Nurse usually notifies the family by phone, and the Social Worker follows up with the family by phone. The HIA also stated that she had not heard of a notification for the LTCO, nor was she aware of written notification needing to be sent to anyone. On 07/15/22 at 10:04 AM, a review of the facility's Discharges and Transfers Policy and Procedure, dated June 2008, noted the following: "Procedures:... 4. All transfers and discharges from the facility... require a completed Transfer/Discharge Notice explaining the reason for discharge... 8. A copy of the Transfer/Discharge Notice and the bed holding policy are given to the resident and/or family/responsible representative at the time of discharge to an acute hospital. 2) Resident (R)10 is a 15-year-old admitted to an acute care facility on 02/28/22. Record review (RR) of her medical records on 07/15/22 at 12:30	F 623	was unaware of the requirement to send written notification. Effective August 4, 2022, the Ombudsman's Transfer/Discharge Notice and the Notice of Involuntary Discharge have been set in place and all further transfer and discharges from the facility will have the notices mailed to the Ombudsman's Office and Responsible Party by the Social Services Director or designee. In-service will be held by the Social Services Director with the Charge Nurse staff on August 19, 2022, to remind them of the facility procedure pertaining to the Transfer/Discharge Notice and Notice of Involuntary Discharge. To prevent further missed notices, nursing will include training on the notification during their Charge Nurse orientation on the units. The Director of Social Services will track transfers and discharges from the facility to ensure proper notices are mailed out to the Ombudsman's Office and Responsible Party. The Social Services Director will log transfers and discharges on the newly created Transfer/Discharge Tracking Form and report results at the quarterly QA/QI Committee meetings.	

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	125057	A. BUILDING _____ B. WING _____	07/15/2022

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F 623	Continued From page 12 PM revealed that the resident had been discharged and transferred without their family representative receiving a written notification of their discharge/transfer. Written notification to the long term ombudsman was not done as well.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 625		8/19/22

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F 625	Continued From page 13 Based on interview and record review, the facility failed to provide written notice of the facility's bed hold policy to Resident (R)18 and R10 or their family representatives upon transfer to an acute care hospital. Findings include: Resident (R)18 is a 9-year-old female admitted to the facility on 09/01/20. During a review of her electronic health records (EHR) on 07/15/22 at 08:23 AM, it was noted that R18 was transferred and admitted to an acute care hospital on 05/29/22. There was no documentation found in the EHR that R18's family representative had received information regarding the facility's bed hold policy/process before or upon this transfer. On 07/15/22 at 09:31 AM, an interview was done with the Health Information Associate (HIA) at the Nurses' Station. The HIA confirmed that she could find no documentation in R18's medical record that her family representative had received written notification of the facility's bed hold policy/process for this transfer. The HIA stated that normally a copy of the Bed Hold Agreement is given to the family upon transfer/discharge to an acute care hospital, however, it was not given or sent this time. On 07/15/22 at 10:04 AM, a review of the facility's Discharges and Transfers Policy and Procedure, dated June 2008, noted the following: "Procedures:... 8. A copy of the Transfer/Discharge Notice and the bed holding policy are given to the resident and/or family/responsible representative at the	F 625	The Bed Hold Policy and Agreement are given to the Responsible Party at the time of admission to the facility while reviewing admission paperwork. The Bed Hold Agreement is normally attached with the other paperwork when transferring a resident to an acute facility. However, after review by the Social Services Director and Health Information Associate on July 18, 2022, there is no clear indication if the Responsible Party for residents 10 and 18 received the form at the other end of the transfer. In some cases, the Responsible Party may not visit the resident in the acute setting. All other residents have the potential to be affected if they, or their Responsible Party, do not see the transfer paperwork in the hospital or if they do not visit with the resident in that setting. Going forward, the Social Services Director or designee will attempt to call the Responsible Party for confirmation of a bed hold, or declination, and that they are aware of the Bed Hold Policy which was provided to them upon admission. A copy of the Agreement will still be sent with the resident in the transfer paperwork that accompanies them to the hospital. If we do not get the Agreement paperwork back from the Responsible Party in a timely manner, the Social Services Director or designee will notate the conversation with the Responsible Party in the chart to indicate acceptance or declination of the bed hold.	

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F 625	Continued From page 14 time of discharge to an acute hospital. On 07/15/22 at 10:09 AM, a review of the facility's Admission Packet noted the following undated information to family representatives regarding bed holds: "... Upon any transfer or discharge from the facility to a hospital, you will receive notice of our Bed Hold and Readmission Policy and must return a Bed Hold Agreement within 24 hours of discharge... Review of the facility's Notice of Bed Hold and Re-admission Policy, revised 5/9/13 noted the following: "... In order to bed hold, the Resident or legal representative or agent must complete, sign, and submit the Facility's Bed Hold Agreement within twenty-four (24) hours of discharge..." 2)Resident (R) 10 is 16-year-old who female who was admitted to an acute care facility on 02/28/22. On 07/15/22 at 09:31 AM, a concurrent record review (RR) and interview was done with the Health Information Associate (HIA) who stated that a bed hold agreement was not given to the family for resident (R)10. On further questioning, a bed hold agreement was not done as well. HIA stated that she had not been aware of a written notification needing to be sent. HIA further stated that normally a copy of the bed hold agreement is given to the family upon transfer/discharge to an acute care hospital; however, it was not sent this time. RR did not reveal a copy of bed hold agreement.	F 625	An in-service will be held by the Social Services Director with the Charge Nurse staff, Health Information Associate, and Unit Clerk to remind them of our Bed Hold Policy and Agreement on August 19, 2022. Included in this in-service will be discussion about our new procedures. The Social Services Director will log transfers and discharges on the newly created Transfer/Discharge Tracking Form and whether the Bed Hold Agreement was received by the family, or a conversation occurred covering the same. Results will be reported to the quarterly QA/QI Committee meeting.	

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F 761	Continued From page 15	F 761		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility's policy and procedure, and interview with staff members the facility failed to ensure all medications used in the facility were securely stored in locked compartments. This deficient practice has the potential to affect all residents in the facility by increasing the risk of injury for any resident, or visitor who can access the medication cart.	F 761	Preliminary staff education was done on August 5, 2022, by the Director of Nursing to discuss locking of the medication carts when not attended. An audit sheet was created on July 20, 2022, to monitor all six medication carts daily x 2 weeks for every shift, then 3 days a week x 2 weeks for every shift, then 1 day a week x 1 week. After this period, carts will be randomly	8/19/22

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F 761	Continued From page 16 Findings Include: On 07/12/22 at 08:19 AM, while entering the facility, observed an unlocked and unattended medication cart. Inquired with Director of Nursing (DON) if the medication cart should be locked, DON immediately locked the cart and confirmed it should have been locked. On 07/12/22 at 03:41 PM, as the Assistant Director of Nursing (ADON) approached this surveyor, observed an unlocked and unattended medication cart. Inquired with ADON if the medication cart should be unlocked and unattended, ADON stated it should have been locked. On 07/15/22 at 09:52 AM observed an unlocked and unattended medication cart outside of resident rooms. Observed Registered Nurse (RN) 3 approach the medication cart and RN3 confirmed she was assigned to the medication cart. Inquired if the medication cart should be unlocked and unattended, RN3 stated she had to get a disinfecting spray and confirmed it should have been locked. Review of the facility's policy and procedure "MEDICATION STORAGE IN THE FACILITY" revised on January 2018 documents "Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications are permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access.	F 761	audited for compliance. Further in-servicing will be done by the Director of Nursing on August 19, 2022 with the nursing staff. Cart 6 is moved in front of the Medication Room when the cart is shared among multiple nursing staff. The shared cart key is kept in the Medication Room and returned when not in use. Audits will be done by the Director of Nursing, Assistant Director of Nursing or designee. Results will be reported at the quarterly QA/QI Committee meetings.	