STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING _____ B. WING _____	10/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE HILO, HI 96720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 10/14/22. The facility was found not to be in substantial compliance with 42 CFR 483, Subpart B. The highest severity/scope was a G. Actual harm was identified at §483.25(b)(1) Pressure Ulcers and §483.25(k) Pain Management. Two facility reported incidents related to allegations of abuse were invested (ACTS #9767 and #9776). There was no deficient practice cited related to these allegations. Survey Dates: 10/10/22 to 10/14/22 Survey Census: 58 Sample Size: 19	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	F 550		12/16/22

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

Electronically Signed | 11/17/2022

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F 550	Continued From page 1 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. §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 observation, interview and record review, the facility failed to treat residents with respect and dignity to promote maintenance or enhancement of his or her quality of life. Findings include: 1) On 10/12/22 at 09:30 AM the resident council interview was conducted. R8 reported not receiving a response from a grievance that was filed regarding the facility withholding his electric wheelchair. R8 reported his electric wheelchair was taken away in April related to an incident with another resident.	F 550	F550 RESIDENT RIGHTS/EXERCISED OF RIGHTS SS:D CORRECTIVE ACTION OF RESIDENT IDENTIFIED: R8 safety assessment and contract meeting completed on 10/24/2022 resulting in the return of the resident's motorized wheelchair for his use in the facility; attendees to the meeting included R8, Administrator, Director of Nursing, Assistant Director of Nursing, Social Services and LTC Ombudsman.	

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F 550	Continued From page 2 Record review found an entry dated 06/16/22 at 10:09 by the Licensed Clinical Social Worker (LCSW) documenting meeting with R8 three times during the month. LCSW asked R8 whether he would intentionally use his electric wheelchair to harm another resident. R8 reported stated that he would intentionally use his wheelchair to harm another resident. LCSW documents with assistance, R8 still participates in activities of choice and eats in the dining room. LCSW planned to reassess the use of the electric wheelchair quarterly. The facility provided a list of the grievances they received. R8's grievance was not listed. Review of the progress notes found no documentation for September regarding the use of the electric wheelchair. Interview with the Assistant Director of Nursing (ADON) on 10/13/22, ADON reported returning R8's wheelchair is assessed on a quarterly basis. 2) On 10/12/22 at 09:30 AM, R57 attended the resident council interview. R57 would answer interview questions, however, the surveyor was unable to understand what he was trying to say. The words were unrecognizable, however, he tried to communicate. R8 reported R57 gets frustrated when he is not understood. R57 began repeatedly stating, "no...no...no..." and self-propelled out of the meeting a little early. Record review noted a care plan as R57 has a communication problem related to aphasia (aphasia is a disorder that results from damage to portions of the brain that are responsible for language). Interventions include resident prefers	F 550	R57 communication notepad and writing materials provided and attached to resident's wheelchair to facilitate communication. Nursing communication will be held in areas that are not occupied by other residents. IDENTIFYING OTHER RESIDENTS HAVING THE POTEMTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKE: Facility-wide audit completed and identified other residents that utilize alternative forms of communication. Identified residents assessed to ensure alternative form of communication is available, in use, and reflected in their care plans. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE: All staff will be educated on Nursing Home Resident Rights. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS: Dignity Focus Round including alternative forms of communication developed and will be completed weekly x 90 days or until 100% compliance is met in order to monitor the effectiveness of these changes and to ensure correction is	

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F 550	Continued From page 3 to communicate by writing with pen and paper; speak on an adult level, speaking clearly and slower than normal; and resident can communicate by using communication board, cards, or gestures. R57 was not provided with items identified in his care plan to facilitate communication, no paper and pencil and no communication board or cards, therefore, he was unable to participate in the meeting. 3) On 10/13/22 at 02:05 PM while seated in the nursing station, observed eleven staff members gathered together. A staff member could be heard informing staff of a new admission this afternoon. The resident has c-difficile and will be on contact precautions. Staff member was also heard reminding staff that they will need to use bleach wipes and ensure waste in placed in a plastic bag. Another staff member also stated the new admission is on antibiotics and has two more days of treatment. This staff member further stated c-difficile includes loose stools so use a face shield to prevent splashing and utilize contact precautions. During this time there were residents present who were able to hear what the staff members were saying regarding the new admission. R13 was observed ambulating around the unit and there were two residents seated in the television room.	F 550	achieved and sustained. The results of this audit will be reviewed in QAPI.	
F 572 SS=D	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and	F 572		12/16/22

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F 572	Continued From page 4 responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is not met as evidenced by: Based on interview with residents, the facility did not assure staff provide ongoing communication to residents about their rights. Findings include: On 10/12/13 at 09:00 AM an interview was conducted with resident council representatives. The representatives were asked whether staff periodically review their resident rights with them. The representatives were unable to confirm their rights are reviewed with them. A review of the "Residents Advisory Council Meeting" minutes found no documentation resident rights were reviewed during their meetings.	F 572	F572 NOTICE OF RIGHTS AND RULES SS:D CORRECTIVE ACTION OF RESIDENT IDENTIFIED: A copy of the Resident Rights were provided to all residents and/or resident representatives of the facility. IDENTIFYING OTHER RESIDENTS HAVING THE POTEMTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKE: All residents have the potential to be affected by this deficiency. MEASURE AND SYSTEMATIC CHANGES TO PREVENT	

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F 572	Continued From page 5	F 572	RECURRENCE: All staff will be educated on Nursing Home Resident Rights. A copy of the Resident Rights has been included in the Admission packet. Resident Rights will be reviewed in the monthly Resident Council meeting. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS: Resident Council minutes will be reviewed and submitted to QAPI x 90 days or until 100% compliance is met in order to monitor the effectiveness of these changes and to ensure correction is achieved and sustained. Admission packet audit report will be reviewed weekly and findings of this report will be submitted to QAPI x 90 days or until 100% compliance is met in order to monitor the effectiveness of these changes and to ensure correction is achieved and sustained.	
F 574 SS=D	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -	F 574		12/16/22

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F 574	Continued From page 6 (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental	F 574		

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F 574	Continued From page 7 Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on resident interview, the facility failed to ensure residents are provided with informational notice of how to contact the Ombudsman or the State Agency. Finding includes: On 10/12/22 at 09:30 AM, an interview was conducted with six resident council representatives. Residents were asked if they know where the contact information is posted for the Ombudsman. The residents did not answer. Residents were asked whether they have been informed of their right and given informaiton on how to formally complain to the State Agency. Further asked if they were aware they can call the State Agency to complain.	F 574	F574 RERQUIRED NOTICES AND CONTACT INFORMATION SS:D CORRECTIVE ACTION OF RESIDENT IDENTIFIED: A copy of the contact information for the Long Term Care State Ombudsman and the contact information for the State Agency was provided to all residents and/or resident representatives of the facility. IDENTIFYING OTHER RESIDENTS HAVING THE POTEMTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKE:	

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F 574	Continued From page 8 None of the residents in attendance were able to confirm they know where to find informaiton to contat the Ombudsman or State Agency to complain or request support.	F 574	All residents have the potential to be affected by this deficiency. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE: All staff will be educated on Nursing Home Resident Rights. A copy of the contact information for the Long Term Care Ombudsman and contact information for the State Agency have been included in the Admission packet. Contact information for the Long Term Care Ombudsman and contact information for the State Agency have been added as a standing item on the agenda for monthly Resident Council meeting. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS: Resident Council minutes will be reviewed and submitted to QAPI x 90 days or until 100% compliance is met in order to monitor the effectiveness of these changes and to ensure correction is achieved and sustained. Admission packet audit report will be reviewed weekly and findings of this report will be submitted to QAPI x 90 days or until 100% compliance is met in order to monitor the effectiveness of these changes and to ensure correction is achieved and sustained.	

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F 577 SS=D	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on resident interview, the facility did not assure residents were aware of their right to examine the results of the most recent survey of the facility conducted by State or Federal surveyors. Findings include: On 10/12/22 at 09:00 AM an interview was conducted with resident council representatives.	F 577	F577 RIGHT TO SURVEY RESULTS/ADVOCATE AGENCY INFO SS:D CORRECTIVE ACTION OF RESIDENT IDENTIFIED: All residents and/or resident representatives of the facility have been provided information on the location of the	12/16/22

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F 577	Continued From page 10 The representatives were asked if they were aware the results of the State inspection are available to read. None of the representatives were able to acknowledge awareness of State inspection results or where to locate the report.	F 577	State and Federal Survey results in the facility. IDENTIFYING OTHER RESIDENTS HAVING THE POTEMTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKE: All residents have the potential to be affected by this deficiency. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE: All staff will be educated on Nursing Home Resident Rights. Information on the location of the State and Federal Survey results have been included in the Admission packet. Information on the location of the State and Federal Survey results have been added as a standing item to the monthly Resident Council meeting agenda. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS: Resident Council minutes will be reviewed and submitted to QAPI x 90 days or until 100% compliance is met in order to monitor the effectiveness of these changes and to ensure correction is achieved and sustained. Admission packet audit report will be	

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F 577	Continued From page 11	F 577	reviewed weekly and findings of this report will be submitted to QAPI monthly meeting x 90 days or until 100% compliance is met in order to monitor the effectiveness of these changes and to ensure correction is achieved and sustained.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		12/16/22

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F 584	Continued From page 12 §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 observation and interview, the facility failed to maintain a clean, sanitary, and homelike environment as evidenced by repeated instances of resident (R) urinal(s), both partially filled and empty, being placed/left on the top of the resident's bedside table(s). As a result of this deficient practice, resident safety was compromised as the residents' food and hydration items were also placed on the bedside table(s). This deficient practice has the potential to affect all residents at the facility who are using urinals. Findings include: 1) On 10/10/22 at 11:30 AM during the initial screening of residents, Residents (R)54 and R2 were observed with empty urinals placed on their overbed trays. On 10/12/22 at 08:30 AM, R32 was interviewed. Observed a plastic urinal containing urine and a plastic bed pan lined with paper towel on his overbed tray. R32 stated nobody emptied his urinal since he used it at 07:00 AM. He ate breakfast and staff removed his tray but did not	F 584	F584 SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT SS:E CORRECTIVE ACTION OF RESIDENT IDENTIFIED Staff have been educated on the proper storage of urinals and cleaning of beside table and surfaces for R2, R32, R34, and R54. IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents that use urinals have the potential to be affected by this deficiency. Facility-wide audit completed to identify all residents who use urinals. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE:	

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F 584	Continued From page 13 empty his urinal. Observed two open containers of dietary supplements next to the used urinal. 2) On 10/10/22 at 10:36 AM, an observation was done at the bedside of Resident (R)34. A urinal with 200 milliliters of urine was observed on R34's bedside table. Approximately two inches from the used urinal was an uncovered plastic cup of water with a straw, and a covered water jug. Directly next to the used urinal were several condiment packets. A half-filled urinal was observed again on his bedside table next to his uncovered water cup with straw and water jug on 10/14/22 at 11:49 AM. When asked, R34 confirmed that his meals were placed on the same bedside table. R34 stated staff will usually empty the urinal when they bring his food in but had not observed staff wipe down the bedside table before placing his meal tray(s) there.	F 584	All staff to be educated on a clean and sanitized environment "EBSCO: Comfortable and Therapeutic Patient Care Environment: Creating -20-634111" Clean and Sanitized Environment Focus Round developed and will be completed weekly to ensure proper storage of urinals and sanitized environment. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS: Findings from the Clean and Sanitized Environment Focus Rounds will be submitted to QAPI monthly x 90 days or until 100% compliance is met in order to monitor the effectiveness of these changes and to ensure the correction is achieved and sustained.	
F 656 SS=F	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 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	F 656		12/16/22

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F 656	Continued From page 14 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 observations, interviews, and record reviews, the facility failed to develop resident-centered comprehensive care plans supporting resident's choices and interventions to achieve the resident's goals for 9 residents (R), R16, R27, R109, R11, R54, R13, R22, R34, and R56, out of a sample of 19 residents. This deficient practice failed to recognize individualized care and medical needs of each resident with measurable objectives and timeframes to help them attain or maintain their	F 656	F656 DEVELOP/IMPLEMENT COMPREHENSIVE CARE PLAN SS: F CORRECTIVE ACTION OF RESIDENT IDENTIFIED: R16 Care plan reviewed and revised to include intervention to place pillows under extremities and head while in wheelchair for proper positioning and comfort and preference for spouse to apply "doterra	

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F 656	Continued From page 15 highest practicable physical, mental, and psychosocial well-being. Finding includes: 1) Cross Reference to F684. On 10/11/22 at 10:43 AM, R16 was observed while an interview was conducted with family member (FM)6. R16 sat up in a 45 degree angle in his wheelchair with pillows on either side of him, under his head, and under his legs. R16's skin to his arms and neck had red bumps that R16 occasionally scratched. FM6 stated that R16 returned here after spending the last two weeks of September in the hospital. R16's tube feeding formula was changed and a rash appeared on R16's arms, chest, back, and neck. FM6 stated that she had alerted the staff, but no one could explain the reason for his rash. FM6 stated that she uses her own "Doterra" oils to moisturize his skin and treat his rash. On 10/12/22 at 08:24 AM, R16 was observed to be sitting up in his wheelchair in the television room. R16 had bilateral skin protectors on his arms, and he was attempting to take them off. R16 was also noted to be scratching his ears and neck, where red bumps were noticeable. On 10/12/22 at 09:19 AM, reviewed R16's electronic health record (EHR). R16's care plan did not address his rash to his chest, back, arms, and neck. Under the "Orders" screen, there was no medical treatment indicated for the rash. The "PCC Skin & Wound - Total Body Skin Assessment" documentation for 09/28/22, 10/05/22, and 10/12/22 were reviewed and there was no rash to R16's arms, chest, back, and neck documented. "Progress Notes" revealed on 10/04/22 at 10:44 AM, a "Nutrition/Dietary Note"	F 656	oils" to skin. R27 care plan focus was added for risk for constipation. R109 care plan focus was added for risk for constipation. R11 care plan reviewed and revised to include intervention of using universal precautions for infection prevention related to risk for skin impairment. R54 care plan reviewed and revised to include intervention of using universal precautions for infection prevention related to risk for skin impairment and also added intervention for use of foot cradle. R13 care plan focus added under behavioral to include risk for verbal/physical altercations, intervention to redirect resident as needed when in same common areas with other resident with previous altercation and also added wander risk to elopement risk focus. R22 resolved care plan intervention for use of elbow braces and air hand orthosis. OT referral for evaluation ordered. R34 resident discharged and care plan closed. Routine pain medication were ordered and administered per schedule. Psychologist follow up appointment on 10/20/2022.	

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F 656	Continued From page 16 documented: " ...Discussion with wife today regarding change of formula planned for next week. Wife agreeable and appreciative. Expressed concern about a rash that disappeared at [hospital] and seems to come back now, wondering if can be r/t [related to] Nepro formula. Informed that we will look into ingredients. Will follow up." Review of "Comprehensive Care Plans" policy effective 03/2022. It stated, "GUIDELINES ...8. Care plan will include: a. The services the facility will provide to assist the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being." 2) Cross Reference to F684. R27 reported that he has experienced constipation. Review of R27's record found no care plan to address his constipation. 3) Cross Reference to F684. R109 reported he has experienced constipation. Review of R109's record found no care plan to address his constipation. 4) Cross Reference to F686. R11 was admitted to the facility without pressure injuries and the facility did not develop and implement a person-centered care plan to prevent the development of pressure injuries. Also, the facility did not develop a care plan to prevent infection. This deficient practice resulted in facility-acquired presure injuries and infection of injuries. 5) Cross Reference to F686. R54 was admitted to the facility with pressure injuries. The facility did not develop and implement a person-centered care plan to prevent the development of pressure	F 656	R56 care plan reviewed and revised to reflect resident's preference regarding use of the "stop sign". IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORECTIVE ACTION WILL BE AKEN: All residents have the potential to be affected by this deficiency. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE: All staff to be educated on "Person-Centered Care Planning-20872912". All license staff to be educated on "SMART Goals". Comprehensive care plans will be reviewed quarterly, and as needed by interdisciplinary team. IDT Care Plan conference evaluations will be reviewed weekly to ensure care plans support resident choices and include interventions to achieve the residents' goals. Director of Nursing or designee will be responsible for ongoing compliance. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS:	

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F 656	Continued From page 17 injuries and prevent infection of the injuries. This deficient practice resulted in facility-acquired pressure injuries, worsening of pressure injuries, and infection. 6) R13 is a 72-year-old male admitted to the facility on 01/13/22 with admitting diagnoses that include schizophrenia, and post-traumatic stress disorder. On 10/11/22 at 07:39 AM, observations were made of R13 wandering in the hallway unattended. Staff were present along the hallway assisting other residents and/or performing other duties such as preparing medication for administration. R13 approached Surveyor to talk, and during this interaction it was observed that he had little awareness of personal space/boundaries. R13 walked up less than a foot away from Surveyor and placed his face even closer as he spoke. As Surveyor repeatedly moved slightly back to create some distance, R13 advanced so that his face was consistently within inches of the Surveyor's face. On 10/11/22 at 11:54 AM, while standing outside of room 107, observed R13 walk out of his room, loudly apologizing, wearing only a t-shirt and a pair of adult incontinent briefs, quickly walk directly across the hall to R56's room and with no obstructions in the doorway, was about to enter. A staff member was able to stop and redirect him back to his room just as he entered R56's doorway. Interview with staff member at the time confirmed that R13 often wanders and lacks insight, impulse control, and awareness of personal boundaries. On 10/12/22 at 04:23 PM, a review of R13's	F 656	Findings of the IDT care plan conference evaluations will be submitted by the Director of Nursing or designee to QAPI monthly meeting x 90 days or until 100% compliance is met in order to monitor the effectiveness of these changes and to ensure correction is achieved and sustained.	

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F 656	Continued From page 18	F 656		

comprehensive care plan (CP) noted that despite having identified wandering behavior in R13, the facility had not developed a care plan specifically to address his wandering behavior and/or lack of boundaries. Several interventions for wandering had been created but placed under the focus of "Elopement Risk."

On 10/12/22 at 04:58 PM while investigating the facility-reported incident ACTS #9767, an allegation of resident-to-resident abuse where R13 alleged that R5 had cut him with a broken beer bottle, it was noted that the facility was aware that the two residents involved did not get along. Another review of R13's CP noted no plans, problems identified, or interventions created to address resident safety in relation to personal interactions/altercations with other residents.

On 10/14/22 at 07:37 AM, an interview was done with R13 in the hallway outside his room. R13 stated that he does not feel safe at the facility, reporting "there's a number of staff and residents" that make him feel unsafe. R13 could not or would not express specifically who, what, or how he feels unsafe. When asked about the recent incident with R5, R13 stated he could not remember any altercations with R5.

On 10/14/22 at 08:00 AM, an interview was done with R5 in the common area. When asked how he gets along with all the other residents, R5 brought up how R13 "annoys" him and "pushes all my buttons." R5 stated he does not get along with R13 and he is "just waiting" for R13 to hit him "so I can have my turn." R5 reported R13 knows exactly how long his "chain" is and he pushes him "until I am at the end of my chain."

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F 656	Continued From page 19 On 10/14/22 at 08:35 AM, an interview was done with the Social Services Assistant (SSA)1 in the Adult Day Health room. SSA1 reported that R5 and R13 originally were roommates but never got along. The facility separated them into different rooms on the same wing, then separated them further onto different wings because they kept having conflicts between the two. After the most recent allegation of assault, the facility attempted to separate them onto different floors, however both refused. SSA1 stated that the plan is to redirect each resident when they are observed in the same areas and to try to keep them separate/apart as much as possible. When asked about why this "plan" was not reflected on R13's CP, SSA1 stated she was unaware of what was on the CP. 7) R22 is an 86-year-old male admitted to the facility on 01/18/19 with diagnoses that include dementia, Alzheimer's Disease, and contractures of the right hand and left elbow. On 10/12/22 at 10:58 AM, during a review of R22's electronic health record (EHR) orders were noted for right and left soft elbow braces and a "comfy air hand orthosis" for his right hand. Observations done on 10/11/22 at 12:00 PM, 10/12/22 at 03:27 PM, 10/13/22 at 02:20 PM, 10/14/22 at 07:35 AM, and 10/14/22 at 10:07 AM noted no visible signs of hand or elbow braces/devices or splints, either on his body or at the bedside. Review of R22's CP noted interventions planned for "Right hand: to apply comfy air hand orthotic start of day shift and remove end of the day shift with skin check ... CNA [certified nurse aide] Splint/Brace Program #1. Apply Right and Left soft elbow extension	F 656		

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F 656	Continued From page 20	F 656		

braces at 0830-1030am ... Resident to wear left hand orange hand carrot in AM and during day shift as tolerated ..."

On 10/14/22 at 10:10 AM, an interview was done with Licensed Practical Nurse (LPN)1 near the nurses' station. LPN1 stated that she thought the "carrot" and the comfy air orthosis were the same thing. Concurrent review of the Treatment Administration Record (TAR) with LPN1 revealed the comfy air hand orthosis being documented, but no sign of the elbow braces. LPN1 stated that she would apply the "carrot" to his right hand on the day shift and document it on the TAR as the comfy air hand orthosis. Concurrent review of physician orders with LPN1 revealed the order for elbow braces was still active. LPN1 reported she did not know why the elbow braces were not on the TAR. Discussed with LPN1 that the comfy air hand orthosis was a hand brace device that had an inflatable section that went under the fingers so that the device could be adjusted depending on the severity of the resident's contracture. LPN1 stated she had never seen a device like that either on R22 or at his bedside.

8) Cross-reference to F697 Pain Management. Based on observation, interview, and record review, the facility failed to ensure that adequate pain management was provided to one resident (R34) in the sample. The facility failed to effectively care plan for pain management or include any non-pharmacological interventions in R34's CP.

Cross-reference to F740 Behavioral Health Services. Based on observation, interview, and record review, the facility did not assure R34 received necessary behavioral health services to

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F 656	Continued From page 21 attain or maintain his highest practicable mental and psychosocial well-being. The facility failed to effectively care plan, monitor, and treat signs of depression identified at admission. 9) Cross-reference to F744 Treatment/Service for Dementia. Based on observation and record review, the facility failed to ensure one resident (R)56 diagnosed with dementia, received the appropriate treatment and services to attain or maintain her highest practicable physical, mental, and psychosocial well-being. The facility failed to implement interventions consistent with R56's CP and wishes.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		12/16/22

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F 657	Continued From page 22 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review, the facility failed to timely update the care plans for two residents (R), R21 and R49, out of a sample of 19 residents. This deficient practice does not assure interventions were revised to meet the care needs of the residents. Findings include: 1) On 10/11/22 at 10:43 AM, R21 was observed to be in his room lying on his bed with a specialty mattress watching television. Boots were noted to be on both of his feet. On 10/11/22 at 2:05 PM, an interview was done with R21. R21 stated that he looked forward to going home to Maui, but the wounds on his feet are slow to heal because of his diabetes (high blood sugar medical disorder). On 10/13/22 at 11:22 AM, R21's electronic health record (EHR) was reviewed. The "Medical Diagnosis" screen revealed that R21 is an 82 year old resident initially admitted to the facility on 02/28/22 for "TYPE 2 DIABETES MELLITUS WITH FOOT ULCER [high blood sugar disorder with foot wound]" and then readmitted to the facility on 08/15/22 for long-term bone infection in his left ankle and foot. R21's care plan stated, "INFECTION The resident is on antibiotic [medication to fight infection] therapy for sepsis	F 657	F657 CARE PLAN TIMING AND REVISION SS:D CORRECTIVE ACTION OF RESIDENT IDENTIFIED R21 infection care plan was resolved as he no longer had an active infection. R49 care plan revised which removed "LCSW" intervention and include mental health services referral as needed. IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected by this deficiency. Facility-wide audit completed to identify any resident with resolved infections and care plans updated as appropriate. Facility-wide audit completed to identify all residents with who currently receive mental health services and care plans have been updated as appropriate. MEASURE AND SYSTEMATIC	

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F 657	Continued From page 23 [infection in the blood]." Review of the "Orders" revealed that R21 was not currently on any antibiotics. On 10/14/22 at 10:00 AM, the Assistant Director of Nursing (ADON) was interviewed. ADON stated that R21 no longer has sepsis, and it should have been resolved on R21's care plan. Review of the facility's policy, "Comprehensive Care Plans," effective 03/22 stated, " ... GUIDELINES ... 7. The care plan will be person-specific with measurable objective, interventions, and timeframes. It will address goals, preferences, needs and strengths of the resident." 2) On 10/12/22 at 09:23 AM, R49 was interviewed. R49 stated that she has PTSD (post-traumatic stress disorder) but has had no support. R49 further stated that the facility's licensed clinical social worker (LCSW) had been gone since July and that the facility's one SSA (social services assistant) had been doing all the work. On 10/13/22 at 11:25 AM, R49's electronic health record (EHR) was reviewed. R49's "Medical Diagnosis" screen revealed that R49 is a 81-year old resident admitted to the facility on 05/15/19 for heart failure. R49's current care plan stated these interventions under the focus for "BEHAVIORAL EXPRESSIONS:" "LCSW [Licensed Clinical Social Worker] to provide counseling when needed," "LCSW to provide psychotherapy approaches of; EMDR [Eye Movement Desensitization and Reprocessing, type of psychotherapy], Strength-Based Modalities, Solution Focus Therapy, Trauma	F 657	CHANGES TO PREVENT RECURRENCE: 24 Hour Report which includes clinical documentation from the last 24 hours will be reviewed daily in Clinical Meeting to identify any updates and/or revisions necessary to resident care plans. All staff to be educated on "Person-Centered planning-20-872912". All License staff to be educated on "SMART Goal" All education will be completed by December 16, 2022. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS: Care Plan Revision log developed and will be reviewed weekly and the findings of this report will be submitted to QAPI monthly x 90 days or until 100% compliance is met in order to monitor the effectiveness of these changes and to ensure the correction is achieved and sustained.	

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F 657	Continued From page 24 Cognitive Behavioral Therapy (TCBT), CBT [Cognitive Behavior Therapy], and DBT [Dialectical Behavior Therapy]. On 10/14/22 at 10:45 AM Social Services Assistant (SSA)1 was interviewed. SSA1 stated that she is not qualified to perform the duties of the LCSW. Counseling and psychotherapy are being provided by a psychologist because the facility had been unable to hire a new LCSW. SSA1 stated that the use of the psychologist, instead of a LCSW, should be reflected in the care plan. Review of "Comprehensive Care Plans" policy effective 03/22. It stated, "GUIDELINES ...8. Care plan will include: a. The services the facility will provide to assist the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being."	F 657		
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, interviews, and record reviews, the facility failed to provide appropriate medical care for four residents (R), R27, R109, R39, and R16 residents. The facility failed to	F 684	F684 QUALITY OF CARE SS: D CORRECTIVE ACTION OF RESIDENT IDENTIFIED:	12/16/22

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F 684	Continued From page 25 manage bowel regimen to treat constipation for R27 and R109; obtain weights for R39 who has a complex medical history and is on medication to help rid his body of excess fluid; and medically treat and manage R16's rash. These deficient practices affected residents' ability to attain or maintain their highest practicable physical well-being. Findings include: 1) Cross Reference F656 (Comprehensive Care Plan). R27 was admitted to the facility on 02/23/22. Diagnosis includes, bipolar disorder, benign prostatic hyperplasia without lower urinary tract symptoms, severe obesity due to excess calories, and borderline personality disorder. On 10/10/22 at 01:29 PM, R27 reported that he gets constipated, clarified in the past he was "stopped up" three times. R27 further reported he is provided a "red pill" and pudding for constipation. Review of the "Order Summary Report" found the following physician orders: -fiber pudding one time a day for BM (bowel movement) regularity (start date: 08/24/22); -docusate sodium capsule 100 mg by mouth two times a day for constipation, hold for loose bowel (start date: 10/05/22); -docusate sodium capsule 100 mg, give one tablet by mouth every 24 hours as needed for constipation (start date: 05/28/22); -lactulose solution 10 gm/15 mL, give 30 mL by mouth as needed for constipation if no BM in 3 days (start date: 02/23/22); and -fleet enema, insert one application rectally as needed for bowel care if no BM times four days	F 684	R27 and R109 care plans were updated identify risk for constipation. R39 was educated on Risk vs. Benefits of taking his weight. R39's care plan was reviewed and updated to include resident's preference with his weights. R16 had a head-to-toe skin assessment completed which confirmed rash was resolved. IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All resident have the potential to be affected by this deficiency. Facility wide audit completed to identify residents with a diagnosis of constipation and those who receive opioids to determine if no bowel movement noted for 3 days and if facility bowel protocol was initiated. Facility wide audit of weights summary for the past 6 months completed to identify residents who refused weights and have a complex medical condition. Those residents identified have been provided with education via Risk vs Benefit. Facility wide audit of head-to-toe skin assessment completed to identify residents skin rash and confirmed medical treatment in place.	

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F 684	Continued From page 26 and not relieved by lactulose (02/23/22). A review of the electronic health record (EHR) under the "Tasks" tab found no documentation of bowel elimination for the following time periods: 06/12/22 to 06/14/22 (three days), 06/26/22 to 06/30/22 (five days), 07/21/22 to 07/22/22 (two days), 08/26/22 to 08/27/22 (two days), 09/01/22 to 09/02/22 (two days), 09/22/22 to 09/24/22 (three days), and 10/03/22 to 10/04/22 (two days). Review of the Medication Administration Record (MAR) for June 2022 found no documentation prn (as needed) medications (docusate, suppository, or fleet enema) were administered during the time period of no bowel elimination. Review of the progress note found no documentation prn medications as ordered by the physician were offered and/or refused by R27 during the time periods where there was no documentation of bowel elimination. A progress note dated 06/26/22, R27is documented as reporting his urinal and wheelchair were not where it was supposed to be, out of reach. Further stating if items are out of reach, he may "have to shit and piss" himself. There was no documentation R27 did not have bowel movement or offering of prn medications as ordered by physician from 06/26/22 to 06/30/22. On 10/14/22 at 09:23 AM interview and concurrent record review was done with the Minimum Data Set Coordinator (MDSC). MDSC confirmed there was no documentation in MAR or progress note that R27's bowel protocol was implemented in June 2022. MDSC reported there should be an alert progress note when there is no	F 684	MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE: All License Nursing staff to be educated on reviewing clinical dashboard (which identifies residents with no bowel movement for 3 days) and initiating bowel protocol when appropriate. Clinical Dashboard will be reviewed daily in clinical meeting for bowel alerts to ensure bowel protocol initiated. All nursing staff will be educated on documentation of weights and/or refusals of weights. Weight Summary report will be reviewed weekly to identify resident refusal of weights. All license nursing staff will be educated on initiating alert charting for residents with a change in skin integrity. 24 hour report which includes clinical documentation and alert charting for the past 24 hours will be reviewed daily in clinical meeting to ensure appropriate treatment and management for changes in skin integrity. The Director of Nursing or designee will be responsible for ongoing compliance. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS:	

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F 684	Continued From page 27 bowel movement. MDSC could not locate any alert messages in the progress note. 2) Cross Reference F656 (Comprehensive Care Plan). R109 was admitted to the facility on 09/23/22. Diagnoses include necrotizing fasciitis, cellulitis of right lower limb, cellulitis of left lower limb, and bacteremia. On 10/11/22 at 11:07 AM, R109 reported having problems with bowel movement for a couple of weeks. R109 reported he did not have a bowel movement for one week. R109 stated he got out of bed for therapy and that night he could not stop and had twelve bowel movements. Review of the EHR under the Tasks tab found documentation of no bowel elimination for the following time periods: 09/23/22 to 09/25/22 (three days); 09/27/22 to 09/28/22 (two days); and 10/02/22 to 10/03/22 (two days). A review of the physician's order noted the following orders: -miralax packet, give 17 gram by mouth as needed for constipation once daily (start date: 09/23/22); -docusate sodium capsule 100 mg give one capsule by mouth as needed for constipation twice a day (start date: 09/23/22); -lactulose solution 10 gm/15 ml by mouth as needed for constipation if no bowel movement in three days (start date: 09/23/22); and -Dulcolax suppository 10 gm insert rectally as needed for bowel care if no bowel movement times four days and not relieved by lactulose (start date: 09/23/22). R102 is also prescribed oxycodone HCl 5 mg	F 684	Bowel Alert report developed and reviewed weekly by the Director of Nursing or designee and will report findings to QAPI x 90 days or until 100% compliance is met in order to monitor the effectiveness of these changes and to ensure correction is achieved and sustained. Weight Summary report developed and reviewed weekly by the Director of Nursing or designee and will report findings to QAPI x 90 days or until 100% compliance is met in order to monitor the effectiveness of these changes and to ensure correction is achieved and sustained.	

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tablet for pain. Order includes, oxycodone HCl 5 mg, give one every four hours as needed for pain rated four to six related to necrotizing fasciitis and oxycodone HCl tablet 5 mg, give two tablets every four hours as needed for pain rated seven to ten related to necrotizing fasciitis. A side effect of oxycodone is constipation.

Review of the MAR found docusate sodium capsule was provided on 09/25/22 at 07:00 PM (on the third day of no bowel elimination) which was effective.

On 10/13/22 at 02:15 PM an interview and concurrent record review was conducted with the MDSC. Inquired when would docusate sodium be administered as there was no parameters when to administer prn. MDSC reported R109 is independent and would be able to tell staff if he is constipated. MDSC confirmed R109 did not have bowel movement 09/23/22 to 09/25/22 (three days). MDSC reported based on the physician order, a prn of lactulose should have been administered. MDSC also confirmed there was no documentation prn medications for bowel regimen was offered and/or refused.

Requested the facility's policy and procedure for bowel regimen. On 10/14/22 at 07:34 AM, the Director of Nursing (DON) provided a copy of an order set which documents the checked medications listed under "bowel standard," fleet enema one PRN if Dulcolax suppository is ineffective, Dulcolax suppository 10 mg prn if no bowel movement times four days and not relieved by lactulose, and lactulose 10 gm/15 ml - 30 ml daily PRN if no bowel movement times three days. The DON reported when residents don't have a bowel movement, the EHR software

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should originate an alert. Further queried whether the facility develops care plans to address constipation, the DON replied "do we need one."

3) On 10/11/22 at 1:00 PM, observation and interview were done with R39 in his room. R39 sat at the edge of his bed wearing a nasal cannula (tubing placed into the nose to deliver oxygen) connected to an oxygen compressor. R39 was visibly short of breath, and he was unable to speak in long sentences. R39 stated he recently completed a course of radiation and chemotherapy to treat his lung cancer.

On 10/12/22 at 08:24 AM, R39 was observed sitting at the edge of his bed in his room using his nasal cannula. R39 was slicing and eating mangoes brought by his sister. R39 was visibly short of breath.

On 10/12/22 at 08:35 AM, a query was made with a staff member about R39, and she stated that R39 is always short of breath because of his COPD (chronic obstructive pulmonary disease, lung disease causing obstructed airflow), but more so with increased activity.

On 10/12/22 at 10:11 AM, R39's electronic health record (EHR) was reviewed. His recent Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) of 09/01/22 revealed a Brief Interview for Mental Status (BIMS) score of 15 meaning he is cognitively intact. R39's "Admission Record" shows that he was initially admitted on 11/09/18 with a diagnosis of heart

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failure, COPD, diabetes, and depression. R39 showed a recent diagnosis of right lung cancer on 09/13/21. The active "Order" revealed "Furosemide [medication to rid the body of excess fluid] Tablet 80 mg (milligrams) orally two times a day related to HEART FAILURE ..." No order for R39 to be weighed was found. Review of R39's care plan revealed the following:
" ...The resident has Congestive Heart Failure ...Monitor/document/report ...weight gain unrelated to intake ..."
" ...The resident has altered cardiovascular status r/t [related to] HTN [hypertension, high blood pressure], CHF [congestive heart failure] ...Monitor/document report ...any changes in ...edema [swelling] and changes in weight ..."
" ...The resident has potential for fluid deficit [decreased fluid in the body] r/t use of diuretics [medication to rid the body of excess fluid] for CHF ...Monitor/document/report ...recent/sudden weight loss ..."
" ...The resident has Diabetes Mellitus [DM] type II [elevated blood sugar in the body] and is receiving DM medications including insulin ...Report to nurse any s/sx [signs and symptoms] ...weight loss ..."
" ...The resident uses antidepressant medication r/t Major Depressive Disorder and Pain ...Monitor/document/report ...wt [weight] loss ..."
" ...The resident is at nutritional risk r/t dx [diagnosis] of cancer, on a therapeutic diet and COPD increasing needs. Also at risk of complications of Dx: Obesity, DM-II, CHF. The resident may have slow trend of weight loss but will remain free from significant weight loss of 5% in 30 days, 7.5% in 90 days and 10% in 10 days through review date."
" ...The resident has pain r/t PVD [peripheral vascular disease], left shoulder pain, and right leg

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pain ...Monitor/record/report to nurse loss of appetite, refusal to eat and weight loss."
Under VS [vital signs] the last documented weight was on 12/07/21.

On 10/14/22 at 08:32 AM, conducted interview with the Registered Dietitian (RD)1. RD1 stated that R39 needed to be weighed but he refuses. The risk vs benefit of not obtaining R39's weights was not discussed with R39 until this morning and R39 agreed to be weighed.

4) Cross reference F656 Develop/Implement Comprehensive Care Plan

On 10/11/22 at 10:43 AM, R16 was observed while an interview was conducted with family member (FM)6. R16 sat up in a 45 degree angle in his wheelchair with pillows on either side of him, under his head, and under his legs. R16's skin to his arms and neck had red bumps that R16 occasionally scratched. FM6 stated that R16 returned here after spending the last two weeks of September in the hospital. R16's tube feeding formula was changed and a rash appeared on R16's arms, chest, back, and neck. FM6 stated that she had alerted the staff, but no one could explain the reason for his rash. FM6 stated that she uses her own "Doterra" oils to moisturize his skin and treat his rash.

On 10/12/22 at 08:24 AM, R16 was observed to be sitting up in his wheelchair in the television room. R16 had bilateral skin protectors on his arms, and he was attempting to take them off. R16 was also noted to be scratching his ears and neck, where red bumps were noticeable.

On 10/12/22 at 09:19 AM, reviewed R16's EHR.

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Medical diagnosis screen revealed that R16 was admitted on 04/26/21 for "aphasia following cerebral infarction" or difficulty communicating after suffering from a stroke. There was no person-centered problem of a rash addressed in R16's care plan nor was there any order for medical treatment of R16's rash to his arms, chest, back, and neck. The "PCC Skin & Wound - Total Body Skin Assessment" documentation for 09/28/22, 10/05/22, and 10/12/22 were reviewed and there no rash to R16's arms, chest, back, and neck noted. "Progress Notes" revealed on 10/04/22 at 10:44 AM, a "Nutrition/Dietary Note" was written: " ... Discussion with wife today regarding change of formula [tube feeding] planned for next week. Wife agreeable and appreciative. Expressed concern about a rash that disappeared at [hospital] and seems to come back now, wondering if can be r/t [related to] Nepro formula. Informed that we will look into ingredients. Will follow up." No "Nutrition/Dietary Note" was found to address that any education or follow up was given to FM6.

On 10/14/22 at 08:32 AM, an interview was conducted with the Registered Dietitian (RD)1. RD1 stated that she didn't think the rash was from the tube feeding formula but from phosphorus deposits under his skin from his recent kidney failure that cause him to be hospitalized. RD1 stated that she had provided education to FM6 that R16's rash was from phosphorus deposits. RD1 stated that R16's tube feeding formula was recently changed back to his original formula.

On 10/14/22 at 10:59 AM, a follow up interview was done with FM6. FM6 was applying "Doterra" oil to R16's right arm. FM6 stated that R16's skin

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F 684	Continued From page 33 seems better now that the tube feeding formula was changed to the original formula. FM6 stated that she was never educated by the dietitian that R16's rash was caused by phosphorus deposits because of his recent temporary kidney failure.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview with staff members, the facility failed to ensure residents received care to prevent development of new pressure inuries and provide care to promote healing and prevention of infections from developing for two (Residents 11 and 54) of four residents included in the sample. The facility failed to develop a person-centered care plan for the prevention of development and infection of pressure injuries; implement the resident's care plan to facilitate healing of the pressure injuries (application of foam boots and elevating feet); and provide resident with	F 686	F686 TREATMENT/SERVICES TO PREVENT/HEAL PRESSURE ULCER SS: G CORRECTIVE ACTION OF RESIDENT IDENTIFIED: Assistant Director of Nursing met with R11 on 10/14/2022 and provided education on the importance of complying with interventions to prevent skin breakdown and improve wound healing. Risk vs Benefits presented to resident. R11 verbalized willingness to comply with	12/16/22

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informed choices regarding the treatment of the pressure ulcers. As a result of the deficient practice, Resident (R)11 developed two facility-acquired pressure injuries which worsened, Stage 4 pressure injury to the left heel and Stage 3 pressure injury to the right buttock. R11's pressure injury also became infected requiring antibiotic treatment.

R54 was admitted to the facility with deep tissue injury (DTI) to the left heel. The facility failed to develop a person-centered care plan to prevent the development of pressure injuries and infection of pressure injuries. As a result of this deficient practice, R54 had pressure injury related infections, including osteomyelitis (infection to the bone) requiring four rounds of antibiotic treatment (orally and intravenously) for treatment of infection and developed pressure injuries to the coccyx, spine/back, and right foot (Stage 3).

Findings include:

1) Cross Reference F656 (Comprehensive Care Plan). Resident (R)11 was admitted to the facility on 07/07/22. Diagnoses include, essential hypertension, benign prostatic hyperplasia without lower urinary tract symptoms, chronic obstructive pulmonary disease, malignant neoplasm of colon, peripheral vascular disease, anxiety disorder, and edema.

Observation during the initial tour of the facility on 10/10/22 found R11 seated in a recliner with a urinal hanging on his rubbish can. R11's head was hanging down to the right and appeared asleep. R11 has an air mattress and on oxygen. On 10/11/22 at 07:41 AM observed R11 sleeping in his recliner. He was upright and slouched over

elevating legs, applying foam boots to bilateral feet and going to bed as able.

R54's pressure ulcers have resolved. Care plan reviewed and updated as appropriate.

IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN:

All resident have the potential to be affected by this deficiency.

Facility wide audit of residents with existing pressure injuries completed to ensure the plan of care addresses the promoting of healing, prevention of infection and alternative treatments.

Facility-wide Braden scale evaluation completed for all residents to identify residents at high risk (12 or below) for skin breakdown. Care plans were reviewed and revised to include interventions for prevention of skin breakdown.

MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE:

Braden scale evaluations will be reviewed weekly for any changes in residents' risk score and ensure appropriate care plan interventions in place.

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F 686	Continued From page 35 to the right side. R11 was wearing socks and feet were not elevated. His lower legs were wrapped. Second observation at 10:49 AM, R11 was lying on his left side in bed, uncovered with his personal brief open. Two staff members entered and R11 was asked whether he wanted to be covered up and get out of bed. R11 was agreeable. Observation at 12:40 PM, R11 was seated in his recliner, leaning to his right side and feet were not elevated. R11 had earphones on and did not respond to greeting by surveyor. On 10/11/22 at 10:58 AM, Registered Nurse (RN)7 was observed leaving R11's room. RN7 reported the wound team saw R11 and the pressure injury on the buttock has worsened, it's not getting better. RN7 reported they will be changing treatment and awaiting physician orders. On 10/12/22 at 01:15 PM and 02:15 PM, R11 was seated in the recliner, his feet were not elevated. At 02:15 PM, R11 was asleep, leaning on the right of the armrest. At 03:15 PM, R11 had a shower and was assisted back to bed. On 10/13/22 at 08:32 AM, R11 observed seated in his recliner, wearing socks and his feet were not elevated. Second observation at 09:30 AM, the privacy curtain was drawn, staff stated pericare was being provided. At 09:45 AM, staff asked whether he wanted to go back to his recliner. R11 was agreeable to transfer back to his recliner. Restorative Nurse Aide (RNA) waited for assistance to transfer R11 via mechanical lift. Certified Nurse Aide (CNA)2 assisted with the transfer. R11 was placed in the recliner, no foam boots and legs were not elevated. CNA2 was asked whether R11's foam	F 686	All nursing staff will be educated on interventions to prevent skin breakdown, prevention infection, providing aseptic wound care, and providing residents with education on risk vs benefits of compliance. Nursing staff to accompany wound specialist during weekly rounds of residents with pressure injuries to coordinate appropriate treatment and services to promote wound healing and prevention of infection. The Director of Nursing or designee will be responsible for ongoing compliance. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS: Braden Scale evaluation report will be audited by the Director of Nursing or designee and findings will be reported to QAPI x 90 days or until 100% compliance is met in order to monitor the effectiveness of these changes and to ensure correction is achieved and sustained. Wound round report will be reviewed weekly in Skin and Weight meeting. Findings of this report will submitted to QAPI x 90 days or until 100% compliance is met in order to monitor the effectiveness of these changes and to ensure correction is achieved and sustained.	

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boots should be applied. CNA2 responded the RNA will apply and thinks it is applied only when in bed. CNA2 further reported she needs to read the Kardex as she is new to the facility. RNA reported R11 does not like to wear foam boots, he will get mad if it is applied and will kick it off. RNA also reported R11 does not like to elevate his feet, he just wants to sit in his recliner. RNA placed a pillow to R11's right side and proceeded to tidy the resident's bed. Observed R11's air mattress was not covered with a sheet; a sheet was laid across the bed under the resident's lower half of his torso.

Review of R11's admission Minimum Data Set (MDS) with an assessment reference date of 07/12/22 noted he yielded a score of 14 (cognitively intact) when the Brief Interview for Mental Status was administered. R11 was also noted to require extensive assistance with two+ (plus) person physical assist for bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture) and toilet use. R11 was coded as occasionally incontinent (less than 7 episodes of incontinence) for bladder and always incontinent of bowel. In Section M - Skin Conditions, R11 noted to be at risk of developing pressure ulcers and no unhealed pressure ulcer(s) at Stage 1 or higher.

Review of R11's Braden Scale (standardized, evidence-based assessment tool commonly used in health care to assess and document a patient's risk for developing pressure injuries) for 07/14/22, 07/21/22 and 07/28/22 documents a score of 15 (moderate risk). A review of the "PCC Skin & Wound: Total Body Skin Assessment" for 07/14/22 and 07/21/22 documents no wounds.

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The assessment for 07/28/22 and 08/04/22 documents one new wound. The assessment includes skin turgor (elasticity), color (ashen, pale, cyanotic, flushed, jaundiced, mottled), temperature, moisture (normal, moist, diaphoretic, clammy), condition (extremely dry, dry, normal, oily, friable), and number of new wounds.

A review of the progress note dated 07/28/22 documents R11 "developed a pressure injury - DTI (deep tissue injury) to the left heel. Also noted, the outer layer of skin has ruptured and about 40% of wound filled with eschar (a dry, dark scab or falling away of dead skin). The plan was to apply bordered foam every evening shift, foam boats to both feet, and consult wound specialist.

Review of the wound note of 08/02/22 notes R11 is a 92-year-old with wound on left heel, wound occurred by pressure mechanism, started as deep tissue injury (DTI) prior to admission. R11 was admitted from an acute hospital due to femoral neck fracture and post-surgery.

Subsequent wound consult note dated 08/16/22 documents R11 with a pressure ulcer to the left heel, unstageable. Subsequent note of 08/23/22 notes an unstageable pressure ulcer of the left heel and a non-pressure chronic ulcer of other part of left lower leg. R11 noted with severe peripheral artery disease, limited elevation, and worsening edema. Culture of the wound found bacteria, enterococcus, MSSA, and mixed GNR indicative of an infection. R11 was prescribed antibiotic (Augmentin from 08/30/22 to 09/09/22 and cipro from 10/04/22 to 10/11/22).

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Review of the physician order notes treatment for multiple wounds on the lower extremities (left lower leg/shin, left dorsal foot, left heel. right toe, and right lower leg). R11 also noted with a sacral wound. The diagnoses included pressure ulcer of left heel, unstageable and pressure ulcer of sacral region, Stage 3.

R11 has a care plan for pressure injury (Stage 4 pressure injury to the left heel and Stage 3 pressure injury to the right buttock). Interventions included:
-Administer treatments as ordered and monitor for effectiveness;
-Foam boots to bilateral feet in bed and in wheelchair;
-Pressure injury to left heel (report to nurse if dressing is soiled or displaced);
-Remind resident to keep pressure off left heel when transferring and ambulating; and
-Roho cushion and dycem for offloading.

There was no care plan including interventions for the prevention of pressure injuries and prevention of infection. Review of the "Task" bar which provides direction to CNAs regarding care did not include offloading or ensuring position change.

On 10/13/22 at 10:00 AM an interview was conducted with the Assistant Director of Nursing (ADON). ADON confirmed R11's pressure ulcer was facility acquired. ADON reported the pressure ulcer to the heel started as a deep tissue injury, a blister. ADON further reported R11 spent a lot of time sitting up in bed and has poor circulation, so they brought a recliner for him to keep his feet slightly elevated off the ground. ADON explained R11's pressure ulcer became infected as he was very swollen and with the use

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of diuretics his legs were "really weeping" providing opportunity for bacterial growth.

ADON also reported R11 is not compliant with wearing the foam boots and elevating his legs. Inquired whether R11 was provided with informed choices about his treatment (i.e., treatment options, consequences of refusing treatment) and offering of alternative treatment. ADON referred to Wound Care Consult report where it is documented education was provided. The ADON stated the facility was concerned about R11's comfort. ADON was agreeable to follow up on providing care plan for the prevention of pressure ulcers and documentation of the facility's discussion with R11 regarding informed choices and offering of alternative treatment.

On 10/13/22 at 12:20 PM, ADON provided a copy of the care plan for skin integrity. The date of initiation was 07/20/22 (14 days after admission) and documents resident has moisture associated skin damage (MASD) and pressure ulcers due to weakness and impaired mobility. This care plan was initiated/developed after R11 presented with skin breakdown. The interventions include:
-Administer treatments as ordered and monitor for effectiveness
-Educate the resident/family/caregivers as to cause of skin breakdown; including transfer/positioning requirement; importance of taking care during ambulating/mobility, good nutrition, and frequent repositioning
-Follow facility policies/protocols for the prevention/treatment of skin breakdown

The ADON did not provide documentation of the facility's discussion with R11 regarding informed choices and offering of alternative treatment.

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2) R54 was admitted to the facility on 11/18/21. Diagnoses include spondylosis (a condition in which there is abnormal wear on the cartilage and bones of the neck, cervical vertebrae), radiculopathy (injury or damage to nerve roots in the area where they leave the spine), spinal stenosis (narrowing of the spinal canal), and occlusion and stenosis of right carotid artery.

On 10/11/22 at 07:45 AM, R54 was interviewed in his room. R54 was observed lying in bed with his blanket suspended off his feet by a wired apparatus and an IV pole next to his bed. R54 reported that he currently has an infection in the bone and has sores to the left heel and on the right side. He reported the sores were very painful and the wired apparatus helps to keep the weight of his blanket off his feet. R54 reported he also had a sore on his "backside." On 10/11/22 at 12:53 PM, R54 reported the wound team came to see him and he requires two more weeks of antibiotics and wounds have healed up. R54 stated he will be discharged to his home after he completes the antibiotics.

On 10/12/22 at 01:15 PM, R54 was observed in bed. Inquired whether staff reposition him while in bed. He replied, staff do not assist to reposition him. Observed R54 has an air mattress and no sheet covering the mattress. Queried whether a sheet is used on his mattress, he replied a sheet is not used. He commented the mattress is slippery and he slides down, so he needs to be pulled up every four hours. R54 reported he wears the foam boots in bed and the doctor has told him he can remove the boots when out of bed. R54 further reported he received education about his wounds and has

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been cooperative. He stated that he was not aware the wound was present upon admission to the facility. Subsequent observation at 02:15 PM, R54 was seated in a wheelchair with prevalon boots on. On 10/13/22 at 08:32 AM, R54 was lying in bed, he was observed wearing his prevalon boots.

Review of the admission MDS with an ARD of 11/22/21 notes upon administration of the BIMS, R54 yielded a score of 15 (cognitively intact) required extensive assist with one-person physical assist for bed mobility, toilet use, and personal hygiene. Section M. Skin Conditions, documents R54 was at risk for development of pressure ulcer and had one unhealed pressure ulcer at Stage 1 or higher. The pressure ulcer was documented as unstageable. The treatment included pressure reducing device for chair, pressure reducing device for bed and pressure ulcer care.

A review of the resident's care plan provided by the facility found a focus area for infection (resident has IV antibiotic treatment due to osteomyelitis of the right lateral foot), there were no interventions for prevention of infections. The care plan for pressure injury with the goal to remain free from infection does not include interventions to ensure prevention of wound infections. Interventions include administer treatment as ordered and monitor for effectiveness, air mattress, apply foam boots to both feet while in bed, elevate resident's both legs with heel suspension/leg elevation cushion while in bed, monitor nutritional status, and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, type of tissue and exudate.

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The first documentation of wound care note (11/23/21) documents R54 with a DTI on left heel which reportedly occurred after falling asleep sitting down with foot down about 1.5 months prior to admission. R54 was admitted from home.

Summary of subsequent wound care notes include:
-12/21/21: DTI on the left heel measuring larger with a new DTI to right lateral foot which may be related to use of new footrests. The impression was pressure injury of deep tissue of left heel and pressure injury of deep tissue of right foot.
-01/11/22: "coccyx appears healed with dimple deformity."
-02/08/22: addition of pressure injury of deep tissue of toe on right foot. Also noted, resident reporting he slips down his bed and fee are up against the footboard. On 03/02/22 R54 assessed with MASD to right buttock as resident "insists on sitting in his wheelchair."
-03/01/22: culture of the wound found mixed skin-type flora
-03/22/22: new opening to spine/back and R54 on IV antibiotic for bacteremia
-05/03/22: pressure injury of right foot (Stage 4) and pressure injury to left heel (unstageable), there is exposure of bone on right lateral foot, and poor compliance with prevalon boots.
-05/24/22: bone culture of left heel grew staph lugdunensis (bacteria) and recommendation was for treatment
-06/14/22: R54 completed course for oral doxycline (antibiotic) for right foot infection
-06/28/22: missed appointment with wound team due to COVID-19 infection and poor compliance to boots and pillow offloading (elevating feet)

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F 686	Continued From page 43 -08/02/22: culture of left heel and right foot grew MRSA, poor compliance with prevalon boots and pillow offloading -08/16/22: R54 on oral doxycline for right and left wound infection -09/13/22: wound not visualized as R54 in hurry for PICC line insertion, recommendation for IV antibiotics for six weeks (vancomycin and Zosyn) -10/04/22: R54 continues IV antibiotics, left heel intact, and right foot (stage 4 pressure injury). Also noted under "Miscellaneous" the resident received meropenem for bacteremia (03/17/22 to 03/24/22), doxycycline for right foot wound infection (05/24/22 to 06/07/22), and doxycycline for left heel infection (08/02/22 to 08/16/22). Review of the weekly wound care notes from 07/05/22 through 10/04/22 documents R54 had poor compliance with the application of prevalon boots since 11/18/21. However, a review of R54's treatment record provided by the facility found from December 2021 through October 2022 there was no documentation of refusal for the application of bilateral foam boots. On 10/13/22 an interview was conducted with the ADON, the identified Infection Preventionist. ADON reported osteomyelitis (infection of the bone) was in the left lateral foot and R54 developed the pressure injury on his right foot due to poor circulation. Inquired how did R54 develop osteomyelitis. ADON reported organisms causing infections are introduced to the wound. ADON further reported she tracks infections and has observed facility staff performing dressing change and there has not been infection control breeches. The ADON suggested the surveyor contact the wound consultants.	F 686		

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F 686	Continued From page 44 A review of the facility's policy and procedure, titled "Quality of Care Skin Integrity." The guidelines include the following: -3. The facility will implement, monitor and modify interventions to attempt to stabilize, reduce or remove underlying risk factors. -6. A resident identified as at risk of developing PU/PIs (pressure ulcer/pressure injury) will have individualized interventions implemented to attempt to prevent PU/PI from developing. Interventions will be monitored for effectiveness. The resident's care plan will reflect the interventions. -15. Prevention and treatment plans will be individualized and consistently provided. -41. The first sign of infection in a PU/PI may delay in healing and an increase in exudate. In a chronic wound, signs of infection may include: a. Increase in amount or change in characteristics of exudate; b. decolonization and friability of granulation tissue; c. Undermining; d. Abnormal odor; 3. Epithelial bridging at base of the wound; and f. Sudden pain.	F 686		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that adequate pain management was provided to one resident	F 697	F697 PAIN MANAGEMENT SS: G CORRECTIVE ACTION OF RESIDENT	12/16/22

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F 697	Continued From page 45 (R34) in the sample. As a result of this deficient practice, R34 experienced pain that interfered with his movement, affected his mood, and diminished his appetite, thereby preventing him from attaining his highest practicable level of well-being. Findings include: Resident (R)34 is a 79-year-old male admitted to the facility on 08/10/22 with diagnoses that include muscular dystrophy, heart failure, and chronic pain syndrome. On 10/11/22 at 01:29 PM, an interview was done with R34 at his bedside. R34 reported constant pain "everywhere", but worse in his neck and hands. When asked, R34 stated that the pain medications he was on did little to relieve his pain. Concurrent observations noted several signs indicating severe pain. R34 was observed grimacing, biting his lower lip, holding his breath and or taking very shallow breaths, speaking in few words at a time, frequently stopping to catch his breath. His posture was stiff, and he moved slowly, making small, careful movements. R34 rated his pain at the time as a 10 out of 10 and stated that he was waiting for the Licensed Practical Nurse (LPN) to bring him his pain medication. R34 shared feelings of hopelessness, acute depression, and feeling overwhelmed. "I'm miserable, I hate it here, I hate being here, but I feel like there is no way I will ever get out of here now [due to constant pain affecting his mobility]." Expressed many fatalistic thoughts, feels he "will die here." When asked if he gets out of bed, R34 stated "I just can't ... it hurts ... just everywhere." At 01:58 PM when LPN2 brought in his pain medication, he asked	F 697	IDENTIFIED: R34s pain management regimen was reviewed and adjusted to include scheduled pain medication. Reviewed Administered PRN medication audit to determine pain medication effectiveness for all residents. IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All resident have the potential to be affected by this deficiency. Facility wide audit completed to identify residents receiving pain medication to determine the effectiveness of scheduled and PRN pain medication as documented in the clinical record. License nurse met with residents who are cognitively intact to discuss effectiveness of their pain management. MD notified for residents with reported concerns with current pain management regimen. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE: All nursing staff will be educated on pharmacologic and non-pharmacologic pain management.	

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YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE HILO, HI 96720

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F 697	Continued From page 46 her to put the tablet in his mouth and hold the water cup and straw for him because his hands "hurt too much." On 10/12/22 at 03:52 PM, a review of R34's medication orders noted an order for acetaminophen 500 milligrams (mg) every 6 hours as needed for pain rated 1-6/10, and an order for hydrocodone-acetaminophen 10-325mg every 6 hours as needed for pain rated 7-10/10. Despite the diagnoses of muscular dystrophy and chronic pain syndrome, no orders were found for continuous, round-the-clock, scheduled pain management. A review of R34's comprehensive care plan noted no non-pharmacological interventions for pain management. A review of R34's progress notes noted a dietary note on 10/11/22 documenting, "The resident is having decreased appetite ... pain in his hands/arms, affecting his appetite ..." A nursing note from 10/08/22 documented "Resident has poor intake and requires increased assistance with eating. OT (occupational therapy) eval (evaluation) requested. On 10/13/22 at 08:40 AM, observed R34 lying in bed with his breakfast tray on his bedside table. Some of his oatmeal was eaten, but nothing else on the tray had been touched. R34 reported severe pain and that he was waiting for pain medication. R34 stated he takes "hydrocodone" for pain but that "it does not help much." R34 was observed with facial grimacing and shallow breathing, speaking in short, slow sentences, and seemed short of breath. When asked if he wanted the Surveyor to get his nurse, R34 stated "no, I'm tired of arguing with them, f*ck, I don't want to get you involved." R34 reported that the pain in his hands was so bad, it made it hard to	F 697	Pain scale rating report will be reviewed weekly in the clinical meeting for pain 4 or higher to assess need for adjustment in pain management. Administered PRN medication report will be reviewed weekly in clinical meeting to assess need for adjustment in pain management. The Director of Nursing or designee will be responsible for ongoing compliance. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS: The pain scale rating report will be audited by the Director of Nursing or designee x 90 days or until 100% compliance is met in order to monitor for effectiveness of these changes and to ensure correction is achieved and sustained. The Administered PRN medication report will be audited by the Director of Nursing or designee x 90 days or until 100% compliance is met in order to monitor for effectiveness of these changes and to ensure correction is achieved and sustained.	

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F 697	Continued From page 47 eat or do much of anything.	F 697		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations and interview with residents and staff, the facility failed to ensure there were sufficient nursing staff to assure residents' highest practicable physical, mental and psychosocial well-being was attained or	F 725	F725 SUFFICIENT NURSING STAFF SS: F CORRECTIVE ACTION:	12/16/22

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F 725	Continued From page 48 maintained. Findings include: 1) On 10/12/22 at 09:00 AM an interview was conducted with the resident council representatives. The representatives were asked if they receive the help and care needed without waiting a long time. A representative reported the facility doesn't have enough workers, they leave faster than they are coming. The representative commented, the certified nurse aides are the "backbone of the company." A representative reported waiting "quite a while" for call light response, at times for 30 minutes or more, for assistance with urinal or going to the toilet. The late response often results in bowel incontinence. The representative noted it is usually around mealtimes when there aren't enough staff as they are occupied with assisting other residents with their meals and passing out trays. A representative reported there are times when a resident on his unit is yelling for help constantly as he is unable to use the call light. A review of the meeting minutes of 08/23/22, representatives shared concern about the shortage of nurses, they noticed nurses are hired and they are leaving. They expressed they are "afraid" of not being taken care of as a result of too little or no staffing. 2) On 10/11/22 at 08:30 AM an observation and interview was done with R32. R32 reported there aren't enough staff available. R32 reported he used the urinal at 07:00 AM and it was placed on	F 725	Recruitment efforts by management entity of Yukio Okutsu State Veterans Home have been proposed and approved to include salary increase for all nursing staff. Recruitment for agency traveler staff proposed and approved to fill FTE licensed positions needed to meet staffing grid. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURENCE: Human Resources Director or designee will develop employee recruitment and retention monthly report for Certified Nurse Aide and License Nurses to monitor effectiveness of recruitment efforts of salary increases. Call Light Focus Round developed and to be completed weekly to ensure timely response to residents needs. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS: Human Resources Director or designee will provide findings of the monthly Recruitment/Retention report to monthly QAPI meeting x 90 days to monitor effectiveness of recruitment efforts. Call Light Focus Rounds will be reviewed weekly by the Director of Nursing or designee and the findings will be submitted to QAPI monthly meeting x 90 days or until 100% compliance is met in	

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F 725	Continued From page 49 the overbed tray. Staff brought him his breakfast tray, he ate his breakfast, and staff removed his breakfast tray but didn't empty his urinal. R32 ate his breafast with a used urinal on his overbed tray. Observation confirmed a urinal containing urine was on R32's overbed tray. 3) On 10/13/22 at 03:31 PM, Registered Nurse (RN)5 was interviewed. RN5 stated that there were 30 residents to care for today because there was no treatment nurse, or third licensed nurse to help. In addition to caring for 30 residents, RN5 was still expected to answer phone calls from physicians, follow up with physicians, input physician's orders into the resident's electronic health record (EHR), update residents' care plans, and administer residents' treatments and medications. RN5 further stated that the load is too heavy and that's why newly hired RNs quit. 4) On 10/14/22 at 09:00 AM, Certified Nursing Assistant (CNA)16 was interviewed. CNA16 stated that the facility is short-staffed. They are supposed to have four CNAs in the unit, but most time there would only be two to three CNAs working. 5) On 10/14/22 at 10:59 AM, family member (FM)6 was interviewed. FM6 stated that while visiting R16 yesterday, R16 was never repositioned while he sat in his wheelchair from the time she arrived at 09:30 AM and leaving at 11:30 AM. FM6 stated that R16 was already up in his wheelchair when she arrived at 09:30 AM. FM6 further stated that she felt that R16 was checked on less because he had a tube to drain his urine into a collection bag.	F 725	order to monitor the effectiveness of these changes and to ensure correction is achieved and sustained.	

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F 725	Continued From page 50 6) On 10/10/22 at 12:00 PM, an interview was done with a family member (FM)2 who wished to remain anonymous. FM2 stated that she visited her husband almost daily and had witnessed several times "especially on the weekends" when the nurse and nurse aide staffing seemed short. Stated that she will usually do as much as she can herself rather than wait for staff to respond because it takes so long. 7) On 10/10/22 at 11:45 AM, during an interview at his bedside, when asked about staffing, Resident (R)29 stated that he had noticed the facility frequently seemed understaffed "on nights and weekends." 8) On 10/11/22 at 01:29 PM, an interview was done with R34. The interview was done in the resident's room at his bedside. When asked about staffing, R34 reported "understaffing ... sometimes weekends ... frequently on the night shift." It was observed that the resident's room was located at the end of the hall with no roommate, and no residents in the room across the hall. R34 stated that on the night shift, he "can go almost the whole shift with no one checking" on him unless he calls for help. When he does call, he "can wait up to an hour" for staff response. Wanted to make it clear that he was "not complaining," and verbalized a fear of retaliation.	F 725		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest	F 740		12/16/22

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F 740	Continued From page 51 practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility did not assure 2 of 5 residents (Resident 109 and 34) received necessary behavioral health services to attain or maintain their highest practicable mental and psychosocial well-being. As a result of this deficient practice, these residents did not have their needs met, and were placed at risk for a decline in their quality of life. This deficient practice has the potential to affect all the residents at the facility in need of behavioral health services. Findings include: 1) R109 was admitted to the facility on 09/23/22. Diagnoses include necrotizing fasciitis, cellulitis of right lower limb, cellulitis of left lower limb, and bacteremia. On 10/11/22 at 08:06 AM, R109 reported his mother died and while picking maile leaves for her funeral he fell and was impaled by a tree branch. He did not seek medical attention, then went to the beach where he contracted bacteria from the water. R109 was hospitalized, reported almost losing his foot but the doctor saved his leg by performing a skin graft. R109 stated that he was unable to grieve the loss of his mom. He expressed concern regarding discharge as he does not want to rely on his father to care for him	F 740	F740 BEHAVIORAL HEALTH SERVICES SS:D CORRECTIVE ACTION OF RESIDENT IDENTIFIED: R109 was provided with mental health services by Psychologist on 10/20/22 and has ongoing appointments. R34 was provided with mental health follow up by Psychologist on 10/20/22 with ongoing appointments. IDENTIFYING OTHER RESIDENTS HAVING THE POTEMTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKE: All residents have the potential to be affected by this deficiency. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE: Facility-wide audit completed to identify residents with PHQ9 score of mild or higher. Residents identified will be provided with weekly visits by social	

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F 740	Continued From page 52 as he is grieving the loss of his wife. R109 also expressed that he is embarrassed about the care he needs (can't even wipe my behind) and is a "crippled bastard." R109's admission Minimum Data Set with an assessment reference date of 09/29/22 was reviewed. The Brief Interview for Mental Status was administered, R109 yielded a score of 15 indicative of no cognitive impairment. R109 was interviewed for mood status. R109 reported having trouble falling asleep or staying asleep, or sleeping too much, feeling tired or having little energy, and poor appetite or overeating nearly every day. R109 yielded a score of 9 on the scale for depression (nine item depression scale of the patient health questionnaire) which indicated mild depression. A review of the Interdisciplinary Team (IDT) Care Plan Conference - Welcome Meeting dated 09/26/22 notes R109 scored an 8 when the PHQ was completed. Also noted, R109 has signs and symptoms of depression, social services offered mental health services which was declined. A review of R109's care plan notes a goal for "resident will have minimal adverse effects throughout the next review period," the interventions included encourage alternate communications with family, follow facility protocol for COVID-19, provide in room activities of choice, when able, and provide support and allow resident to express feelings, fears and concerns. Further review found no documentation in the progress notes that support services were provided.	F 740	services and or designee to identify need for additional mental health services. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS: Social Service or designee will submit report from weekly check ins to QAPI monthly meeting x 90 days or until 100% compliance is met in order to monitor the effectiveness of these changes and to ensure correction is achieved and sustained.	

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F 740	Continued From page 53	F 740		

On 10/13/22 at 04:50 PM an interview was conducted with Social Services Assistant (SSA). Inquired how is support provided for R109. SSA replied she is talking to him to see how he's doing, and he is not reporting that he is depressed, but upset with the situation. R109 reportedly does not participate in group activities and is keeping in touch with his family via telephone. SSA reported R109 has been referred to the psychologist via email. Requested to review the SSA's progress notes of supportive services and the email that was sent to the psychologist. As we were walking to the office, SSA reported the referral for the psychologist was not sent and there is no documentation of the meetings with R109.

2) Resident (R)34 is a 79-year-old male admitted to the facility on 08/10/22 with diagnoses that include muscular dystrophy, heart failure, and chronic pain syndrome.

On 10/11/22 at 01:29 PM, an interview was done with R34 at his bedside. R34 reported constant pain "everywhere", but worse in his neck and hands. When asked how he was doing, R34 shared feelings of hopelessness, acute depression, and feeling overwhelmed. "I'm miserable, I hate it here, I hate being here, but I feel like there is no way I will ever get out of here now [due to constant pain affecting his mobility]." Expressed many fatalistic thoughts, feels he "will die here." When asked if he gets out of bed, R34 stated "I just can't ... it hurts ... just everywhere." Reported activities staff does come in and try to involve/engage him but he "just can't get excited about any of that [due to constant pain]." R34 also shared that his dog died since he was admitted and that added to his feelings of

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F 740	Continued From page 54 depression and hopelessness. On 10/12/22 at 03:52 PM, a review of R34's electronic health record (EHR) was done. The depression screening done on 08/13/22 documented "There is signs and symptoms of depression." Despite identifying signs of depression at admission, and nursing notes documenting "gloomy all the time, lethargic in energy ...," record review found only one referral/evaluation done by a mental health professional. The consulting Psychologist documented "Is depressed, exacerbated by loss of independence ..." There were no new orders or recommendations as a result of the 09/22/22 psychological consult except for a 2-week follow-up. Record review and document request to the administration produced no documentation that the follow-up had occurred. A review of R34's comprehensive care plan found no care plan to address the depression identified at admission.	F 740		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure one resident (R) diagnosed with dementia, received the appropriate treatment and services to attain or maintain her highest practicable physical, mental, and psychosocial well-being. As a result of this	F 744	F744 TREATMENT/SERVICE FOR DEMENTIA SS: D CORRECTIVE ACTION OF RESIDENT IDENTIFIED:	12/16/22

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F 744	Continued From page 55 deficient practice, R56 did not have her needs met, and was placed at risk for a decline in her quality of life. This deficient practice has the potential to affect all the residents at the facility with a diagnosis of dementia. Findings include: R56 is an 84-year-old female admitted to the facility on 03/28/19 with admitting diagnoses that include Parkinson's Disease, major depressive disorder, generalized anxiety disorder, and dementia with agitation, behavioral disturbances, and anxiety. On 10/11/22 at 10:38 AM, during a review of R56's comprehensive care plan (CP) the following intervention was noted: "Resident prefers to have "STOP SIGN" placed on her door." There were no observations made throughout the survey period of a stop sign placed on resident's door. Further review of R56's CP also noted the facility had identified that R56's anxiety and behavioral disturbances could be triggered by unfamiliar people approaching her and/or entering her room unannounced, and loud noises. On 10/11/22 at 11:54 AM, while standing outside of room 107, observed R13 walk out of his room, loudly apologizing, wearing only a t-shirt and a pair of adult incontinent briefs, quickly walk directly across the hall to R56's room and with no obstructions in the doorway, was about to enter. A staff member was able to stop and redirect him back to his room just as he entered R56's doorway. Review of R13's electronic health record noted that the facility had previously identified R13 as a wanderer and had several	F 744	R56 care plan has been updated to reflect her care preference regarding use of "stop sign" IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected by this deficiency. Comprehensive care plans will be reviewed for residents with a diagnosis of dementia to ensure interventions are implemented to attain or maintain residents highest practicable physical, mental, and psychosocial well-being. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE: All staff will be educated on person-centered care plans (Person-Centered Planning-20-872912. Comprehensive care plans will be reviewed quarterly and as needed by the Interdisciplinary Team. The Director of Nursing or designee will be responsible for ongoing compliance. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS: IDT Care Plan Conference Evaluations will be reviewed weekly by the Director of	

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F 744	Continued From page 56 interventions to address his wandering behavior in his CP.	F 744	Nursing or designee and findings will be submitted to QAPI monthly meeting x 90 days or until 100% compliance is met in order to monitor the effectiveness of these changes and to ensure correction is achieved and sustained.	
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 observation and interview, the facility failed to ensure that one resident (R) was free from a significant medication error as evidenced by R47 being administered an insulin pen that was labeled as expired for six days. In addition, the insulin would have been administered for a seventh day had the state agency (SA) not intervened. Safe medication administration practices are essential for the health and well-being of the residents. As a result of this deficient practice, R47 was placed at risk of inadequate glucose control as a result of being administered expired insulin. This deficient practice has the potential to affect all residents in the facility receiving insulin. Findings include: On 10/13/22 at 09:30 AM, Registered Nurse (RN)5 was observed preparing medications for Resident (R)47. One of the medications prepared was an insulin pen that RN5 removed from a plastic bag labeled with the prescription label. In addition to the prescription label	F 760	F760 RESIDENTS ARE FREE OF SIGNIFICANT MED ERRORS: D CORRECTIVE ACTION OF RESIDENT IDENTIFIED: R47's insulin pen was disposed of. Audit of all medication carts were checked for additional expired medications on 10/13/2022 with no additional findings. IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORECTIVE ACTION WILL BE AKEN: All residents have the potential to be affected by this deficiency. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE:	12/16/22

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F 760	Continued From page 57 identifying the medication, dose ordered, and resident name, there were two small stickers attached to the bag that identified the pen as being opened on 09/08/22, and to discard the pen "after 10/06/22." There were no labels observed on the insulin pen itself. RN5 dialed in the correct dose and showed the insulin pen to the SA for confirmation. The SA asked RN5 to read the discard label, which RN5 read aloud twice, specifying the date opened and the date to discard. After the SA pointed out that the current date was well past the discard date, RN5 confirmed that she had not checked the expiration date and would have given the insulin had she not been stopped by the SA.	F 760	All license nurses will be educated on medication labeling and storage. Medication carts will be checked weekly for any expired medications. The Director of Nursing or designee will be responsible for ongoing compliance. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS: Findings of the Medication Cart checks will be submitted by the Director of Nursing or designee and findings will be submitted to QAPI monthly meeting x 90 days or until 100% compliance is met in order to monitor the effectiveness of these changes and to ensure correction is achieved and sustained.	
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population,	F 838		12/16/22

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	125058	A. BUILDING _____ B. WING _____	10/14/2022

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F 838	Continued From page 58 including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing	F 838		

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F 838	Continued From page 59 information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on review of the facility's assessment, the facility failed to include the facility's assessment of the facility's resources to meet the needs of their resident population. Findings include: The facility assessment was reviewed as interviews with residents indicated the facility does not have enough staff to provide care in a timely manner. Review of the facility assessment found documentation that describes the facility's resident population, however, based on the acuity level of the residents, there was no documentation of the staffing levels, contract services required, and equipment, supplies required to meet the residents' needs.	F 838	F838 FACILITY ASSESSMENT: F CORRECTIVE ACTION OF RESIDENT IDENTIFIED: Facility Assessment reviewed and updated to include the assessment of resources necessary to meet the needs of the resident population. IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORECTIVE ACTION WILL BE AKEN: All residents have the potential to be affected by this deficiency. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE: Facility Assessment will be reviewed monthly x 90 days, then annually and as needed. The Administrator or designee will be responsible for ongoing compliance. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS:	

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F 838	Continued From page 60	F 838	Findings of the Facility Assessment reviews will be submitted by the Administrator or designee to the monthly QAPI meeting x 90 days or until 100% compliance is met in order to monitor the effectiveness of these changes and to ensure correction is achieved and sustained.	
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. §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;	F 842		12/16/22

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F 842	Continued From page 61 (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 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 observation, record review and	F 842	F842 RESIDENT	

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F 842	Continued From page 62 interview, the facility failed to ensure that the health record for one resident (R)7, out of a sample of 19 residents, accurately conveyed R7's current wishes for medical treatment. This deficient practice has the potential to confuse caregivers to ensure the resident's wishes are executed. Findings include: On 10/11/22 at 12:25 PM, a concurrent observation and interview were done with R7. R7 laid in bed at a 45 degree angle watching television, his body leaning to the left and his feet towards the right lower edge of his mattress. Both feet were noted to have foot drop (toes pointing down with the inability to lift that part of the foot) and he wore padded boots on both feet. R7 wore tubing in his nares that delivered oxygen from the oxygen compressor located next to his bed. On 10/12/22 at 10:57 AM, R7's electronic health record (EHR) was reviewed. The "Medical Diagnosis" screen revealed that R7 is a 74 year-old resident who was admitted on 04/27/16 for heart failure. R7 has additional diagnoses of "spinal stenosis, lumbar region without neurogenic claudication" or narrowing of the spinal cord in the lower back causing compression of the lower back nerves not causing difficulty in walking, bipolar disorder, and presence of an artificial heart valve. R7's Advance Health Care Directive (AHCD) revised on 02/11 assigned his sister to be his health care agent and that he did not want to have life-sustaining treatments. A Physician Orders for Life-Sustaining Treatment (POLST) document prepared on 04/27/16 was also found in R7's EHR. It did not identify his sister as being his	F 842	RECORDS-IDENTIFIABLE INFORMATION SS: D CORRECTIVE ACTION OF RESIDENT IDENTIFIED: R7 was offered to complete a new Advanced Health Care Directive IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORECTIVE ACTION WILL BE AKEN: All residents have the potential to be affected by this deficiency. Facility-wide audit of all residents Advanced Health Care Directives, Providers Order for Life Sustaining Treatment (POLST), and MD orders was completed to confirm that the content is consistent. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE: Advanced Health Care Directives will be reviewed and compared with POLST and MD Orders in quarterly IDT meetings and as needed to ensure consistency. IDT Care Plan conference evaluations will be audited weekly to ensure AHCD, POLST and MD orders are consistent. Social Services or designee will be responsible for ongoing compliance.	

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F 842	Continued From page 63 health care agent and it indicated that he wanted cardiopulmonary resuscitation (CPR), "full treatment" which includes a breathing tube, ventilator to help him breathe, electrical shock of his heart to bring it back into a normal rhythm, and to be transferred to the hospital. "Orders" also indicated that R7's treatment is "Full Code, Full Treatment, Defined trial period of artificial nutrition by tube," which are all life-sustaining treatments. R7's current care plan indicated under the focus, "ADVANCE DIRECTIVE/POLST," the goal of "Resident's desires and wishes will be followed according to signed Advanced Directive & POLST. Date initiated 04/19/2019," the interventions of: "Staff will review with me my healthcare directives quarterly thereafter to verify that my wishes have not changed" and "Staff will understand and follow resident's Advanced Directive & POLST." The facility's "RESIDENT RIGHTS- ADVANCE HEALTHCARE DIRECTIVES QUARTERLY REVIEW" document dated 07/12/22 showed check marks that indicated the following were done with R7: "Review Code Status," "Advance Directives reflects current wishes," and "Staff has reviewed the Advanced Directives/Code Status with me." On 10/14/22 at 10:45 AM, Social Services Assistant (SSA)1 was interviewed. SSA1 stated that the wishes on the POLST and AHCD do not coincide because the POLST takes effect when R7 needs immediate emergency medical treatment and the AHCD goes into effect when R7 becomes incapacitated. SSA1 further stated that R7's wishes should be clearly documented in his record and care plan. Review of "Advance Directive/POLST" policy	F 842	MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS: Findings of the IDT care plan conference audits will be submitted by Social Services or designee to the monthly QAPI meeting x 90 days or until 100% compliance is met in order to monitor the effectiveness of these changes and to ensure correction is achieved and sustained.	

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F 842	Continued From page 64 effective 06/22 stated, " ... V. Procedure ... e. If the resident has an existing AD [Advanced Health Care Directives form], the physician or APRN [advanced practice registered nurse] should ensure the content is consistent with those indicated on the POLST. In the event where a resident's choices have changed, the MD [medical doctor] should encourage the resident to update his/her AD and inform nursing and social services staff."	F 842		