STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING _____ B. WING _____	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 10/03/2022 to 10/06/2022. The facility was not in substantial compliance with 42 CFR §483 Subpart B. Survey dates: 10/03/2022 to 10/06/2022 Census: 34 Sample size: 12	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		10/28/22

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

Electronically Signed | 10/30/2022

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews, and facility policy review, the facility failed to ensure a dependent resident was dressed in a manner to maintain the resident's dignity for 1 (Resident #14) of 2 sampled residents reviewed for dignity. Findings included: Review of an undated facility policy titled, "Resident Bill of Rights," revealed, "The facility will treat you with dignity and respect in full recognition of your individuality." Review of an "Admission Record" revealed Resident #14 had a diagnosis of essential (primary) hypertension (high blood pressure). Review of a significant change Minimum Data Set (MDS), dated 08/06/2022, revealed Resident #14 was severely impaired in cognitive skills for daily	F 550	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. - #14 the care plan dated as initiated 07/14/2022 will be reviewed and modified to reflect and address the residents current status and any planned intervention. - The MDSC will revise and update the care plan to ensure the prevention of skin impairment and discomfort to hand by utilizing proper positioning. - The MDSC will revise and update the care plan to prevent bruising, and interventions will be discussed with the nursing staff. - Resident #14 is being ordered a palm grip protector instead of using socks, and is currently using a brand-new wash cloth	

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F 550	Continued From page 2 decision-making per a staff assessment for mental status. The MDS indicated the resident was totally dependent on one-person assistance for dressing. Observation on 10/03/2022 at 11:00 AM revealed Resident #14 in bed, wearing non-skid socks on both hands. Observation on 10/06/2022 at 10:46 AM revealed Resident #14 in bed, not wearing a sock on either hand. No bruising or scratches were noted to the resident's arms/hands. During an interview on 10/05/2022 at 1:25 PM, Certified Nursing Assistant (CNA) #3 and CNA #6 stated Resident #14 wore socks on both hands due to hand contractures, because the resident wanted to prevent cuts to the palms of the hands. During an interview on 10/05/2022 at 2:09 PM, the Director of Nursing (DON) stated Resident #14 wore socks on both hands because of the resident scratching their back and face. The DON could not recall whether any other interventions were attempted prior to applying the socks. The DON did not respond when asked if she thought wearing socks on the hands was dignified. As of 10/05/2022, a review of the resident's care plan, dated as initiated 07/14/2022, revealed the resident was at risk for pressure ulcer and other skin impairment related to incontinence of dependence with activities of daily living. The care plan also indicated the resident used a left hand roll related to a contracture and was at risk for skin impairment and discomfort to the hand. The care plan did not address any issues with the resident scratching and there was no	F 550	rolled up and changed daily. How the facility will identify other residents having the potential to be affected by the same deficient practice. - The DON and the ID Team will review each residents care plan quarterly to ensure accurate reporting of a residents status. - DON/designee and SWD conducted a residents audit to make sure that all residents were dressed in a manner that preserves their dignity. For those residents who dont have appropriate clothing, their family were informed and encouraged to get clothing that portrays residents dignity. What measures will be put into place or systematic changes made to ensure that the deficient practice does not recur. - All new admission assessment will be reviewed by the DON and the ID Team will review comprehensive care plans for all new admissions. - After the ID Team reviews the care plan, the MDSC will meet with all Certified Nurse Aides to review interventions. - All preventive interventions will be placed in the PCC tasks (EHR) for daily monitoring. - A mandatory staff training will be completed between 11/ 7/22 - 11/10/22 on Resident Rights for all shifts to re-educate staff on dressing residents in a manner to	

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F 550	Continued From page 3 documentation of a planned intervention to apply socks to the resident's hands. During an observation and interview with the DON on 10/05/2022 at 2:55 PM, Resident #14 was in bed, wearing a non-skid sock on the right hand. The DON stated Resident #14 used to be able to scratch, but there had been a change in condition, and she did not think the resident could scratch anymore. The DON removed the sock from Resident #14's right hand and did not put it back on. During an interview on 10/06/2022 at 9:07 AM, the Social Services (SS) employee stated she was aware staff were putting socks on Resident #14's hands. The SS employee stated staff were protecting Resident #14's skin from self-scratching/pinching. She indicated the staff had been applying the socks to the resident's hands for about two weeks. SS stated having socks on the resident's hands was not dignified.	F 550	preserve their dignity and will be conducted by the SWD. How the facility plans to monitor its performance to make sure that solutions are sustained. - A comprehensive audit tool will be utilized by the DON for a weekly round or until compliance is verified to make sure that all residents are dressed in a manner to preserve their dignity. The DON/designee will complete weekly audits by interviewing 5 residents or resident representatives per week for 12 weeks to ensure the plan of correction is effective or until complete compliance has been achieved. The QAPI committee will determine the need for further auditing after the initial 12 weeks. - Results of the weekly audits and findings will be presented by the DON/designee to the staff every week during staff meeting and quarterly QAPI meeting and any negative concerns will be addressed promptly.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and	F 584		10/28/22

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F 584	Continued From page 4 homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews, and facility policy review, the facility failed to provide a homelike environment for 3 (Residents #9, #22, and #24) of 34 residents whose rooms were observed. Specifically, the facility failed to ensure the shared room of	F 584	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. - The extra bed in the room were	

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F 584	Continued From page 5 Residents #9, #22, and #24 was not used for storage of supplies and equipment. Findings included: Review of a facility policy titled, "Safe/Clean/Comfortable/Homelike Environment Policy," dated 1/2012, revealed, "The facility must provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible." Review of a quarterly Minimum Data Set (MDS), dated 07/27/2022, revealed Resident #9 was severely impaired in cognitive skills for daily decision-making per a staff assessment for mental status. Review of a quarterly MDS, dated 08/26/2022, revealed Resident #22 was severely impaired in cognitive skills for daily decision-making per a staff assessment for mental status. Review of a quarterly MDS, dated 08/31/2022, revealed Resident #24 was severely impaired in cognitive skills for daily decision-making per a staff assessment for mental status. Observation on 10/03/2022 at 11:06 AM revealed the 4-bed room shared by Residents #9, #22, and #24 was being used for storage. The extra bed in the room had cardboard boxes stored on it, and a mechanical lift was also stored in the room. Observation on 10/04/2022 at 9:27 AM revealed the room shared by Residents #9, #22, and #24 continued to be used for storage. There was a large unopened box of incontinence briefs on the nightstand and two large boxes of briefs on the	F 584	subsequently cleared of the cardboard boxes and the mechanical lift was relocated to a storage unit. - The DON and ID Team discussed with Bristol Hospice and all hospice supplies were moved to a new storage unit designated only for hospice supplies. How the facility will identify other residents having the potential to be affected by the same deficient practice. - All residents using medical equipment have the potential to be affected by the same deficient practice. - The Office Manager and SWD made rounds throughout facility to ensure no other resident rooms were being used as storage and will continue to make quarterly rounds or until compliance is achieved. What measures will be put into place or systematic changes made to ensure that the deficient practice does not recur. - The housekeeping and nursing staff will be re-in serviced on the policy and procedure for storage of medical equipment by the housekeeping manager. How the facility plans to monitor its performance to make sure that solutions are sustained. - A bi weekly audit of the cleaning and	

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F 584	Continued From page 6 extra bed in the room. The mechanical lift also remained in the room. Observation on 10/05/2022 at 10:19 AM revealed a closet in the room shared by Residents #9, #22, and #24 was being used to store incontinence briefs, pads, perineal cleanser, shampoo and body wash, oxygen equipment, wipes, gauze pads, abdominal (ABD) pads, and suction kits. During an interview on 10/05/2022 at 10:17 AM, Certified Nursing Assistant (CNA) #1 stated the closet in the room shared by Residents #9, #22, and #24 was used as a hospice stock room for all the residents in the building who required those supplies, and the mechanical lift was stored in the room for use by all residents in the building who required mechanical lift transfers. During an interview on 10/06/2022 at 9:05 AM, the Social Services (SS) employee stated the room shared by Residents #9, #22, and #24 was used for hospice storage. The SS stated since the facility did not have storage space for hospice, they decided to use the empty bed in the residents' room for storage. SS acknowledged the use of the room for storage did not contribute to a homelike environment. During an interview on 10/06/2022 at 2:55 PM, the Director of Nursing (DON) stated she was not aware the shared resident room was being used for storage. She stated residents' rooms should not be used for storage. The Administrator was not available for interview during the survey.	F 584	storage of medical equipment will be done by the housekeeping manager for the next 6 months and the results of the audit will be reported to the administrator and at the QAPI meeting by the housekeeping manager for any comments and recommendations for the next 6 months.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan	F 656		10/28/22

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F 656	Continued From page 7 CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR 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.	F 656		

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F 656	Continued From page 8 (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 observation, record review, and interviews, the facility failed to develop a care plan to address hand contractures for 1 (Resident #28) of 2 sampled residents who had hand contractures. This had the potential to affect 11 residents who had contractures, per the Resident Census and Conditions of Residents form dated 10/03/2022. Findings included: During an interview on 10/06/2022 at 3:57 PM, the Director of Nursing (DON) stated she was looking for a care plan policy. A care plan policy had not been provided as of the end of the survey. Review of an "Admission Record" revealed Resident #28 had diagnoses that included Alzheimer's disease. Review of an annual Minimum Data Set (MDS) dated 09/09/2022 revealed Resident #28 was severely impaired in cognitive skills for daily decision-making per a staff assessment for mental status. The MDS indicated the resident was totally dependent for activities of daily living (ADLs). According to the MDS, the resident had no functional limitation in range of motion in the upper or lower extremities. During an observation on 10/03/2022 at 10:30 AM, Resident #28 was in bed. Both hands had	F 656	How the corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice - A comprehensive care plan policy was updated by the Admin and DON to ensure that all resident will have personalized care plan tailored to their individual needs - #28 the MDSC will ensure the resident have complete and accurate care plan that accurately reflect the resident□s status with personalized interventions. #28□s care plan was updated with person-centered approaches in regards to the upper extremities contractures. How the facility will identify other residents having the potential to be affected by the same deficient practice - All current and new residents have the potential to be affected by the same deficient practice What measures will be put into place or systematic changes made to ensure that the deficient practice does not recur - A facility wide audit was completed to verify all residents who have contractures	

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F 656	Continued From page 9 contractures. There was a rolled towel in the resident's left hand. No device was in place in the right hand. As of 10/03/2022, review of Resident #28's care plan revealed it did not address hand contractures or restorative nursing services. During an observation and interview with the DON on 10/05/2022 at 2:15 PM, the DON stated Resident #28's hands were not contracted and that the resident used hand rolls to protect the skin, because the fingernails touched the resident's palm. The DON attempted to demonstrate passive range of motion on Resident #28's hands but was unable to open them. The DON initially stated that Resident #28 was resisting but concluded after an additional attempt that the hands were contracted. The DON acknowledged Resident #28 had contractures in both hands. During an interview on 10/06/2022 at 2:55 PM, the Director of Nursing (DON) stated if a resident had contractures, this should be addressed on the care plan.	F 656	have accurate and person-centered approaches to their care plans related to the contracture - #28 the MDSC will update and revise the care plan and provide an in-service for all Certified Nurse Aides and nursing staff about interventions to prevent further contractures How the facility plans to monitor its performance to make sure that solutions are sustained - The MDSC will review the care plans of all residents who have contractures weekly to ensure that the care plan accurately reflects the goals and interventions in place to manage or improve contracture - As residents develop contractures via assessments or as residents are admitted with contractures, they will be added to the targeted list and this monitoring will continue for 4 consecutive weeks or until zero findings has been achieved - Contracture care plans will be monitored weekly for no less than 6 months to ensure ongoing compliance with contracture acre plans, then after that, random monitoring will occur and any issues/concerns will be addressed - A comprehensive care plan audit tool will be utilized for a quarterly review by the DON - The MDSC will in-service all nursing staff on the importance of proper documentation and accurate care planning that is personalized and will be	

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F 656	Continued From page 10	F 656	reviewed by the DON, and any failure to follow in-service points will result in further education - At the monthly QAPI meetings, the results of the contracture care planning by the MDSC will be reviewed and any concerns will be addressed and an action plan by the ID Team will be written and will be monitored by the Administrator weekly until resolved	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure nursing care was provided in accordance with accepted standards of practice for Resident #2 and Resident #24. Specifically, the facility: - failed to ensure assistance with repositioning was promptly provided to promote comfort for 1 (Resident #2) of 1 sampled resident reviewed for positioning. - failed to ensure neurological (neuro) checks were consistently conducted and documented after an unwitnessed fall for 1 (Resident #24) of 3 sampled residents reviewed for accidents.	F 684	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. - The nursing facility has put in place a positioning policy and procedure and the DON will in-service all nursing staff to ensure correct compliance with the policy. - #2 the MDSC will revise and update plan of care to include interventions for repositioning and a non-skid padding has been provided for the resident. - All Certified Nurse Aides will be	10/28/22

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F 684	Continued From page 11 Findings included: 1. During an interview on 10/06/2022 at 3:02 PM, the Director of Nursing (DON) stated she was looking for the facility's policy on positioning. No policy was provided by the end of the survey. Review of an "Admission Record" revealed the facility admitted Resident #2 on 06/07/2022 with diagnoses that included unspecified dementia with behavioral disturbance and history of falling. Review of a quarterly Minimum Data Set (MDS), dated 09/20/2022, revealed Resident #2 was severely impaired in cognitive skills for daily decision-making per a staff assessment for mental status. According to the MDS, the resident required extensive assistance with bed mobility, was totally dependent for transfers and locomotion, and did not walk. During an observation on 10/03/2022 at 1:06 PM, Resident #2 was sitting in a wheelchair. The resident had slid down into a slightly slouched position. During an observation on 10/05/2022 at 9:54 PM, Resident #2 was sitting in the wheelchair in a slouched position. The wheelchair was in the upright position, and Resident #2's feet were dangling above the floor. Further observations on 10/05/2022 revealed the following: - At 10:00 AM, Certified Nursing Assistant (CNA) #2 approached the resident and adjusted the blanket but did not assist the resident to reposition in the wheelchair. - At 10:10 AM, Resident #2 attempted to scoot up	F 684	educated on the use of non-skid padding on the resident (s) Geri chair. - Those residents in the last week/quarter with an unwitnessed fall have been reviewed to ensure they have had neurological assessments done. If neurological assessments were not performed, a neurological assessment were performed and any negative outcomes were communicated to the physician. - The nursing facilitys clinical guideline on Neurological Assessment has been reviewed and revised by the DON to clarify neurological monitoring for unwitnessed fall and witnessed fall when there is a head injury/trauma. - Nurses have been re-educated by the DON on the performance expectations to meet facilitys professional standards. - The DON will conduct weekly audits of all unwitnessed and witnessed falls will be completed for 4 weeks or until 100% compliance of neurological assessment compliance is achieved. How the facility will identify other residents having the potential to be affected by the same deficient practice. - Residents with poor posture and residents that exhibits restlessness will be affected by the same deficient practice. - A weekly plan of care updates review will be conducted by the MDSC, and interventions will be monitored by the charge nurse.	

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F 684	Continued From page 12 in the chair. Activity Assistant (AA) #1 moved Resident #2's overbed table but did not assist the resident to reposition in the wheelchair. Resident #2 pushed on the arms of the wheelchair and attempted to scoot up in the chair but was unsuccessful. - At 10:21 AM, Resident #2 remained in the wheelchair. The resident's legs were elevated but the resident remained in a slouched position. The resident attempted to scoot up in the chair by pushing with one foot but was unsuccessful. During an interview on 10/05/2022 at 11:47 AM, CNA #3 and CNA #6 stated Resident #2 sometimes slid down in the reclining wheelchair, but that they would reposition the resident. During an observation on 10/06/2022 at 9:11 AM, Resident #2 was sitting in the reclining wheelchair with legs elevated. The resident had slid down in the chair, and the resident's lower back was resting on the wheelchair's seat. Further observations on 10/06/2022 revealed the following: - At 9:15 AM, Registered Nurse (RN) #1 approached Resident #2, gave the resident a blanket, and walked away without assisting the resident to scoot up in the chair. - At 10:34 AM, Resident #2 remained in a slouched position in the wheelchair, and the resident's lower back was resting on the seat of the chair. During an interview on 10/06/2022 at 10:38 AM, CNA #3 was asked why the resident's back was positioned on the seat of the wheelchair. The	F 684	What measures will be put into place or systematic changes made to ensure that the deficient practice does not recur. - The DON will conduct a random plan of care review on a quarterly basis to ensure that preventive measures are implemented. How the facility plans to monitor its performance to make sure the solutions are sustained. - A quarterly plan of care audit will be conducted by the DON. - Visual monitoring will be done by conducting routine rounds by the DON/designee and ID team members will discuss residents care needs with residents or representatives to ensure that residents are being repositioned in a timely manner. - Findings from the positioning and neuro check monitoring will be reviewed quarterly in the QAPI meeting.	

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CNA stated Resident #2 always slid down in the chair. When asked if any interventions had been attempted to assist the resident with maintaining a comfortable position in the chair, CNA #3 stated no but that she would try putting something in the chair.

During an observation on 10/06/2022 at 10:49 AM, CNA #3 and CNA #4 repositioned Resident #2 and placed a rolled blanket under the resident's knees.

During an interview on 10/06/2022 at 2:55 PM, the Director of Nursing (DON) stated if the resident was sliding down in the wheelchair, staff should have repositioned the resident. The DON stated a non-slip mat should have been placed in the chair to prevent the resident from sliding down.

2. Review of a facility policy titled, "Fall Protocol Policy," revised January 2005, revealed, "In case of fall, the following protocol/policy shall be applied: 1. Assess resident by the RN [Registered Nurse]; 2. Check for injuries; if applicable for First Aid intervention; 3. Report any noted injury to the Physician; 4. Report to the DON [Director of Nursing] or Administrator (if applicable); 5. Notify the family. 6. Apply First Aid as applicable and initiate Physician's orders/instructions; 7. Prepare incident report by the staff concerned; 8. Follow neurological protocol and monitor vital signs within 72 hours (if applicable) with required charting." Review of the attached, "Observation of Neurological Signs" policy (not dated) revealed, "The purpose of this observation is to detect clinical manifestations of increased intracranial pressure [a rise in the pressure inside the skull that can result from or cause brain injury]."

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Additionally, the policy indicated neurological signs and vital signs were to be monitored every 15 minutes times (x) 4, then every 30 minutes x 2, then every four hours x 5. The policy included a blank copy of a "Neurological Assessment Flow Sheet," which included instructions for completing the neuro checks, including checking the resident's level of consciousness, pupil response, motor functions, pain response, and vital signs.

Review of an "Admission Record" revealed Resident #24 had diagnoses that included neurocognitive disorder with Lewy bodies (decreased mental function due to abnormal build-up of proteins into masses known as Lewy bodies) and malignant neoplasm of the brain (brain cancer).

Review of a quarterly Minimum Data Set (MDS), dated 08/31/2022, revealed Resident #24 was severely impaired in cognitive skills for daily decision-making per a staff assessment of mental status. The MDS indicated the resident required extensive assistance with bed mobility and transfer and had no falls since admission, reentry, or the prior assessment.

Review of an "Incident Report," dated 02/23/2022, revealed Resident #24 had an unwitnessed fall. The probable cause was a sit/slide from bed. No injuries were noted. The section of the report titled, "Medical/Emergency Actions/Administered" included an option to check that neurological monitoring was initiated; however, this option was not checked. There was no "Neurological Assessment Flow Sheet" with the Incident Report.

During an interview on 10/05/2022 at 2:45 PM,

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Registered Nurse (RN) #2 stated he was working when Resident #24 fell on 02/23/2022. RN #2 stated the resident's family had gone home, and the resident was restless. Staff had just provided incontinence care about 30 minutes prior to the fall. RN #2 stated neurological checks were started and were done every 15 minutes for the first hour and then "went from there."

Review of "Progress Notes" revealed the following:

- The note dated 02/23/2022 at 9:50 PM, revealed a Certified Nursing Assistant (CNA) reported the resident was "on the ground" at 8:28 PM. Upon the nurse's arrival to the room, the resident was lying beside the bed crying for help. The resident was assessed, and no injury was noted. The resident was placed back in bed. The note did not address whether neuro checks were initiated. The next "Progress Note" in the clinical record was dated 02/24/2022 at 2:47 AM.

- The "Progress Note" dated 02/24/2022 at 2:47 AM indicated there was no change in the resident's level of consciousness; no other information related to neuro checks was included in this note. The next "Progress Note" in the clinical record was dated 02/24/2022 at 12:59 PM.

- The "Progress Note" dated 02/24/2022 at 12:59 PM indicated, "Continue neuro check." The note indicated the resident was alert and that the blood pressure was 96/52. No other neurological assessment information was included. There were no further "Progress Notes" referencing neuro checks related to the resident's fall on 02/23/2022.

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F 684	Continued From page 16 During an interview on 10/06/2022 at 9:47 AM, RN #1 stated when a resident had an unwitnessed fall, there should be neurological checks, even if the resident looked okay. During an interview on 10/06/2022 at 8:20 AM, the Director of Nursing (DON) stated she was attempting to find a "Neurological Assessment Flow Sheet" for Resident #24 but did not know where it was. The DON stated neurological checks should have been done. The Administrator was not available for interview during the survey.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 688		10/28/22

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F 688	Continued From page 17 Based on observations, record review, and interviews, the facility failed to ensure care and services were provided to prevent further potential decline in range of motion (ROM) for 2 (Resident #14 and Resident #28) of 2 sampled residents who had hand contractures. Specifically, the facility failed to: - regularly provide passive range of motion (PROM) exercises for Resident #14 and Resident #28. - promptly identify and address a contracture to Resident #14's right hand. - promptly identify and address bilateral hand contractures for Resident #28. - ensure licensed nursing staff regularly assessed to determine if range of motion was intact for Resident #14 and Resident #28. Findings included: 1. Review of an "Admission Record" revealed Resident #14 had diagnoses including age-related osteoporosis and essential hypertension. Review of a significant change in status Minimum Data Set (MDS), dated 08/06/2022, revealed Resident #14 scored a three on the staff assessment for mental status, indicating severe cognitive impairment. The MDS indicated the resident had functional limitation in range of motion (ROM) to the upper extremity on one side. Review of an "Order Summary Report" revealed Resident #14 had a physician's order dated 06/02/2021 which indicated, "May use hand rolls." Review of a care plan, dated 07/15/2022, revealed Resident #14 used a hand roll in the left	F 688	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. - A contracture/Restorative policy will be put in place and nursing staff will be educated on the importance of assessing for mobility. - Resident #14 A plan of care was put into place, and the nursing staff is documenting the ROM services provided for resident #14. - A comprehensive care plan policy was updated by the Admin and DON to ensure that all resident will have personalized care plan tailored to their individual needs. - #28 the MDSC will ensure the resident have complete and accurate care plan that accurately reflect the residents status with personalized interventions. #28s care plan was updated with person-centered approaches in regards to the upper extremities contractures. How the facility will identify other residents having the potential to be affected by the same deficient practice. - All current and new residents have the potential to be affected by the same deficient practice. - A complete list of all residents was complied and the DON met with a trained Certified Nurse Aide to review and assess all residents needing ROM based on physical function, limitations, and risk for decreased mobility. Certified Nurse Aides	

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F 688	Continued From page 18 hand related to a contracture. The goal was for the resident's left hand contracture not to worsen and for comfort to be maintained. Interventions included applying the hand roll as ordered, monitoring the skin under the hand roll for redness or swelling three times a day as ordered, and providing passive range of motion to the left hand three times daily. Review of a "Task: Rehab - Range of Motion" report, with entries dated from 08/08/2022 through 09/25/2022, revealed Resident #14 received passive range of motion (PROM) exercises on 08/08/2022, 08/09/2022, 08/11/2022, 08/12/2022, 08/23/2022, and 08/29/2022. The ROM task was marked as "not applicable" on 08/22/2022, 09/04/2022, and 09/25/2022. There were no other entries on the report. During an interview on 10/05/2022 at 1:25 PM, Certified Nursing Assistants (CNAs) #3 and #6 revealed Resident #14 wore socks on both hands because they were contracted. The CNAs stated they did PROM with Resident #14 daily. During an interview on 10/05/2022 at 2:09 PM, the Director of Nursing (DON) stated the physician was informed of Resident #14's contracture to the left hand but was unable to confirm when this was done. The DON stated Resident #14 only had a contracture in one hand. The DON stated the doctor ordered a hand roll for the left hand, and the hand roll stayed in the resident's hand 24 hours at a time. During an observation and interview with the DON on 10/05/2022 at 2:15 PM, the DON confirmed both of Resident #14's hands were	F 688	were notified about residents assessed to receive ROM. All residents discharged from therapy in the last 60 days were also reviewed including those currently on therapy. What measures will be put into place or systemic changes to ensure that the deficient practice does not recur. - The DON will do a monthly audit of all residents to determine which resident will benefit from ROM. - The ROM audit will be completed by the DON monthly for 6 months or until complete compliance has been achieved and the audits will be reviewed at the QAPI meeting by the DON and the ID Team and plan of next action adjusted accordingly. How the facility plans to monitor its performance to make sure that solutions are sustained. - A quarterly ROM audit will be conducted by the DON and findings will be reviewed at the quarterly QAPI meeting by the DON and the ID Team and any plan of next action will be adjusted accordingly.	

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contracted.

During an observation on 10/06/2022 at 10:46 AM, Resident #14 was observed with hand rolls applied to both hands.

During an interview on 10/06/2022 at 2:55 PM, the DON stated she was looking for documentation and assessments for Resident #14's contractures. No documentation was received to indicate the facility identified and addressed the right hand contracture prior to 10/06/2022.

2. Review of an "Admission Record" revealed the facility admitted Resident #28 on 08/30/2021 with diagnoses that included Alzheimer's disease and chronic kidney disease.

Review of an annual Minimum Data Set (MDS), dated 09/09/2022, revealed Resident #28 was severely impaired in cognitive skills for daily decision-making per a staff assessment for mental status. The MDS indicated the resident had no functional limitation in range of motion.

Review of a "Task: Rehab - Range of Motion" report, with entries dated from 06/26/2022 through 09/25/2022, revealed Resident #28 received PROM exercises on 08/08/2022, 08/09/2022, 08/11/2022, 08/12/2022, 08/23/2022, and 08/29/2022. The ROM task was marked as "not applicable" on 06/26/2022, 07/31/2022, 08/22/2022, 08/28/2022, 09/11/2022, and 09/25/2022. There were no other entries on the report.

During an observation on 10/03/2022 at 1:40 PM, Resident #28 was in bed with a towel in the left

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hand, which was contracted. The right hand was also contracted, but there was no device in place.

During an observation on 10/04/2022 at 1:40 PM, Resident #28 was in bed with a folded towel in the right hand and nothing in the left hand.

As of 10/05/2022, review of Resident #28's care plan revealed it did not address contractures or restorative nursing services. Review of an "Order Summary Report" revealed Resident #28 had no physician's orders related to contractures.

During an interview on 10/05/2022 at 2:08 PM, when asked how contractures were identified, the Director of Nursing (DON) stated the Certified Nursing Assistants (CNAs) would report if a resident was stiff. The DON stated monitoring of contractures was documented in the progress notes. The DON stated all residents received PROM whether they had a contracture or not. The DON stated if a resident had a very stiff contracture, therapy would be contacted to evaluate whether the resident needed a splint or device, but therapy had not been contacted for any current facility residents. The DON stated Resident #28 was "not listed as contracted" but was stiff when the CNAs performed ROM exercises. The DON stated when the CNAs provided care, the resident's arms were stiff but when the resident was relaxed, the arms were no longer stiff, so the resident was "not contracted."

During an observation and interview with the Director of Nursing (DON) on 10/05/2022 at 2:15 PM, the DON stated Resident #28's hands were not contracted and that the resident used hand rolls to protect the skin, because the fingernails touched the resident's palm. The DON attempted

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F 688	Continued From page 21 to demonstrate passive range of motion on Resident #28's hands but was unable to open them. The DON initially stated that Resident #28 was resisting but concluded after an additional attempt that the hands were contracted. The DON acknowledged Resident #28 had contractures in both hands. During an interview on 10/06/2022 at 9:21 AM, Certified Nursing Assistant (CNA) #5 stated that if she noticed a resident had stiffness in their joints, she would provide ROM exercises and would notify the nurse. CNA #5 stated she performed ROM exercises with Resident #28and informed the nurse of the resident's contractures, but she was not sure when. During an interview on 10/06/2022 at 9:47 AM, Registered Nurse (RN) #1 stated contractures were monitored by the CNAs. During an interview on 10/06/2022 at 2:55 PM, the DON stated she was looking for documentation of assessments related to Resident #28's contractures. No documentation was received. The Administrator was not available for interview during the survey.	F 688		
F 728 SS=D	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless-	F 728		10/28/22

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F 728	Continued From page 22 (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on document review, interviews, and facility policy review, the facility failed to ensure a nursing assistant (NA) who was a full-time employee completed the required competency exam for certification within four months of hire for 1 (NA #1) of 1 NA reviewed for competencies.	F 728	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. - The facility will not use any Nurse Aides (NA) to provide nursing related services.	

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HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

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F 728	Continued From page 23 Findings included: Review of the facility's staffing schedule for October 2022 revealed the facility employed a non-certified nursing assistant (NA #1) on a full-time basis. Review of an untitled and undated facility document with staff credentials and hire dates revealed NA #1 was hired 01/24/2022 and was not certified. During an interview on 10/05/2022 at 12:45 PM, the Director of Nursing (DON) was asked when NA #1 would be certified. The DON stated NA #1 was working on getting her certification, but the DON was not sure "what her plan is." The DON indicated she was not sure what training the NA had received or whether she had taken Certified Nursing Assistant (CNA) courses. The DON stated NA #1 assisted the CNAs with feeding, toileting residents, assisting with transfers, and changing incontinent briefs. During an interview on 10/05/2022 at 3:04 PM, the DON stated the Business Office Manager (BOM) was responsible for training and competencies, including verification of certification; however, the BOM was on vacation at this time. During an interview on 10/06/2022 at 8:20 AM, the DON stated the facility did not have a policy related to the use of NAs. During an interview on 10/06/2022 at 1:54 PM, NA #1 verified she was not certified and stated she had taken CNA classes but did not take the exam. She stated she was trained by another	F 728	How the facility will identify other residents having the potential to be affected by the same deficient practice. - All current and new residents have the potential to be affected by the same deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur. - All new employees hired to provide nursing related services will be certified. - The facility will not hire NAs. - The Office Manager will verify certification prior to employment. - The Office Manager was re-educated by the Administrator on 11/2/22 on the responsibility of verifying certification prior to employment. How the facility plans to monitor its performance to make sure that solutions are sustained. - NAs were previously accepted to provide nursing related services on a temporary basis. In the future, the facility will provide specific dates as to when they will be terminated or reassigned to a different position. - The Office Manager will monitor certification and recertifications of Certified Nursing Assistants (CNAs) and	

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F 728	Continued From page 24 CNA on the proper way to bathe residents and change residents' incontinence briefs. The NA stated she assisted the CNAs as needed, with care such as manual and mechanical lift transfers, bathing, and changing incontinence briefs. She stated she assisted with activities and helped CNAs on the floor but not by herself. During an interview on 10/06/2022 at 2:55 PM, the DON was asked if she had located information regarding NA #1's training and stated she had not. The Administrator was unavailable for interview during the survey.	F 728	contact anyone with an upcoming expiration at 120 days, 90 days, 60 days, and 30 days, and also offer support in submitting application and process knowledge. An expired license or exceeding 120 days will result in termination. The Office Manager will audit the expiration files on a weekly basis for a period of 6 months and the findings of the audit will be reported to the ID Team during weekly Managers meeting and quarterly QAPI meeting to verify compliance.	
F 811 SS=D	Feeding Asst/Training/Supervision/Resident CFR(s): 483.60(h)(1)-(3) §483.60(h) Paid feeding assistants- §483.60(h)(1) State approved training course. A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if- (i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and (ii) The use of feeding assistants is consistent with State law. §483.60(h)(2) Supervision. (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). (ii) In an emergency, a feeding assistant must call a supervisory nurse for help. §483.60(h)(3) Resident selection criteria. (i) A facility must ensure that a feeding assistant	F 811		10/28/22

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F 811	Continued From page 25 provides dining assistance only for residents who have no complicated feeding problems. (ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. (iii) The facility must base resident selection on the interdisciplinary team's assessment and the resident's latest assessment and plan of care. Appropriateness for this program should be reflected in the comprehensive care plan. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews, and document review, the facility failed to ensure a paid feeding assistant provided dining assistance only for residents who had no complicated feeding problems and that decisions regarding which residents were appropriate to receive assistance from the paid feeding assistant were based on residents' assessments and plans of care for 2 (Resident #24 and Resident #30) of 2 sampled residents reviewed for feeding assistance. Findings included: During an interview on 10/06/2022 at 3:57 AM, the DON stated there was no feeding assistant policy. Review of a "Certificate of Completion," revealed Activity Aide (AA) #1 completed a "Temporary Feeding Assistant" program on 12/04/2021. 1. Review of an "Admission Record" revealed Resident #30 had diagnoses that included Alzheimer's disease and severe protein-calorie malnutrition.	F 811	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. - The facility will not use paid feeding assistants unless they have completed a State approved training course. - Paid feeding assistants will work under the supervision of a registered nurse (RN), and must call the RN for help in an emergency. The paid feeding assistant will only provide dining assistance to those residents who have no complicated feeding problems like residents with lung aspirations, difficulty swallowing or tube/IV feedings, and these residents will be selected based on the ID Teams assessment and the resident□s care plan assessment. How the facility will identify other residents having the potential to be affected by the same deficient practice. - All current and new residents have the	

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F 811	Continued From page 26 Review of a quarterly Minimum Data Set (MDS), dated 09/13/2022, revealed Resident #30 was severely impaired in cognitive skills for daily decision-making per a staff assessment for mental status. The MDS indicated the resident was totally dependent on one-person assistance with eating and received a mechanically altered diet. Review of a care plan, dated 10/03/2022, revealed Resident #30 had a swallowing problem related to a history of dysphagia (difficulty swallowing) and received a mechanically altered diet with thickened liquids. Interventions included instructing the resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly; monitoring for shortness of breath, choking, labored respirations, or lung congestion; and monitoring/documenting/reporting any signs/symptoms of dysphagia such as pocketing (holding food in the cheek/mouth), choking, coughing, several attempts at swallowing, refusing to eat, or appearing concerned during meals. During an observation on 10/05/2022 at 11:53 AM, AA #1 was feeding Resident #30 lunch. During an interview on 10/05/2022 at 12:41 AM, AA #1 stated she took an online course to assist residents with meals. During an observation on 10/06/2022 at 11:47 AM, AA #1 was feeding Resident #30 lunch. During an interview on 10/06/2022 at 11:13 AM, AA #1 stated she assisted anyone in the dining room who needed assistance with eating.	F 811	potential to be affected by the same deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur. - Employees who feed residents will complete a State approved training course. - The facility developed a policy for paid feeding assistants and which residents can receive assistance from the paid feeding assistants. How the facility plans to monitor its performance to make sure that solutions are sustained. - The Office Manager will monitor employees who become paid feeding assistants. - The DON/designee will assess/audit residents to determine if they are appropriate candidates to be fed by the paid feeding assistants and will monitor during meals daily to ensure that those residents who have been approved are being assisted by the paid feeding assistance. Selection of appropriate residents will be based on the ID Teams assessment and the residents care plan and selection will also be reflected in the residents comprehensive care plan and the findings/results of the audit will be reviewed in weekly Managers meeting and quarterly QAPI meeting.	

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F 811	Continued From page 27	F 811		

During an interview on 10/06/2022 at 2:55 PM, the Director of Nursing (DON) stated AA #1 fed whomever was in the dining room. The DON stated there was no selection process to determine which residents received assistance from AA #1.

2. Review of an "Admission Record" revealed Resident #24 had diagnoses including neurocognitive disorder with Lewy bodies (decreased mental function due to abnormal build-up of proteins into masses known as Lewy bodies) and malignant neoplasm of the brain (brain cancer).

Review of a quarterly Minimum Data Set (MDS), dated 08/31/2022, revealed Resident #24 was severely impaired in cognitive skills for daily decision-making per a staff assessment for mental status. The MDS indicated the resident displayed signs and symptoms of a swallowing disorder and received a mechanically altered diet. According to the MDS, the resident required extensive assistance with eating.

Review of a care plan, dated 09/06/2022, revealed Resident #24 had a swallowing problem related to coughing or choking during meals or when swallowing medications and held food in the mouth/cheeks. Interventions included:
- All staff to be informed of resident's special dietary and safety needs.
- Alternate small bites and sips. Use a teaspoon for eating. Do not use straws.
- Check mouth after meal for pocketed food and debris.
- May suction as needed (PRN) to maintain airway.
- Monitor for shortness of breath, choking,

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F 811	Continued From page 28 labored respirations, lung congestion. - Monitor/document/report any signs/symptoms of dysphagia: pocketing, choking, coughing, drooling, several attempts at swallowing, refusing to eat, appearing concerned during meals. - Resident to eat only with supervision. During an interview on 10/05/2022 at 12:41 AM, AA #1 stated she took an online course to assist residents with meals. During an interview on 10/06/2022 at 11:13 AM, AA #1 stated she assisted anyone in the dining room who needed assistance with eating. AA #1 stated she assisted Resident #24 "a lot." During an interview on 10/06/2022 at 2:55 PM, the Director of Nursing (DON) stated AA #1 fed whomever was in the dining room. The DON stated there was no selection process to determine which residents received assistance from AA #1.	F 811		
F 835 SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews, and document review, the facility's nursing administration failed to ensure processes were in place to promptly identify resident-specific care needs including range of motion/contracture	F 835	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.	10/28/22

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F 835	Continued From page 29 management and feeding assistance. Specifically, the facility: - failed to ensure licensed nursing staff regularly assessed residents to determine if their range of motion (ROM) was intact and determine if additional interventions were needed to address declines in range of motion. This failed practice affected 2 (Residents #14 and #28) of 2 sampled residents who had hand contractures. - failed to ensure a process was developed and implemented to ensure a paid feeding assistant provided dining assistance only for residents with no complicated feeding problems. This failed practice affected 2 (Residents #24 and #30) of 2 sampled residents reviewed for feeding assistance. Findings included: 1. During an interview on 10/06/2022 at 8:20 AM, the Director of Nursing (DON) stated there was no facility policy related to contractures or restorative nursing. During the survey conducted from 10/03/2022 to 10/06/2022, observations, record review, and interviews revealed Residents #14 and #28 had hand contractures that were not promptly identified and addressed. Refer to F688 for further details. During an interview on 10/05/2022 at 2:08 PM, when asked how contractures were identified, the DON stated there were not assessments for contractures but that the Certified Nursing Assistants (CNAs) would report if a resident was stiff. The DON stated monitoring of contractures was documented in the progress notes; however, the DON was unable to provide progress notes	F 835	- A contracture/Restorative policy will be put in place and nursing staff will be educated on the importance of assessing for mobility. - Resident #14 A plan of care was put into place, and the nursing staff is documenting the ROM services provided for resident #14. - A comprehensive care plan policy was updated by the Admin and DON to ensure that all resident will have personalized care plan tailored to their individual needs. - #28 the MDSC will ensure the resident have complete and accurate care plan that accurately reflect the residents status with personalized interventions. #28s care plan was updated with person-centered approaches in regards to the upper extremities contractures. - The facility will not use paid feeding assistants unless they have completed a State approved training course. How the facility will identify other residents having the potential to be affected by the same deficient practice. - All current and new residents have the potential to be affected by the same deficient practice. - A complete list of all residents was complied and the DON met with a trained Certified Nurse Aide to review and assess all residents needing ROM based on physical function, limitations, and risk for decreased mobility. Certified Nurse Aides were notified about residents assessed to receive ROM. All residents discharged	

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F 835	Continued From page 30 that demonstrated monitoring of contractures for Residents #14 and #28. The DON stated if a resident had a "very stiff" contracture, therapy would be contacted to evaluate whether the resident needed a splint or device; however, she confirmed that therapy had not been contacted for any current facility residents related to their contractures. The Administrator was not available for interview during the survey. 2. During an interview on 10/06/2022 at 3:57 AM, the DON stated the facility had no feeding assistant policy. Review of a "Certificate of Completion," revealed Activity Aide (AA) #1 completed a "Temporary Feeding Assistant" program on 12/04/2021. During the survey conducted from 10/03/2022 to 10/06/2022, observations, record review, interviews, and document review revealed AA #1 was providing feeding assistance to residents with known swallowing problems, including Residents #24 and #30, and that the facility had no process in place for identifying which residents were appropriate to receive feeding assistance by AA #1. Refer to F811 for further details. During an interview on 10/06/2022 at 2:55 PM, the Director of Nursing (DON) stated AA #1 fed whomever was in the dining room. The DON stated there was no selection process to determine which residents received assistance from AA #1.	F 835	from therapy in the last 60 days were also reviewed including those currently on therapy. - All current and new residents have the potential to be affected by the same deficient practice. What measures will be put into place or systemic changes to ensure that the deficient practice does not recur. - The DON will do a monthly audit of all residents to determine which resident will benefit from ROM. - The ROM audit will be completed by the DON monthly for 6 months or until complete compliance has been achieved and the audits will be reviewed at the QAPI meeting by the DON and the ID Team and plan of next action adjusted accordingly. -Employees who feed residents will complete a State approved training course. How the facility plans to monitor its performance to make sure that solutions are sustained. - A quarterly ROM audit will be conducted by the DON. - The Office Manager will monitor employees who become paid feeding assistants. - The Office Manager and SWD will monitor the removal of the straw, chop sticks, staff handling of utensils,	

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F 835	Continued From page 31	F 835	condiments, tray set-up, place mats set-up and meal tray set-up daily for 6 months or until complete compliance has been achieved to ensure that staff follow infection control practices throughout the process.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		11/1/22

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F 880	Continued From page 32 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. §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 and interviews, the facility failed to ensure staff implemented appropriate infection control practices during 3 of 3 meals	F 880	How the corrective action will be accomplished for those residents found to have been affected by the deficient	

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F 880	Continued From page 33 observed. Specifically, staff opened and handled residents' straws and chopsticks with their bare hands while preparing residents' beverages and setting up residents' meal trays. Findings included: On 10/05/2022 at 4:30 PM, Activity Aide (AA) #1 was observed placing straws in two beverages on a resident's meal tray with her bare hands, touching the ends that would go into the resident's mouth. On 10/06/2022 at 7:09 AM, Registered Nurse (RN) #1 was observed preparing water and juice for a resident. RN #1 opened straws and placed them in the cups, touching the straws at the ends that would go into the resident's mouth with bare hands. On 10/06/2022 at 11:17 AM, Certified Nursing Assistant (CNA) #1 was observed opening disposable chopsticks for Resident #15; CNA #1 touched both ends of the chopsticks with bare hands before giving them to the resident. On 10/06/2022 at 11:21 AM, CNA #1 opened straws for two drinks for a resident and touched the ends of the straws with bare hands before placing them in the drinks. On 10/06/2022 at 11:26 AM, AA #1 prepared three drinks for a resident and touched the end of one of the straws with bare hands before placing it in one of the drinks. On 10/6/2022 at 11:30 AM, RN #1 prepared two drinks for a resident and touched the ends of the straws with bare hands before placing them in the	F 880	practice. - Employees watched training videos that were sent with letter from the Department of Health - Videos that were watched included Sparkling Surfaces, Clean Hands, Keep COVID-19 Out!, and PPE Lessons - Employees signed attendance sheet showing that they watched all the videos How the facility will identify other residents having the potential to be affected by the same deficient practice. - All current and new residents have the potential to be affected by the same deficient practice What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur. - Infection control in-services will be continue to be conducted, with information included regarding infection control for dining practices. This includes hand hygiene, and proper handling of utensils or condiments in a sanitary manner. - If an employee is unable to correctly demonstrate how to unwrap utensils or how and when to perform hand hygiene, the proper method will be demonstrated. How the facility plans to monitor its performance to make sure that solutions	

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F 880	Continued From page 34 drinks. During an interview on 10/06/2022 at 2:55 PM, the Director of Nursing (DON) stated that when straws and chopsticks were opened, the two ends should not be touched. The Administrator was not available for interview during the survey.	F 880	are sustained. - The office manager, social work designee, or another designated employee will monitor dining related infection control practices at least monthly. - On-the-spot coaching will be provided for staff that do not perform these tasks properly. - In-services on infection control and prevention and how infections can spread throughout the facility will be conducted annually and as needed when problems are identified or new emerging infectious disease of concern are identified.	