STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125046	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

(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) COMPLETE DATE
4 000	Initial Comments A relicensure survey was conducted by the Office of Health Care Assurance (OHCA) on August 2-10, 2022. The facility was not in compliance with Title 11 Chapter 94.1. ACTS #9494, 9555, 9561, 9662 was also investigated and unsubstantiated. Survey Census: 60 Sample Size: 24	4 000		
4 102	11-94.1-22(d) Medical record system (d) Records to be maintained and updated, as necessary, for the duration of each resident's stay shall also include: (1) Appropriate authorizations and consents for medical procedures; (2) Records of all periods, with physician orders, of use of physical or chemical restraints with justification and authorization for each and documentation of ongoing assessment of resident during use of restraints; (3) Copies of initial and periodic examinations and evaluations, as well as progress notes at appropriate intervals; (4) Regular review of an overall plan of care setting forth goals to be accomplished through individually designed activities, therapies, and treatments, and indicating which professional services or individual is responsible for providing the care or service; (5) Entries describing all care, treatments, medications, tests, immunizations, and all ancillary services provided; and	4 102		9/16/22

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4 102	Continued From page 1 (6) All physician's, physician assistant's, or APRN's orders completed with appropriate documentation (signature, title, and date). This Statute is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to accurately document that Resident (R) 36 was experiencing symptoms of losing consciousness in his medical record. As a result of this deficient practice, R36 was put at an increased risk for injuries. Findings include: On 08/02/22 at 01:43 PM, a concurrent observation and interview was done with R36. R36 was observed sitting in bed, with the head of the bed up at 45 degrees. R36's bed mattress was approximately elevated 2 feet off the ground. R36's bed also had handler bars approximately 6 inches in length located approximately 6 inches from the top of the mattress. R36 had amputations below both knees. He was alert and oriented to person, time, and place and answered questions appropriately. His eyes appeared gray and cloudy. He was able to move his body, grabbing items from his bedside table. He stated that he was legally blind and had an internal cardiac defibrillator. He then suddenly sat up straight on the bed and was silent for approximately 10 seconds. He was unresponsive to surveyor's inquiries if he was okay. He then forcefully laid down backwards in bed, groaned, and turned his head to the right until it touched the right handler bar. His body also shifted to right side of the bed. He stopped moving. He was then silent and unresponsive to surveyor's inquiries if he was okay. Surveyor stated out loud	4 102	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. 1. Resident # 36 was discharged. Licensed nurses caring for resident were inserviced regarding documentation of residents condition by the Staff Developer. Inservices will be ongoing as needed. 2. Facility residents have the potential to be affected by this alleged practice. 3. Licensed nurses were inserviced regarding documentation of residents condition by the Staff Developer / DON/designee. Inservices will be ongoing as needed. 4. DON / Unit managers /designee will monitor compliance through observations on rounds and medical record reviews weekly for a minimum of 12 weeks or until compliance is achieved. The results of these observation and record review audits will be brought to the monthly Quality Assurance and Performance meeting for a minimum of three months or until compliance is achieved.	

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4 102	Continued From page 2	4 102		

to R36 that she will leave to get R36's nurse. Surveyor then left R36's room to contact Nurse (N) 3. Surveyor explained to N3 her observation of R36 during their interview. N3 stated that R36 has episodes of low blood pressure and a toothache. At 01:44 PM, N3 and surveyor went to R36's room and found R36's lying in bed. R36 stated that he was hot and dizzy and had tooth pain. RN3 proceeded to lower R36's head of the bed and take R36's vital signs.

On 08/02/22 at 01:47 PM, an interview was done with R36 where surveyor asked R36 what happened during their interview. R36 stated he remembered being interviewed by the surveyor and then the next thing he remembered was lying in bed asking out loud if the surveyor had any more questions.

On 08/02/22 at 01:48 PM, an interview was done with N3. Surveyor repeated to N3 that R36 had become suddenly unresponsive during their interview, fallen backwards in bed and groaned, stopped moving and remained silent, did not answer surveyor's repeated questions if he was okay, and did not remember becoming unresponsive during the interview. N3 responded that he has a toothache and will alert the doctor.

On 08/03/22 at 10:00 AM, R36's medical record was reviewed. "Progress Note" dated 08/02/22 at 04:49 PM, N3 documented, "At approx. 1400 (02:00PM), resident complained of dizziness and laid down in bed. Head of bed down and foot of bed elevated due for possible low blood pressure. VS (vital signs) collected BP (blood pressure) 120/61, P (pulse) 80, 96% on RA (Room air), T (temperature) 96.7F (Fahrenheit), and RR (respiratory rate) 19. Blood glucose 191 mg/dL. At this time resident sat up in bed and HOB (head

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4 102	Continued From page 3	4 102		

of bed) elevated. No dizziness reported. About 5 minutes later resident called out for this CN and asked for oxygen. Resident complained of shortness of breath with no dizziness or chest pain. Resident sating at 98% on RA but still insisted that oxygen by applied. Nasal cannula on and resident sating 98% on 1 lpm. Mouth assessed due to resident complaining of pain and discomfort to right back tooth, last tooth on the right is black in color with the base of tooth white. Resident stable with no other concerns at this time. MD (medical doctor) called and aware of resident tooth and change in condition. MD ordered dental appointment and to start antibiotic Augmentin 500mg BID (twice a day) x 2 weeks. Dental appointment on 08/05/22 and Augmentin with start tonight. Endorsed." No documentation was found regarding surveyor's observation reported to N3 that R36 had become unresponsive during his interview with surveyor on 08/02/22. Cross Reference to F689: Accidents

On 08/04/22 at 08:47 AM, R36 was observed laying in his bed with a rolled-up towel on top of his forehead. R36 stated that he was in bed when he "blacked out" and ended up on the floor. R36 stated that his roommate called staff for help and that he had a bump on his forehead.

On 08/04/22 at 09:09 AM, R36 was observed being transferred to the hospital.

"Progress Note" dated 08/05/22 at 01:48 PM, documented that a follow-up call was placed by the facility to R36's cardiology clinic who stated that "resident was admitted to hospital with diagnosis: Ventricular tachycardia status-post fall from bed and resident stating he had "blacked out". Inquired if reports in office show that his internal cardiac defibrillator (ICD) had been firing

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4 102	Continued From page 4 at the time of fall yesterday at 0830...report shows he was shocked at 0812 and 0835."	4 102		
4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: Based on observations, interviews, record reviews, and review of policy, the facility: 1) failed to ensure Resident (R)26 remained free of accident hazards, 2) failed to keep R36's bed in the lowest position resulting in a fall and a laceration to R36's head that required stitches, 3) failed to collect/secure smoking material (lighter) from Resident (R)17, and as a result put R17 as well as all other residents at risk for accident hazards. Findings include: 1) On 08/03/22 at 11:36 AM, conducted a record review of R26's Electronic Health Record (EHR).	4 136	1. Resident # 26 continues as a resident in the facility. A scoop mattress was ordered to provide additional safety for resident when turning. CNAs involved in the incident were inserviced regarding turning by the Staff Developer. Resident 36 was discharged. Resident 17□s lighter was secured at the nurses□ station. Licensed nurses on resident□s unit were inserviced regarding the smoking policy by the Staff Developer. Inservices will be ongoing as needed. 2. Facility residents have the potential to be affected by this alleged practice. 3. Licensed nurses and cnas were	9/16/22

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4 136	Continued From page 5 R26 was admitted with diagnosis that include chronic respiratory failure, quadriplegia, anoxic brain damage, tracheostomy, dysphagia, epilepsy, and contracture. The resident is unable to speak or move independently. On 04/26/22. R26 fell and sustained a laceration to his forehead that required stitches. A progress note documented R26 had an assisted fall onto the left side of his bed during a bed bath. Certified Nurse Aide (CNA)85 on the right side of the bed turned R26 and CNA63 (on the left side of the bed) held R26 and attempted to keep him on the bed but could not because of the resident's weight and uneven distribution of R26's body. R26 was sent out to the emergency room due to the amount of blood (coming from the injury to the resident's head). Review of the facility's Focused Clinical Event Review form documented the R26 was too heavy for CNA63 to hold and CNA85 (on the right side) was unable to help as R26 went to the floor. On 08/04/22 at 3:25 PM, conducted an interview with the Director of Nursing (DON) regarding R26's fall. The DON confirmed R26 is unable to move (quadriplegic), is totally dependent on staff to move, and staff was not able to manage the uneven distribution of weight resulting in the R26 falling. Inquired and requested to review documentation of staff training regarding safely turning R26. The DON stated the nurse manager had provided training but there was no documentation of the training or what the training consisted of. 2) On 08/02/22 at 01:43 PM, a concurrent observation and interview was done with R36. R36 was observed sitting in bed, with the head of the bed up at 45 degrees. R36's bed mattress	4 136	inserviced regarding turning procedures, fall precautions and smoking policy by the Staff Developer / DON/designee. Inservices will be ongoing as needed. 4. DON / Unit managers /designee will monitor compliance through observations on rounds weekly for a minimum of 12 weeks or until compliance is achieved. The results of these observation audits will be brought to the monthly Quality Assurance and Performance meeting for a minimum of three months or until compliance is achieved.	

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4 136	Continued From page 6	4 136		

was approximately elevated 2 feet off the ground. There were no fall mats on the floor. R36's bed also had handler bars approximately 6 inches in length located approximately 6 inches from the top of the mattress. R36 had amputations below both knees. He was alert and oriented to person, time, and place and answered questions appropriately. His eyes appeared gray and cloudy. He was able to move his body, grabbing items from his bedside table. He stated that he was legally blind.

A review of R36's electronic health record was done on 08/03/22 at 10:00 AM. "Resident Face Sheet" documented that R36 was admitted on 10/12/2016 for ischemic cardiomyopathy. He also has diagnoses of hypertensive heart and chronic kidney disease with heart failure, type 1 diabetes, bipolar disorder, major depressive disorder, legal blindness, presence of automatic implantable cardiac defibrillator (ICD), and acquired absence of both left leg and right leg below the knee. Minimum Data Set (MDS) Quarterly Review with assessment reference date (ARD) 06/20/22 documented a Brief Interview for Mental Status score of 15, meaning that R36 is cognitively intact. MDS with ARD 06/20/22, Section G documented that R36 requires one-person physical assist for bed mobility and transfers. Section H documented that R36 has no history of falls since admission.

On 08/04/22 at 08:47 AM, R36 was observed laying in his bed with a rolled-up towel on top of his forehead. The bed was observed to be 16 inches off the ground. R36 stated that he was in bed when he "blacked out" and ended up on the floor. R36 stated that his roommate called staff for help and that he had a bump on his forehead.

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4 136	Continued From page 7 On 08/04/22 at 09:09 AM, R36 was observed being transferred to the hospital. On 08/04/22 at 09:30 AM, a review of R36's medical record was done. R36's Care Plan stated, "Resident at Risk for falling related to impaired balance and use of antidepressant." The Care Plan stated, "Approach Start Date: 03/26/2020 ...Keep bed in lowest position with brakes locked." On 08/04/22 at 10:12 AM, a concurrent interview and observation was done with Certified Nursing Assistant (CNA) 1. CNA 1 stated that she was feeding another resident when she was called to R36's room because he had fallen. CNA1 stated that Nurse (N) 3 was there and R36 was on the ground. CNA1 stated that the height of R36's bed when she entered R36's room was approximately 2 feet high. CNA1 stated the bed was then lowered and staff transferred him from the ground to the bed. On 08/04/22 at 10:20 AM, a concurrent interview and observation was done with N3 in R36's room. N3 stated that this morning she was alerted by R36's roommate that something was happening in their room. N3 stated she went to check R36's room and found R36 on the ground. R36 was on the left side of the bed on the ground and was lying down on his right side. N3 stated he was able to talk and that he had a bump in the middle of his forehead. N3 stated that she called CNA1 for help. N3 stated that R36's bed was higher off the ground when she found R36 and that one of the staff lowered the bed afterwards. N3 observed the bed in R36's room and confirmed that R36's bed was now in the lowest position (16 inches off the floor) and that R36's bed was higher than 16 inches when she found R36 on the	4 136		

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floor. When asked about R36's care plan that stated to keep bed in the lowest position, N3 stated that R36's bed is usually higher than 16 inches off the floor and that he prefers it higher than 16 inches. N3 stated that she was not sure whether R36 was educated on keeping his bed in the lowest position.

On 08/04/22 at 12:06 PM, Resident Care Manager was interviewed. RCM reviewed R36's care plan and confirmed that the care plan documented to keep bed in the lowest position with breaks locked. RCM stated that there is no facility policy on what height is the standard for the lowest bed position.

On 08/05/22 at 10:00 AM, "Incident Report" dated 08/04/22 was reviewed. "Incident Report" stated that R36 had a fall at 08:30 AM and that resident stated "I don't know. I was on the bed and the next thing I know I heard you and I was on the floor ...My head kind of hurts." "Incident Report" stated "Resident reported hitting head on floor. Red lump to middle of forehead. Ice." "Incident Report Witness Statement" dated 08/04/22 by N3 stated that R36 was eating breakfast at the time of the fall and that prior to the fall resident did not attempt to get out of bed. N3 also stated "No" to the question "Did the resident have safety devices intact (i.e. mats, alarms, low bed) at the time of the fall?".

On 08/05/22 at 01:19 PM, a concurrent record review and observation was done with the Director of Nursing. DON reviewed "Johns Hopkins Fall Risk Assessment Tool" dated 06/14/22 and confirmed that R36 had a fall risk score of 9 points meaning that R36 had a "Moderate Fall Risk". DON stated that interventions for Moderate Fall Risk would be to

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4 136	Continued From page 9	4 136		

have the bed in the lowest position. DON then observed R36's bed in R36's room. DON pressed the height button to lower R36's bed and stated that the bed would be in the lowest position once it stops moving towards the ground. The bed did not move. DON confirmed that R36's bed should always be at this height (approximately 16 inches off the ground) as this would be the lowest position for R36's bed. DON stated that R36 prefers his bed to be higher than 16 inches. DON stated that he could not confirm whether R36 was educated on the purpose of keeping his bed being in the lowest position and that R36's preference of having the bed higher was not documented in his care plan.

3) During an observation and concurrent interview on 08/03/22 at 02:20 PM, R17 had a lighter stored in the bedside bottom drawer. R17 stated that the lighter was stored there after the last smoking session and that he was not aware that it should have been handed over to the nursing staff and stored in the medication cart.

During staff interview on 08/03/22 at 02:30 PM, Nurse (N)4 acknowledged that the smoking material (lighter) should have been collected from R17 and stored in the medication cart.

Review of facility policy on Smoking revealed the following pertinent statements: Purpose, ... to provide a comprehensive and explicit policy governing the parameters of resident smoking to accommodate all residents and remain with Federal & State Law. To stay in compliance with F-Tag 323; 483.25(h) Accidents and Supervision and F-Tag 242; 483.15(B) Self-determination and Participation, and 42 CFR 483.15(g) (1)(F250) meeting the physical and emotional needs of each resident, and 42 CFR 483.15(d)(F245) to

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4 136	Continued From page 10 accommodate an individuals ' needs and choices for how she/he spends time, both inside and outside the facility, 483.90(h)(5) smoking safety and takes into account nonsmoking residents. All residents/guest that smoke ...3. Will adhere to this policy & procedure ... 6. Resident/guest will be required to return smoking material (lighter / matches / cigarettes) to Charge Nurse/or designee upon returning from smoking area.	4 136		
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty- first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided. This Statute is not met as evidenced by:	4 149		9/16/22

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4 149	Continued From page 11 Based on interview and record review, the facility failed to develop a baseline care plan that included the minimum healthcare information necessary to safely care for one resident Resident (R)156 sampled. Findings include: On 08/03/22 at 2:16 PM, conducted a record review of R156's Electronic Health Record (EHR). R156 was admitted to the facility on 07/22/22 with diagnosis that include cardiomyopathy, congestive heart failure, hypertension, and chronic obstructive pulmonary disease (COPD). Review of the Physician Orders documented R156 was ordered Furosemide (strong diuretic and may cause dehydration and electrolyte imbalance) 40 milligrams (MG) once a day on 07/22/22. Review of R156's baseline care plan (completed on 07/23/22) did not include management of the ordered medication to ensure the resident would not experience dehydration or electrolyte imbalance. On 08/03/22 at 3:12 PM, conducted a concurrent record review and interview with the Director of Nursing (DON). DON confirmed the medication (furosemide) was not included on R156's baseline care plan and should have been due to the "how easy it is for a resident to become dehydrated if the input and output of fluids is not addressed properly."	4 149	1. Resident # 156 has been discharged. MDS Coordinator, Staff Developer and Unit managers were inserviced regarding base line care plans and medications by the Director of Nursing. Inservices will be ongoing as needed. 2. Newly admitted residents have the potential to be affected by this alleged practice. 3. Licensed nurses were inserviced by the Staff Developer / DON/designee regarding comprehensive base line care plans and medications. Inservices will be ongoing as needed. 4. To ensure compliance, MDS Coordinator / Unit managers will audit baseline care plans through record review weekly for a minimum of 12 weeks or until compliance is achieved. The results of these audits will be brought to the monthly Quality Assurance and Performance meeting for a minimum of three months or until compliance is achieved.	
4 175	11-94.1-43(c) Interdisciplinary care process (c) The overall plan of care shall be reviewed periodically by the interdisciplinary team to determine if goals have been met, if any changes are required to the overall plan of care,	4 175		9/16/22

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PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

(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) COMPLETE DATE
4 175	Continued From page 12 and as necessitated by changes in the resident's condition. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure comprehensive person-centered care plan was implemented for one resident Resident (R)30 sampled. As a result of this deficiency, the resident is at risk for potential harm due to constipation. Findings include: Cross reference to F760- Medication Errors On 08/03/22 at 10:05 AM, conducted a record review of R30's Electronic Health Record (EHR). Review of the resident's care plan documented a care plan for pressure ulcers related to incontinence of bowels and bladder with an approach (intervention) to ensure bowel movement (BM) at least every 2-3 days, use laxatives as ordered. Review of the R30's Medication Administration Record (MAR) documented the resident has routinely scheduled medications and three (3) as needed (PRN) medications to for constipation. The resident's PRN medications are: -Milk of Magnesia (MOM) suspension 400 mg/5 ml; 30 ml, if no BM in 2 days -Bisacodyl 10 mg suppository, if no BM in 3 days -Enema 19-7 grams/118 ml, if no BM in 4 days Review of R30's Vital Report and June/July MAR documented R30's BM as: 06/02/22 at 10:19 AM- large BM	4 175	1. Resident #30 bowel regimen was reviewed and protocol implemented as needed. Unit managers were inserviced regarding following the bowel protocol to prevent possible constipation by the Director of Nursing. Inservices will be ongoing as needed. 2. Residents on the bowel protocol have the potential to be affected by this alleged practice. 3. Licensed nurses were inserviced by the Staff Developer / DON/designee regarding following the bowel protocol to aid in preventing constipation. Inservices will be ongoing as needed. 4. To ensure compliance, unit managers will audit residents medication administration record, bowel records and medical record weekly for a minimum of 12 weeks or until compliance is achieved. The results of these audits will be brought to the monthly Quality Assurance and Performance meeting for a minimum of three months or until compliance is achieved.	

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4 175	Continued From page 13 06/03/22- no BM 06/04/22- no BM 06/05/22 at 5:49 PM- small BM. R30 should have received MOM 30 mg but did not. 06/20/22 at 9:32 PM- medium BM 06/21/22- no BM 06/22/22- no BM 06/23/22- no BM. R30 should have received MOM 30 mg but did not. 06/24/22 at 3:49 PM. R30 should have received Bisacodyl 10 mg suppository but did not. 07/02/22 at 1:05 PM- large BM 07/03/22- no BM 07/04/22- no BM 07/05/22- no BM. R30 should have received MOM 30 mg but did not. 07/06/22- no BM. R30 should have received Bisacodyl 10 mg suppository but did not. 07/07/22 at 01:59 AM- medium BM 07/07/22 at 06:09 AM- small BM 07/08/22- no BM 07/09/22- no BM 07/10/22- no BM. R30 should have received MOM 30 mg but did not. 07/11/22- no BM. R30 should have received Bisacodyl 10 mg suppository but did not. 07/12/22- no BM. R30 should have received an enema but did not. 07/13/22- no BM. R30 was administered Bisacodyl 10 mg suppository at 11:01 PM. 07/14/22 at 03:01 AM- medium BM 07/16/22 at 8:12 PM- large BM 07/17/22- no BM 07/18/22- no BM 07/19/22- no BM. R30 should have received MOM 30 mg but was administered Bisacodyl 10 mg suppository at 10:52 PM. 07/20/22- large BM	4 175		

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4 175	Continued From page 14 07/21/22- no BM 07/22/22- no BM 07/23/22- no BM. R30 should have received MOM 30 mg but was administered Bisacodyl 10 mg suppository at 11:09 PM. 07/24/22 at 03:14 AM- large BM On 08/04/22 at 3:30 PM, conducted a concurrent record review of R30's EHR and interview with the Director of Nursing (DON). DON stated R30 is always incontinent of bowels and lacks the ability to communicate bowel/constipation needs. DON confirmed R30 was not administered PRN medication as ordered and indicated in the resident's care plan to treat the resident's constipation.	4 175		
4 192	11-94.1-46(i) Pharmaceutical services (i) Appropriately licensed and trained staff shall be responsible for the entire act of medication administration, which entails removing an individual dose from a container properly labeled by a pharmacist or manufacturer (unit dose included), verifying the dosage with the physician's orders, giving the specified dose to the proper resident, and promptly recording the time, route, and dose given to the resident, and signing the record. Only a licensed nurse, physician, or other individual to whom the licensed professional has delegated the responsibility pursuant to chapter 16-89, subchapter 15, may administer medications. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure medications were administered	4 192	1. Resident # 156 has been discharged. Unit managers were inserviced regarding	9/16/22

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4 192	Continued From page 15 as ordered for one resident Resident (R)156 sampled. As a result of this deficiency, the resident had unrelieved constipation and could potentially experience harm if not addresses. Findings include: 1) On 08/03/22 at 11:37 PM, conducted a record review of R156's Electronic Health Record (EHR). Review of R156's Physician Orders documented orders for Milk of Magnesium (MOM) if no bowel movement (BM) in 3 days, Dulcolax suppository 10 milligrams (mg) if no BM by MOM in the morning, and Enema if no result from Dulcolax suppository by the morning, notify the doctor if no BM from enema. Review of the care plan (initiated on 07/27/22), interventions for management of the resident's BM include administering medications as needed for BM. Review of R156's Vital Report (staff documented resident's BM) documented R156 had a bowel movement on 07/27/22 then the next BM was on 07/31/22 (4 days). On 08/4/22 at 3:12 PM, conducted a concurrent record review (of R156's EHR) and interview with the Director of Nursing (DON). After reviewing R156's Physician Orders, Medication Administration Record, and Vitals Report (BM), DON confirmed R156 should have received MOM on 07/30/22 but the medication was not administered as ordered. Cross Reference to F656- Implementation of Care Plan 2) On 08/03/22 at 10:05 AM, conducted a record review of R30's Electronic Health Record (EHR). Review of the resident's care plan documented a care plan for pressure ulcers related to	4 192	following the bowel protocol to prevent possible constipation by the Director of Nursing. Inservices will be ongoing as needed. 2. Residents on the bowel protocol have the potential to be affected by this alleged practice. 3. Licensed nurses were inserviced by the Staff Developer / DON/designee regarding following the bowel protocol to aid in preventing constipation. Inservices will be ongoing as needed. 4. To ensure compliance, unit managers will audit residents medication administration record, bowel records and medical record weekly for a minimum of 12 weeks or until compliance is achieved. The results of these audits will be brought to the monthly Quality Assurance and Performance meeting for a minimum of three months or until compliance is achieved.	

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4 192	Continued From page 16 incontinence of bowels and bladder with an approach (intervention) to ensure bowel movement (BM) at least every 2-3 days, use laxatives as ordered. Review of the R30's Medication Administration Record (MAR) documented the resident has routinely scheduled medications and three (3) as needed (PRN) medications to for constipation. The resident's PRN medications are: -Milk of Magnesia (MOM) suspension 400 mg/5 ml; 30 ml, if no BM in 2 days -Bisacodyl 10 mg suppository, if no BM in 3 days -Enema 19-7 grams/118 ml, if no BM in 4 days Review of R30's Vital Report and June/July MAR documented R30's BM as: 06/02/22 at 10:19 AM- large BM 06/03/22- no BM 06/04/22- no BM 06/05/22 at 5:49 PM- small BM. R30 should have received MOM 30 mg but did not. 06/20/22 at 9:32 PM- medium BM 06/21/22- no BM 06/22/22- no BM 06/23/22- no BM. R30 should have received MOM 30 mg but did not. 06/24/22 at 3:49 PM. R30 should have received Bisacodyl 10 mg suppository but did not. 07/02/22 at 1:05 PM- large BM 07/03/22- no BM 07/04/22- no BM 07/05/22- no BM. R30 should have received MOM 30 mg but did not. 07/06/22- no BM. R30 should have received Bisacodyl 10 mg suppository but did not.	4 192		

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4 192	Continued From page 17 07/07/22 at 01:59 AM- medium BM 07/07/22 at 06:09 AM- small BM 07/08/22- no BM 07/09/22- no BM 07/10/22- no BM. R30 should have received MOM 30 mg but did not. 07/11/22- no BM. R30 should have received Bisacodyl 10 mg suppository but did not. 07/12/22- no BM. R30 should have received an enema but did not. 07/13/22- no BM. R30 was administered Bisacodyl 10 mg suppository at 11:01 PM. 07/14/22 at 03:01 AM- medium BM 07/16/22 at 8:12 PM- large BM 07/17/22- no BM 07/18/22- no BM 07/19/22- no BM. R30 should have received MOM 30 mg but was administered Bisacodyl 10 mg suppository at 10:52 PM. 07/20/22- large BM 07/21/22- no BM 07/22/22- no BM 07/23/22- no BM. R30 should have received MOM 30 mg but was administered Bisacodyl 10 mg suppository at 11:09 PM. 07/24/22 at 03:14 AM- large BM On 08/04/22 at 3:30 PM, conducted a concurrent record review of R30's EHR and interview with the Director of Nursing (DON). DON stated R30 is always incontinent of bowels and lacks the ability to communicate bowel/constipation needs. DON confirmed R30 was not administered PRN medication as ordered and indicated in the resident's care plan to treat the resident's constipation.	4 192		
4 203	11-94.1-53(a) Infection control	4 203		9/16/22

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4 203	Continued From page 18 (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to 1) ensure infection control practices were implemented to help prevent the development and transmission of communicable diseases and infections, 2) label Resident (R) 206's tube feeding formula, saline flush bag, and tube feeding syringe appropriately. As a result of this deficiency, residents are at a higher risk of contracting or developing and infection that could affect their health and potential harm the residents. Findings include: 1) On 08/04/22 at 08:45 AM, observed Kitchen Staff (KS)1 enter a room in the Yellow Zone. KS1 entered the room wearing a face shield, surgical mask, gown, gloves, and a backward baseball cap. KS1 exited the room with a face shield and a surgical mask. KS1 walked out of the yellow zone past the sign, then turned around and went back towards the room to wipe the face shield. KS1 did not don an new surgical mask before exiting the Yellow Zone. On 08/04/22 at 09:05 AM, conducted an interview with the DON (current Infection Preventionist until position is filled). The DON explained Resident (R)156 was newly admitted, unvaccinated, and in the Yellow Zone under quarantine. Inquired what	4 203	1. The staff member was inserviced by the DON regarding appropriate infection control practices when entering and leaving a Yellow Zone. R # 156 has been discharged. Signage for zones was reviewed and updated as needed. Resident #206□s tube feeding bag, tubing and syringe were replaced with labeled supplies. Licensed nurse involved was inserviced regarding labeling and changing tube feeding supplies by Staff Developer. Inservices will be ongoing as needed. 2. Facility residents have the potential to be affected by this alleged practice. 3. Facility staff were re-inserviced regarding infection control practices and procedures, signage precautions and labeling tube feeding supplies by the Staff Developer / DON/designee. Inservices will be ongoing as needed. 4. DON / Unit managers /designee will monitor compliance through observations on daily rounds weekly for a minimum of 12 weeks or until compliance is achieved. The results of these audits will be brought to the monthly Quality Assurance and Performance meeting for a minimum of three months or until compliance is achieved.	

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4 203	Continued From page 19	4 203		

protective equipment (PPE) staff should use when entering rooms in the Yellow Zone. Shared observation of KS1's personal usage in the Yellow Zone with the DON. The DON confirmed KS1 should not have cleaned the face shield immediately after exiting the room and prior to exiting the Yellow Zone area and should have worn an N95 mask into the resident's room.

Inquired with the DON regarding no signs posted outside the Yellow Zone rooms as to how staff knew what type of PPEs they were supposed to don before going into a room on the Yellow Zone if there were no signs posted informing/reminding staff. DON confirmed there were no signs posted because the facility uses a color coded system to identify the type of PPEs they should use. Shared an interview that was conducted on 08/04/22 at 08:50 am with Registered Nurse (RN)9 regarding staff's knowledge of the type of PPEs that should be worn in the Yellow Zone. RN9 stated if staff was vaccinated a surgical mask could be worn in the room, but if staff was unvaccinated they had to wear a N95 mask. The DON confirmed RN9's was incorrect and N95 mask should be worn by all staff in the rooms located in the Yellow Zone.

2) On 08/02/22 at 10:04 AM, R206's tube feeding formula bag, saline flush bag, and tube feeding flush syringe was observed hanging on an intravenous pole in R206's room. The tube feeding formula bag had formula in it. The tube feeding formula bag was not labeled with the resident's name, date, name of the formula, the amount to be given, nor the frequency of feedings. The tube feeding formula bag tubing was not labeled. The saline bag and its tubing were also not labeled. The tube feeding flush syringe was hanging in a plastic bag and was

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4 203	Continued From page 20 also not labeled. On 08/02/22 at 10:27 AM, a concurrent interview and observation was done with Resident Care Manager (RCM). RCM observed R206's tube feeding formula bag, saline bag, and tube feeding flush syringe and confirmed that there were no labels on all the items. RCM stated that the tube feeding formula bag, saline bag, and tube feeding flush should be labeled with the resident's name, date, and time. RCM stated that a new tube feeding formula bag is hanged every night and should have been labeled appropriately. On 08/03/22 at 04:0 PM, a record review of R206's "Physician Order Report" indicated that R206 had an order for "Fibersource HN liquid; 0.05 gram-1.2 kcal/ml; amt: 375 ml; feeding tube ...Four times a day; 09:00, 13:00, 17:00, 21:00." On 08/04/22 at 09:00 AM, a review of the facility's policy, "Enteral Tube Feeding: Intermittent" dated 12/15/21 was done. The policy stated, "Procedure: 6d. Label all bags, tubing, and containers with the Resident's name and the date and time the items were opened for use. Label the bag with the name of the formula, the amount to be given, and frequency of the feedings."	4 203		
4 243	11-94.1-64(a) Engineering and maintenance (a) The facility shall maintain all essential mechanical, electrical, and resident care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a safe environment for one resident Resident (R)26 sampled. As a result of	4 243	1. Resident # 26□s oxygen concentrator was replaced. Director of Nursing inserviced licensed nurse on duty	9/16/22

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4 243	Continued From page 21 this deficiency, there is the potential for harm for residents that use oxygen machines with concentrators. Findings include: Conducted an observation of R26 on 08/02/22 at 12:31 PM. The resident had a tracheostomy and was connected to an oxygen machine. Inspection of the oxygen concentrator revealed the humidifier canister was fastened to the concentrator by a purple bungee cord. Additionally, the oxygen concentrator was plugged into a power strip along with the resident's bed power cord. On 08/05/22 at 10:50 AM, conducted a concurrent interview and observations of R26's oxygen concentrator with the Director of Nursing (DON). The DON confirmed the oxygen concentrator should have been plugged directly into the red (emergency power) outlet and not into a power strip. The DON stated that the humidifier canister was fastened onto the concentrator by a bungee because the manufacturer's holder for the machine was broken. Pointed out to the DON that the bungee cord alone could not prevent the canister from slipping out from the bottom. The DON acknowledged the canister could slip out the bottom from the bungee cord.	4 243	regarding appropriate oxygen concentrator function and usage. Inservices will be ongoing as needed. 2. Residents using oxygen concentrators have the potential to be affected by this alleged practice. 3. Licensed nurse and CNAs were inserviced regarding appropriate oxygen concentrator function and usage by the Staff Developer/ designee. Inservices will be ongoing as needed. 4. DON / Unit managers /designee will monitor compliance through observations on daily rounds weekly for a minimum of 12 weeks or until compliance is achieved. The results of these audits will be brought to the monthly Quality Assurance and Performance meeting for a minimum of three months or until compliance is achieved.	