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

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F 000	INITIAL COMMENTS A recertification and extended survey was conducted by the Office of Health Care Assurance (OHCA) on August 2-10, 2022. The facility was not in compliance with 42 CFR 483 Subpart B. ACTS #9494, 9555, 9561, 9662 was also investigated and unsubstantiated. Survey Census: 60 Sample Size: 24	F 000		
F 623 SS=F	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-	F 623		9/16/22

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

Electronically Signed | 09/05/2022

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F 623	Continued From page 1 (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part	F 623		

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F 623	Continued From page 2 C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide proper notification of discharge or transfer to four residents sampled. Residents (R) 13, 48, 157 and 206 were discharged or transferred without receiving written notification of their discharge or transfer, their right to appeal the discharge, or contact information for the Office of the State LTC [long-term care] Ombudsman (LTCO). This deficient practice has	F 623	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.	

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F 623	Continued From page 3 the potential to affect all residents at the facility who are discharged or transferred. Findings include: On 08/04/22 at 05:57 PM, a review of R206's electronic health record (EHR) indicated that R206 was transferred to the hospital on 07/10/22 and admitted for hyponatremia. R206 was discharged and returned to the facility on 07/25/22. On 08/04/22 at 06:07 PM, a review of R13's EHR indicated that R13 was transferred to the hospital on 06/20/22 and admitted for generalized weakness. R13 was discharged and returned to the facility on 06/24/22. On 08/05/22 at 11:18 AM, a concurrent record review and interview was done with facility's Discharge Planner (DP). DP reviewed R206's "Notice of Resident Discharge/Transfer" and stated that she notified R206's family member of R206's transfer by phone on 07/11/22 but did not mail out a written notice of transfer to R206's family member. DP also stated R13's family representative was not provided with a written notice of transfer. On 08/05/22 at 11:20 AM, Social Worker (SW) was interviewed. SW stated that the facility has not been sending written notification to the families about resident transfers and that the facility needs to redo their whole system of providing these written notifications to the residents and their representatives. On 08/04/22 at 01:00 PM, a review of R48's EHR indicated that R48 was transferred to the hospital	F 623	1. Residents 13, 48, 157 and 206 were provided a notice of discharge/transfer. Social Services and Administrator were inserviced by the Director of Operations regarding notice requirements of discharge or transfer. Inservices will be ongoing as needed. 2. Facility residents being transferred or discharged have the potential to be affected by this alleged practice. 3. Notice will be provided before or at the time of discharge or transfer. In those cases where an emergency transfer occurs, a notice will be mailed/or given to the responsible party within 72 hours or asap by Social Service. Licensed nurses and social service assistants were inserviced by the Social Service Director regarding this practice and the form. Inservices will be ongoing as needed. 4. Social Service / Administrator and/or designee will audit for compliance through record review and observations on transfers and discharges 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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F 623	Continued From page 4 on 07/05/22 and admitted for Gastro-intestinal Bleeding. R48 was re-admitted to the Nursing Facility on 07/13/22. On 08/04/22 at 01:20 PM, SW stated that the facility has not been sending written notification to the families about resident transfers. On 08/04/22 at 10:08 AM, conducted a review of R157's EHR. R157 was transferred to the hospital on 07/09/22 and admitted (resident remains it the hospital) to rule out Gastro-intestinal Bleeding due to lethargy and black tarry stool. On 08/04/22 at 1:30 PM, inquired with the SW regarding R157's notification of transfer. SW provided the facility's Notice of Transfer form for R157, the form was not signed by R157 and there was a handwritten note on the form that R157 was notified by phone that per the facility's policy, the facility does not hod beds. SW confirmed the form was not presented to R157 upon transfer to the hospital and the resident will receive the form when the resident returns to the facility. Also, the SW could not provide documentation that a copy of the notice was sent to a representative of the Office of the State Long-Term Ombudsman.	F 623		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following.	F 626		9/16/22

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F 626	Continued From page 5 (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of policy, the facility failed to establish and/or implement a policy to permit residents to return to the facility following hospitalization or therapeutic leave. As a result of this deficiency, there was potential for discharged residents and/or residents on therapeutic leave to not be allowed to return to their previous room or upon the first available bed.	F 626	1. Social Service Director and the Administrator was inserviced by the Director of Operations on the policy that permits residents to return to the facility after a hospitalization or therapeutic leave. Inservices will be ongoing as needed. 2. Facility residents having a hospitalization or therapeutic leave have the potential to be affected by this alleged	

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F 626	Continued From page 6 Findings include: During record review of the discharge for Resident (R)157, it was noted that the facility did not have a written policy for permitting residents to return to the facility after hospitalization or residents on therapeutic leave. During interview on 08/05/22 at 10:00 AM, Administrator (Admin) concurrently reviewed the facility Policy on Transfer or Discharge and acknowledged that it did not have anything about permitting residents to return to the facility, such as returning to their previous room if available or allowing residents to return immediately upon the first available bed, following hospitalization or therapeutic leave. Review of current policy on Transfer or Discharge read the following: Policy Statement, when a resident/guest is transferred or discharged, details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care community or provider ...	F 626	practice. 3. Notice will be provided before or at the time of transfer or leave. In those cases where an emergency transfer occurs, a notice will be mailed/or given to the responsible party within 72 hours or asap by Social Service. Licensed nurses and social service assistants were inserviced by the Social Service Director regarding this practice and the form. Inservices will be ongoing as needed. 4. Social Service / Administrator and/or designee will audit for compliance through record review and observations on transfers and therapeutic leaves 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.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.	F 655		9/16/22

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F 655	Continued From page 7 The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a baseline care plan that included the minimum healthcare information	F 655	1. Resident 156 has been discharged. MDS Coordinator, Staff Developer and Unit managers were inserviced regarding	

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F 655	Continued From page 8 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."	F 655	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.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		9/16/22

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F 656	Continued From page 9 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure comprehensive person-centered care plan was implemented for one resident	F 656	1. Resident # 30□s care plan was reviewed and updated as needed. Director of Nurses inserviced the MDS	

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F 656	Continued From page 10 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 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	F 656	Coordinator, Staff Developer and Unit managers regarding comprehensive care plans. Inservices will be ongoing as needed. 2. Facility residents have the potential to be affected by this alleged practice. 3. Licensed nurses were inserviced by the Staff Developer / DON/designee regarding comprehensive care plans. Inservices will be ongoing as needed. 4. To ensure compliance, MDS Coordinator / Unit managers will audit 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.	

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F 656	Continued From page 11 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 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	F 656		

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F 656	Continued From page 12 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.	F 656		
F 689 SS=H	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on 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).	F 689	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 # 36 did not receive a laceration or sutures when he fell. 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	9/16/22

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F 689	Continued From page 13 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	F 689	be affected by this alleged practice. 3. Licensed nurses and cnas were 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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F 689	Continued From page 14	F 689		

the bed up at 45 degrees. R36's bed mattress 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

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F 689	Continued From page 15 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. 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	F 689		

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F 689	Continued From page 16	F 689		

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 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

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F 689	Continued From page 17 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 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 689		

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F 689	Continued From page 18 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 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.	F 689		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure medications were administered 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	F 760	1. Resident # 156 has been discharged. 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.	9/16/22

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F 760	Continued From page 19 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 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	F 760	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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F 760	Continued From page 20 -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. 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.	F 760		

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F 760	Continued From page 21 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.	F 760		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records.	F 842		9/16/22

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F 842	Continued From page 22 §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches	F 842		

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F 842	Continued From page 23 legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT 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	F 842	1. Resident #36 was discharged. Licensed nurses involved in his care were inserviced by the Staff Developer regarding documentation of resident□s condition, observations and changes. Inservices will be ongoing. 2. Facility residents have the potential to be affected by this alleged practice. 3. Licensed nurses were inserviced regarding documentation of residents□ condition, observations and changes by the Staff Developer / DON/designee. Inservices will be ongoing as needed. 4. DON / Unit managers /designee will monitor compliance through medical record review audits 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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	125046	A. BUILDING _____ B. WING _____	08/10/2022

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F 842	Continued From page 24	F 842		

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 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.

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F 842	Continued From page 25 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 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.	F 842		

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F 842	Continued From page 26 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 at the time of fall yesterday at 0830...report shows he was shocked at 0812 and 0835."	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		9/16/22

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F 880	Continued From page 27 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 28 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, 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 protective equipment (PPE) staff should use when entering rooms in the Yellow Zone. Shared observation of KS1's personal usage in the	F 880	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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F 880	Continued From page 29 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 also not labeled.	F 880		

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F 880	Continued From page 30 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."	F 880		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT 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	F 921	1. Resident # 26□s oxygen concentrator was replaced. Director of Nursing inserviced licensed nurse on duty	9/16/22

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F 921	Continued From page 31 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.	F 921	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.	