STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING _____ B. WING _____	05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ISLANDS SKILLED NURSING & REHABILITATION	1205 ALEXANDER STREET HONOLULU, HI 96826

(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 on 05/25/23. The facility was found not to be in substantial compliance with 42 CFR 483, Subpart B. Survey Dates: 05/22/23 to 05/25/23 Survey Census: 35 Sample Size: 13	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		

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

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 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 resident interviews and record reviews, the facility failed to ensure the resident's right to an environment that promotes enhancement of his or her quality of life, as evidenced by staff speaking a foreign language while providing care to residents was honored by staff members. Findings include: On 05/22/23 at 10:42 AM an interview was conducted with resident council representatives. During the interview R24 stated, "they don't speak English sometimes." When asked how he felt about staff speaking a foreign language around him, he replied, "you in America, talk English." On 05/24/23 at 11:00 AM R3 stated that staff still speak in Filipino around the residents, but it doesn't bother him. R3 added, "but it might bother other residents." A review of the facility's Resident Council Minutes	F 550		

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F 550	Continued From page 2 was conducted on 05/22/23 at 02:20 PM. According to the Resident Council Minutes dated 06/24/22,"CNAS [Certified Nurse Aides] are talking loud in their language around residents, residents are bothered." Furthermore, Resident Council Minutes dated 04/26/23 stated, "staff continues to speak to each other in foreign language."	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not	F 561		

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F 561	Continued From page 3 interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to identify and support one resident's (R)17 preference to not be placed in a yellow gown. As a result of this deficient practice, R17 did not have his needs met and was placed at risk of not attaining his highest practicable well-being. Findings include: An observation was done on 05/22/23 at 08:20 AM of Resident (R)17 in bed with a bright yellow facility gown on. When asked about the yellow gown, R17 stated "I don't like it, I prefer the other gown, the blue one." On 05/23/23 at 07:29 AM, an interview was done with R17 in his room. R17 stated that he has told "the CNAs [certified nurse aides]" his preference to wear blue, but he still is "put in whatever is available." On 05/25/23 at 08:00 AM, observed R17 in bed wearing another yellow gown. When asked about it, R17 shrugged and stated, "I have no choice in the matter ... they [staff] don't seem to think so, they keep putting me in this."	F 561		
F 577 SS=E	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	F 577		

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F 577	Continued From page 4	F 577		

(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 observations and interviews, the facility failed to post the results of the facility's most recent State survey, that is easily accessible to residents, legal representatives, and family members.

Findings include:

A resident council interview was conducted with resident representatives on 05/24/23 at 11:00 AM. Residents were asked if the result of the State inspection was available for the residents to read, Residents 3 and 26 both answered, "no."

A concurrent observation and interview with the Director of Nursing (DON) was conducted on 05/24/23 at 01:30 PM. When asked for the

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F 577	Continued From page 5 locations of the State survey report, DON pointed at the coffee table located on the first floor near the facility entrance. He then stated that there should also be a copy in the Medical Records Director's office on the fourth floor. Further asked if the residents had access to the State survey results on the units, DON answered, "yes, both the units should have one." SA then requested for the DON to show the locations of the State survey report on both the second and third-floor units. DON and SA walked through the third-floor unit first and DON failed in locating the State survey report on the third-floor unit. DON and SA then walked through the second-floor unit. DON failed in locating the State survey on the second-floor unit. DON then stated, "we will put one on each floor."	F 577		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and 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.	F 584		

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F 584	Continued From page 6 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to provide safe, clean, and homelike environment for the residents. The facility failed to repair damaged linoleum floor, and ripped privacy curtain for one of the residents (Resident (R) 20) sampled and in two additional rooms. Findings include: On 05/22/23 at 08:33 AM, initial observation was done on the third-floor unit. Observed drawn privacy curtain for R20 in room 302 with two holes on the lower portion of it. The linoleum flooring on the foot of the bed was also in disrepair exposing the old, darker colored flooring under the existing one. R20's bed was located closest to the door	F 584		

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F 584	Continued From page 7 making the damaged floor and ripped privacy curtain visible from the hallway of the unit. Observed the rest of the rooms on the third floor and noted rooms 301 and 305 also had cracks in the linoleum by the foot of the beds. On 05/25/23 at 10:11 am, concurrent observation and interview was done with the Director of Maintenance and Environment Services (DMES) by room 302. DMES stated that he is aware of the damaged floor, but they are waiting for the new bed to come in first. DMES stated that the damage was caused by the leg of the bed scrapping the linoleum when the staff move it while the bed is set on the lowest position. DMES also mentioned the cracks on the linoleum floor in rooms 301 and 305 were caused by the staff moving the beds while the brakes are engaged, and the facility is planning to change the linoleum to same material used on the hallway. Asked DMES when he was notified of the damage to the floor in room 302, he responded "I'm not sure of the exact date, but it was a couple of months ago." At 01:25 PM, DMES provided a copy of the work order created on 02/10 (no year noted) with a heading that stated, "Right Bed Rails - Tear in Floor."	F 584		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a	F 623		

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F 623	Continued From page 8 representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is	F 623		

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F 623	Continued From page 9 transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide	F 623		

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F 623	Continued From page 10	F 623		

written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interviews, the facility failed to provide written notice of discharge to the resident or residents' representative for three residents (R) sampled, R6 and R38 who were discharged to an acute care hospital for a higher level of care, and R22, who was discharged home. The facility also failed to send a notice of discharge to the Office of the State Long-Term Care Ombudsman (LTCO).

Findings include:

Cross Reference to F625 - Notice of Bed Hold Policy Before/Upon Transfer (written notification of bed hold policy was not provided to residents or representatives).

1) R6 was admitted to the facility on 11/02/22. On 05/23/22 at 10:45 AM review of the Electronic Health Record (EHR) revealed that R6 was admitted to an acute care hospital on 02/12/23 for scrotal abscess (accumulation of pus). Discharge notification and LTCO notification were not found in EHR.

On 05/25/23 at 08:40 AM, a copy of the discharge notifications was requested from the Medical Records Director (MRD). At 09:36 AM, MRD provided the hospital discharge summary from the acute care hospital where R6 was admitted.

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F 623	Continued From page 11 On 05/25/23 at 01:00 PM, interview conducted with the Director of Nursing (DON) in his office. Asked DON who notifies the resident or resident representative and the LTCO of any discharges and transfers, he replied that the Social Services Director (SSD) does. Met with the SSD in her office and requested copies of the discharge notifications for R6. SSD responded that she does not do the notifications and that it is done by the nurse on the floor. Informed DON the SSD said the notifications are provided by the nurses. Asked DON if he can provide a copy of the resident or representative and LTCO notification of discharges and transfers. DON checked in R6's EHR and said he was not able to provide the documents and that it was not done. 2) R38 is a resident admitted to the facility on 02/17/23 and transferred to an acute care hospital on 04/07/23. Review of the EHR under "Progress Notes" revealed that the last entry was on 04/08/23 at 09:23 AM stated that R38 was admitted to the acute care hospital with a diagnosis of encephalopathy (damage or disease affecting the brain). No other notes or documents of notification of transfer or discharge was found in the EHR. On 05/25/23 at 08:40 AM, a copy of the discharge notifications was requested from the Medical Records Director (MRD). At 09:36 AM, MRD said that there is no notification of discharge for R38 because she was transferred out to the hospital and never returned. 3) R22 was admitted to the facility on 03/07/23. A review of the EHR was conducted on 05/24/23 at	F 623		

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F 623	Continued From page 12 10:00 AM. The EHR indicated that R22 was discharged home from the facility on 05/17/23. Prior to his discharge, the facility failed to provide a written notice of discharge to R22 and/or R22's representative. An interview was conducted with the facility's SSD on 05/24/23 at 02:51 PM. SSD was asked if written notification was given to R22 and/or his representative regarding R22's planned discharge from the facility. SSD answered, "no, I did not give him a written notification because we were in constant communication."	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At	F 625		

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the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interview, the facility failed to provide written notice of the facility's bed-hold policy for two residents (Residents 6 and 38) in the closed record sample. This deficient practice has the potential for miscommunication with residents that are discharged or transferred out of the facility.

Findings include:

Cross Reference to F623 - Notice Requirements Before Transfer/Discharge (written notice of discharge was not provided to residents or residents' representatives)

1) On 05/23/22 at 10:45 AM review of the Electronic Health Record (EHR) for R6 revealed that he was admitted to an acute care hospital on 02/12/23. Discharge and bed-hold policy notifications were not found in EHR. During a concurrent interview and record review with the Director of Nursing (DON) on 05/23/23 at 01:00 PM, DON was not able to find or provide documentation that the resident or resident's family was notified of the facility bed-hold policy.

2) R38 was admitted to the facility on 02/17/23 and transferred to an acute care hospital on 04/07/23. Discharge and bed-hold policy notifications were not found in EHR during record review. On 05/25/23 at 08:40 AM, a copy of the

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F 625	Continued From page 14 discharge and bed-hold policy notifications was requested from the Medical Records Director (MRD). At 09:36 AM, MRD said that there is no notification of discharge for R38 because she was transferred out to the hospital and never returned to the facility.	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		

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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.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to develop and implement person-centered Comprehensive Care Plans (CPs) for 2 of 12 residents in the sample (Residents 19 and 21). As a result of this deficient practice, both Resident (R)19 and R21 were placed at risk for avoidable injury and/or declines in their quality of life and were prevented from attaining their highest practicable well-being.

Findings include:

1) Cross-reference to F684 QOC. Despite two visits to the Emergency Room for malpositioning of his gastrostomy tube (G-tube), the facility failed to develop and implement a care plan to verify proper placement of the G-tube prior to use for R19. As a result of this deficient practice, the facility placed R19 at risk for avoidable pain and injury.

2) R21 was admitted to the facility on 06/22/22

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F 656	Continued From page 16 with admitting diagnoses that include retention of urine, gross hematuria (blood in his urine), and benign prostatic hyperplasia (an enlarged prostate gland that causes problems with urination). As a result of these and other diagnoses, R21 had an indwelling catheter placed at the beginning of March 2023. On 05/23/23 at 04:00 PM, during a review of R21's CP it was noted that there was no care plan developed for monitoring and care of his indwelling catheter, or for the problem of hematuria identified at admission. On 05/25/23 at 01:25 PM, an interview was done with Registered Nurse (RN)3 at the third floor nurses' station. RN3 stated that a care plan for monitoring and care of an indwelling catheter should be initiated the day the catheter is placed. During a concurrent review of R21's electronic health record (EHR), RN3 confirmed that there was no care plan initiated for either the indwelling catheter or the hematuria. RN3 also confirmed that he would have expected to see the care plan for hematuria initiated at admission.	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.	F 657		

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F 657	Continued From page 17 (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 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 record reviews and interviews with staff members, the facility failed to revise the care plan for 2 (Residents 33 and 13) of 12 residents in the sample. Findings include: 1) Cross Reference to F689. Resident (R)33 fell on 05/18/23, a post fall risk assessment was completed. There was no documentation that R33's current care plan interventions were effective, therefore revisions were not indicated to prevent falls. Also, there was no documentation that based on post fall evaluation, the care plan was revised for fall prevention. 2) Cross Reference to F689. R13 had a history of falls and had an actual fall on 04/16/23. There was no documentation of care plan revisions to prevent further falls or there was no	F 657		

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F 657	Continued From page 18 documentation of a need for revisions were needed, the current interventions are effective for fall prevention.	F 657		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with staff, resident, and resident's representative, the facility failed to: 1) provide services for a resident that had a craniectomy (neurosurgical procedure that involves removing a portion of the skull to relieve pressure on the underlying brain) related to a motor vehicle accident, including scheduling of follow up appointments with the nuerosurgeon or development a care plan to address precauations while caring for this vulnerable resident; and 2) ensure nursing care provided for residents with gastrostomy tube (g-tube) met the needs of two residents in the sample (R19 and R189), and were in alignment with standards of good clinical practice and/or facility policy and procedure. as evidenced by nurses not verifying proper placement of the G-tube prior to use. Findings include:	F 684		

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F 684	Continued From page 19 1) Cross Reference to F689, Accidents. Resident (R)33 had a fall and based on a root cause analysis the facility did not revise the care plan to include interventions for fall prevention. R33 was admitted to the facility on 04/26/23 following hospitalization. Diagnoses include but not limited to traumatic subdural hemorrhage with loss of consciousness of unspecified duration; acute and chronic respiratory failure with hypoxia; acute and chronic respiratory failure with hypercapnia; gastrostomy; traumatic cerebral edema with loss of consciousness greater than 24 hours with return to pre-existing conscious level; aphasia; fracture of base of skull; and dysphagia. On 05/23/23 at 09:18 AM interviewed R33's mother. Mother reported R33 had two falls since admission. She also reported her daughter requires two people for transfers and some of the Certified Nurse Aides (CNA) have difficulty. Mother further reported there was an occasion when they almost dropped R33. Inquired whether a Hoyer lift is used for transferring R33. Mother responded sometimes the staff use the Hoyer lift. Record review found a hospital admission report dated 04/06/23 which noted R33 was involved in a moped accident. The trauma progress note dated 04/07/23 documented R33 had a right hemicraniectomy. On 4/26/23, R33 was discharged from the hospital and transferred to the facility. A review of the "After Visit Summary" documented to schedule an appointment with the neurosurgeon "as soon as possible for a visit in 2 week(s)." Further review found no documentation R33 was seen by the neurosurgeon for a follow up appointment.	F 684		

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F 684	Continued From page 20 Review of the oprder summary found a physician order for "common sense for c-spine precaution". Also noted order dated 05/08/23 (eleven days after admission) of a scheduled appointment with neurosurgeon on 07/07/23. On 05/23/23 at 08:15 AM, interviewed Registered Nurse (RN)19. Inquired what precautions are taken while providing care to R33. RN19 responded they have a low bed and fall mat. Further queried whether there are any precautions to protect her brain as she is missing part of her skull. RN19 reported following the Emergency Department (ED) visit on 05/22/23, there was recommendation for a helmet. At 02:05 PM, RN19 reported they are still working on obtaining the soft-shell helmet. Inquired what are the precautions related to the order for "common sense for c-spine precaution." RN19 replied she will need to check with the Director of Nursing (DON). Progress note dated, 05/24/23 at 07:38 AM noted a Certified Nurse Aide (CNA) reported to the nurse that she accidentally bumped R33's head while assisting with shower. CNA reported to nurse, R33 cried, and mother was upset. On 05/23/23 at 02:10 PM reviewed the order for "common sense for c-spine precaution" with the DON. Asked what the precautionary measures are related to this order. The DON responded, the staff are to use log rolling when turning R33. On 05/24/23 at 07:45 AM queried Unit Manager (UM) whether there are safety precautions for staff to follow when providing care to R33. UM was agreeable to "look into it". UM confirmed the	F 684		

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facility has provided care to residents that have had a craniectomy.

On 05/24/23 at 10:04 AM concurrent record review and interview was done with the Director of Nursing (DON). DON confirmed the order for follow-up appointment with neurosurgeon was ordered on 05/08/23 and progress note dated 05/08/23 documented the visit was scheduled for 07/07/23.

Further queried whether the facility has developed a care plan to address providing care to a resident that has a craniectomy (identifying the resident's vulnerability and precautions during care). DON reviewed the care plan and confirmed the facility did not develop a care plan to address R33's risk for injuries related to craniectomy.

2) R19 was admitted to the facility on 09/19/22 with admitting diagnoses including high blood pressure, diabetes, respiratory failure requiring a tracheal tube (inserted to establish and maintain a patent airway and to ensure the adequate exchange of oxygen and carbon dioxide), and G-tube (surgically placed device to give direct access to the stomach for supplemental feeding, hydration, and/or medication). During a review of R19's electronic health record (EHR) on 05/23/23 at 07:40 AM, it was noted that he had been sent out to the emergency room (ER) on 04/03/23 and 05/22/23 for pain, redness, and swelling around his G-tube site. Abdomen and Pelvis CT [computerized tomography] scan results on both dates showed a "malpositioned" G-tube requiring x-ray guided repositioning at the hospital.

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F 684	Continued From page 22 On 05/23/23 at 01:50 PM, an interview was done at the bedside with R19's family representative (FR). FR was very upset that R19 had to go to the ER again. Stated it is exhausting for him, and exhausting for her as well. FR explained that R19's Physician had come to visit him yesterday, "took one look at his G-tube site and said he needs to go to the ER." FR stated that the ER Physician told her, "The nurses [at the facility] are pulling the tube out too much when they are changing the dressing." On 05/23/23 at 02:00 PM, a review of R19's active provider orders noted the following order since 09/19/22: "Every shift Check tube placement before initiation of formula, medication administration, and flushing tube ..." On 05/23/23 at 04:30 PM, during a review of R19's comprehensive care plan, it was noted that nowhere in his care plan were there interventions to verify placement of his G-tube. On 05/24/23 at 07:55 AM, observations were done of Registered Nurse (RN)22 preparing to administer tube feeding through R19's G-tube. Observed RN22 administer an initial flush of water from the bathroom sink into the G-tube without doing a check for placement or residual. After the initial flush, RN22 was observed lifting up the G-tube site dressing to visually check for any leakage. At 07:57 AM, the tube feeding was started. A review of the undated facility-provided policy and procedure, Enteral Feeding, noted the following:	F 684		

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F 684	Continued From page 23 "2. Confirm tube placement prior to use ...." "13. Check placement (see step 3 instructions)" "14. Check residual and check ordered residual when to hold ..." 3) On 05/22/23 at 09:18 AM during the initial observations in room 208, Registered Nurse (RN) 22 entered room and stated he was there to administer R189's morning medications through his G-tube. RN22 placed a medicine cup filled with liquid on the bedside table, poured water into another cup from the water pitcher that was on the bedside table, performed hand hygiene and donned gloves. RN22 then took the syringe that was in a plastic bag hanging on the pole and filled it with the liquid in the medicine cup, inserted the tip of the syringe in R189's G-tube, pushed the liquid into the G-tube then flushed it with water that was in a separate cup. RN22 was not observed to verify the G-tube placement in the stomach prior to administering the medication.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		

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F 689	Continued From page 24 Based on record review and interviews with staff, residents, and resident representatives, the facility failed to ensure residents remained free from accidents for 2 (Residents 33 and 13) of 3 residents in the sample. The facility did not complete an initial fall risk assessment to develop interventions for fall prevention and did not assure monitoring for effectiveness and modifying interventions were done as necessary. Findings include: A review of the "Fall Risk Assessment" policy and procedure provided by the facility documented "the nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information." A review of the "Falls and Fall Risk, Managing" policy and procedure noted in section titled Resident-Centered Approaches to Managing Falls and Fall Risk, "5. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approaches remains relevant ...6. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable." 1) Cross Reference to F684 and F657. Resident (R)33 was admitted to the facility on 04/26/23 following an acute hospitalization. R33	F 689		

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F 689	Continued From page 25 was involved in a moped accident resulting in a right hemicraniectomy. On 05/22/23 at 09:18 AM interviewed R33's mother. Mother reported R33 had two falls since admission, both times R33 was attempting to get out of bed, the first time to get something to drink and the second time to get food. Mother reported, R33 fell yesterday (05/21/23). As a result of the fall, R33 reportedly had bruising and complained of headaches. Mother thinks R33 hit her head when she fell. Mother shared, R33 got into a moped accident and had part of her skull removed. Mother expressed concerns for her daughter's safety. Record review found no documentation of the fall (05/21/23) as Mother reported. There was a progress note dated 05/18/23 at 07:30 AM, which documented R33 was found by the Certified Nurse Aide (CNA) on the floor mat, laying on her right side. R33 reported she wanted to get water. R33 repeatedly complained of headache but not unusual or new pain, compared to baseline. R33 was "re-educated on the importance of fall risk". R33's physician was at the facility and did a neuro-assessment. On 05/22/23 at 11:27 AM, R33 complained of a "bad headache." Asked R33 whether she was provided with medication, R33 confirmed she was given medication, sometimes it works and sometimes it doesn't work. R33 also stated sometimes it just gets bad and then goes away. On the afternoon of 05/22/23, R33 was taken to the Emergency Room (ER) related to complaints of headache. R33 returned to the facility.	F 689		

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F 689	Continued From page 26 On 05/23/23 at 08:15 AM, interviewed Registered Nurse (RN)19. RN19 reported R33 received pain and anti-nausea medication at the ER. RN19 further reported a soft helmet was ordered by the acute hospital. Inquired on the status of the soft helmet, RN19 was agreeable to follow up. On 05/24/23 at 07:45 AM, the Unit Manager (UM) was asked on the status of R33's soft helmet. UM reported he was not sure that the helmet came in. He further asked if rehab ordered it. Record review found an initial fall risk evaluation completed on 04/26/23. The assessment was incomplete, there was no answer to the following questions, level of consciousness/mental state and ambulation/elimination status. Based on the incomplete evaluation, R33 yielded a score of 6. Review of the Baseline Care Plan noted R33 did not have a history of falls. A review of the Post Fall Evaluation dated 05/18/23 describes R33 was found on the ground, bed was in the lowest position and the light was on. The contributing factors identified included floor mat on floor and resident using incontinent supplies at time of fall. There were no identified physiological factors (i.e., change in mental status, change in medication, change in diagnosis) contributing to the fall. A review of R33's care plan initiated 05/09/23 notes an identified problem, R33 "has had an actual fall with trauma injury (mopped crushed), poor balance, poor communication/comprehension, unsteady gait" with an outcome for "head trauma will resolve without complication by review date." The interventions included: continue interventions on the at-risk plan; provide activities that promote	F 689		

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exercise and strength building when possible; provide 1:1 activities if bedbound; and PT (physical therapy) consult for strength and mobility. There was no documentation of an "at-risk plan" for fall prevention. There were interventions for non-verbal communication which included intervention to ensure/provide a safe environment, call light in reach, adequate low glare light, bed in lowest position and wheels locked, and avoid isolation (initiated 04/27/23).

Although a post fall risk evaluation was completed on 05/18/23, there was no documentation of care plan revisions or decision that current interventions were adequate for fall prevention.

On 05/23/23 at 09:22 AM an interview and concurrent record review was done with the Director of Nursing (DON). DON reported R33 was taken to ER on 05/23/23 per Mother's request. A CT scan was done with no changes. DON further reported Mother made queries while at the acute hospital for a helmet. Inquired on the status of obtaining the helmet. DON reported there is no order for the helmet and usually residents are discharged from the hospital to the facility with a helmet, order would come from the neurosurgeon. (Cross Reference to F684: R33 was not scheduled for follow-up appointment with the neurosurgeon since discharge from the hospital on 04/26/23 to consider ordering of a helmet.) DON stated as there is no order for the helmet, Mother would have to purchase on her own.

On 05/24/23 an order was entered for soft shelled helmet, custom internal padding to be changed weekly and as needed soiled or requested by

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patient related to traumatic cerebral edema with loss of consciousness greater than 24 hours with return to pre-existing conscious level.

Reviewed the initial fall assessment with the DON. DON confirmed the initial assessment was incomplete, which resulted in an inaccurate score. DON reported on admission R33 was very lethargic, had no history of falls, and did not require a care plan for fall prevention. DON reported R33's care plan was not revised following her fall on 05/18/23. However, upon return from the ER on 05/22/23, R33 was moved to a bed closer to the nurses' station and provided with the lowest bed possible. DON reported the facility had already provided a floor mat.

2) R13 was admitted to the facility on 01/26/22. Diagnoses include but not limited to hemiplegia and hemiparesis following unspecified cerebrovascular accident affecting left non-dominant side; epilepsy; and protein-calorie malnutrition.

On 05/22/23 at 02:00 PM, interviewed R13. R13 stated she had one fall, but it really wasn't a fall. She recalled she was trying to get onto her bed and slipped down to the floor. R13 stated she used to get out of bed and walk to her dresser next to her bed. After this incident, the staff told her to stay in bed.

A review of the progress note dated 04/16/23 at 06:50 PM, R13 was found sitting on the ground next to her bed. R13 reported to staff that she had been sitting there for 10 minutes, not wanting to call for help as she was embarrassed. R13 reported to staff that she slid off the bed when attempting to put an item away in the dresser.

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Further review found R13 had two previous falls (04/13/22 and 04/20/22). The note of 04/13/22 documents resident slid down from her bed. The note of 04/20/22 notes resident was attempting to self-toilet.

The Minimum Data Set (MDS) for significant change with an assessment reference date of 03/24/23 was reviewed. R13 yielded a score of 10 (moderately impaired cognition) on the Brief Interview for Mental Status. R13 was coded with no falls (has the resident had any falls since admission or prior assessment, whichever is more recent). R13 requires extensive assist with one-person physical assist for bed mobility (how resident moves to and from lying position, turns side to side), transfer (how resident moves between surfaces including to or from bed, chair, wheelchair), walking in room and corridor, personal hygiene, and bathing. R13 coded with a walker for mobility device.

An initial "Fall Risk Evaluation - V2" was done on 01/26/22. R13 yielded a score of 13 (a score of 10 or greater, the resident should be considered at high risk for potential falls). Following the fall on 04/15/23, a Post Fall Evaluation was completed. There were no identified contributing factors. There was no documentation that care plan interventions were updated or that no further interventions were indicated.

A review of the care plan noted revision on 04/07/23 (prior to fall) for resident at risk for fall related to deconditioning, gait/balance problems, and unaware of safety needs. Interventions include answer calls for assist promptly; be sure the resident's call light is within reach and

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F 689	Continued From page 30 encourage the resident to use it for assistance as needed; lock bed in low position at night, place personal items within reach prior to leaving the room; and Physical Therapy (PT) evaluate and treat as ordered or PRN (as needed). R13 also had a care plan for actual falls with no injuries (initiated 04/10/22). There is reference to three falls: 04/10/22: wanted to read book in the wheelchair; 04/13/22: slid down bed onto the floor; and 04/20/22: assisted to floor by staff. The interventions included: bed in lowest position at all times; call light in place within reach at all times; pharmacy consult to evaluate medications; and PT consult for strength and mobility. There was no revision to the care plan or indication that the existing plan was adequate for fall prevention. On 05/25/23 at 09:17 AM an interview and concurrent record review was conducted with DON. DON reviewed the care plan and confirmed the interventions looked the same and there were no revisions made to the care plan following R13's fall on 04/16/23.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary	F 690		

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F 690	Continued From page 31 incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with resident and staff member, the facility failed to assure a resident who is incontinent of bladder received appropriate treatment and services to restore continence to the extent possible for 1 (Resident 13) of 2 residents in the sample. Findings include: Resident (R)13 was admitted to the facility on 01/26/22. Diagnoses include but not limited to hemiplegia and hemiparesis following unspecified	F 690		

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cerebrovascular disease affecting left non-dominant side; epilepsy; and protein-calorie malnutrition.

On 05/22/23 at 02:00 PM, interviewed R13. R13 was asked if she is continent of bowel and bladder. R13 responded that she is told to use her "diaper" for toileting. R13 stated she can recognize the urge for voiding. R13 also reported that she has had some falls and has been told to stay in bed, so she complies.

A review of a significant change Minimum Data Set with an assessment reference date of 03/24/23 noted R13 coded as always incontinent of urine and bowel. R13 was coded as "no" for a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) on admission/reentry of since incontinence was noted in this facility. R13 is also coded as not steady, only able to stabilize with human assistance for moving on and off toilet, surface-to-surface transfer (transfer between bed and chair or wheelchair), and walking (with assistive device if used). Resident noted to require extensive assist with one-person physical assist for transfers (how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position), and walking in room and corridor. R13 also requires extensive assist with two-person physical assist for toilet use. R13 has a walker for mobility device.

R13's care plan noted activities of daily living (ADL) self-care performance deficit due to history of cerebrovascular accident - hemiparesis. A significant change of status assessment was initiated due to improved ADLs. R13 noted to require assistance by one staff for toileting

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F 690	Continued From page 33 (initiated and revised on 04/07/23). On 05/25/23 at 09:17 AM an interview and concurrent record review was conducted with DON. Inquired why is R13 incontinent of bowel and bladder. DON reported R13's cognition isn't bad, resident is oriented x3 and can ambulate with her walker. DON recalled R13 was incontinent upon admission. DON confirmed a trial of a toilet program was not done for R13. DON was unable to identify why R13 was incontinent of bowel and bladder. The statement R13 shared regarding staff telling her to use her personal brief for elimination was shared with the DON. He commented, that's a "dignity issue".	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care	F 692		

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F 692	Continued From page 34 provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to provide nutritional care and services to address significant weight loss for one of two residents sampled, Resident (R)32. The attending physician and facility dietitian was not notified when R32 had a 9.24% weight loss within one month of admission to the facility. As a result of this deficient practice, the resident was placed at risk for potential complications due to impaired nutrition. Findings include: On 05/22/23 at 12:08 PM, observed R32 lying in bed with eyes closed and her lunch tray on the bedside table. Asked Registered Nurse (RN)21 if R32 was able to feed herself. RN21 replied that R23's family member (FM)1 was on her way to assist her with lunch since she did not eat breakfast that morning. RN21 also stated that FM1 works close to the facility and comes in everyday to assist R32 for meals. At 12:37 PM, observed FM1 at R32's bedside assisting her with lunch. Review of Electronic Health Record (EHR) was conducted on 05/23/23 at 06:52 AM revealed that R23 was admitted to the facility on 04/20/23 for short-term rehabilitation services after sustaining a femoral fracture from a fall. Diagnoses include hypertension, gastro-esophageal reflux disease (heartburn) and dementia with behavioral disturbance. Weight taken on admission (04/20/23) was 119 pounds and the latest weight taken on 05/16/23 was 108 pounds. No other	F 692		

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weight was found after 05/16/23 in the EHR. Review of "Progress Notes" revealed that there was no documentation that the dietitian or attending physician was notified. Review of care plan also documented nutritional goal was "Resident will maintain stable wt (weight) between 115-130# (pounds)."

On 09/25/23 at 09:29 AM, concurrent interview and record review conducted with RN3 at the third-floor nurse's station. Asked RN3 to check R32's weight in the EHR and what the facility practice is if there is a significant weight difference noted when weighing a resident. RN3 stated that the RN would notify the facility dietitian and attending physician right away so they can implement an intervention. Asked RN3 if dietitian was made aware of R32's 9.24% weight loss since admission. RN3 responded "No" and that he will notify dietitian and attending physician after they recheck the weight today to verify the weight loss. RN3 also stated, "I have no idea why the dietitian was not notified."

On 09/25/23 at 10:23 AM, interview was conducted with the Director of Nursing (DON) in his office. Asked DON if the facility dietitian was in the facility. DON responded that the dietitian works remotely from home. Asked how the staff communicated significant weight changes to the dietitian. DON stated the staff would call the dietitian and that the dietitian also has access to the EHR from home. The DON added that the dietitian reviews all the weights and will email any recommendations to the DON who then gives them to the RNs on the unit. DON also showed the surveyor emails from the dietitian with recommendations for some residents with significant weight changes. Asked DON if there

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F 692	Continued From page 36 were any emailed recommendations for R32, DON was unable to find one. On 05/25/23 at 10:28 AM, R32 was brought up to the fourth floor for therapy and to check her weight, it was 106.4 pounds (loss of 1.6 pounds since last weight of 05/16/23). Review of facility policy "Weight Assessment and Intervention" stated: " ... 3. Any weight change of 5% or more since last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify Dietitian in writing. Verbal communication must be confirmed in writing."	F 692		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia,	F 693		

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diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:

Based on observations, record review, and interview with staff member, the facility failed to use infection control precautions to ensure syringe used for gastrostomy tube (G-tube) was discarded according to the facility's practice and sanitarily stored to prevent infections. This deficient practice has the potential to expose the resident to infections.

Findings include:

On 05/22/23 at 08:11 AM a feeding tube set was hanging on a pole for Resident (R)33 was observed. Also observed a clear plastic bag containing a syringe. The syringe was not capped. There was pink fluid at the bottom of the plastic bag. The tip of the syringe was stored in the fluid and the cap was immersed in the fluid. Also observed black substance around the interior diameter of the hub. There was a label affixed to the plastic bag with a date of 05/17/23.

Record review noted physician order for: enteral feed every shift for gastrostomy intermittent feed, before each intermittent feeding and PRN check for residual; and flush feeding tube with 100 cc of water four times daily to maintain tube patency and 30 cc of water before and after medication administration.

On 05/22/23 at 10:27 AM, concurrent observation and interview was done with Infection Preventionist (IP). The IP confirmed the date on the label was 05/17/23. The IP reported the syringe is changed every three days. IP also

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(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 693	Continued From page 38 reported the black substance lining the hub may be medication that got stuck in the syringe. IP commented it was embarrassing and threw away the used/expired syringe. The IP noted that there was a new/unused syringe stored in a plastic bag ready for use. Requested a copy of the facility's policy and procedure. On 05/25/23 at 01:00 PM, the IP provided a copy of document, titled "Health Facts for You - Gastrostomy Tube Feeding". The IP reported although the document notes to change the syringe every week, it is the facility's policy to dispose the syringe after three days. IP also stated the nurses are trained to dispose the syringe after three days. Also noted in the document for cleaning the syringe, "Clean the syringe with warm, soapy water and allow to air dry completely."	F 693		
F 725 SS=E	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	F 725		

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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 interview and record review (RR), the facility failed to ensure there was enough staff to provide services and respond to each resident's needs in a timely manner, as evidenced by a complaint of long waits for call light response, and staffing ratios on both the second and third floor that were not in alignment with the Facility Assessment. As a result of this deficient practice, at least one resident experienced a decreased quality of life, was placed at risk of physical decline, and was unable to attain his highest practicable well-being. This deficient practice has the potential to affect all residents at the facility.

Findings include:

On 05/22/23 at 08:20 AM, an interview was done with Resident (R)17 at his bedside. When asked whether there was sufficient staff to meet his needs, R17 reported that he has waited ten (10) minutes "on a good day," up to forty-five (45) minutes at times, for a response to his call light. R17 stated the only way to get help sometimes is to "just keep on the call button." R17 continued on to state that "even a 10-minute wait is too long when you need suctioning." R17 confirmed that

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F 725	Continued From page 40 because of his ventilator/respirator status, he cannot yell or loudly call out for help and is dependent on the call light. On 05/22/23 at 10:36 AM, an observation was made of the staff posting for the second floor (the Respiratory Unit). The staff posting showed a census of 21 residents on the second floor, with two Registered Nurses (RNs) and three Certified Nurse Aides (CNAs) assigned for the day shift, reflecting a 7:1 resident to CNA ratio. On 05/25/23 at 01:30 PM, an observation was made of the staff posting for the third floor which showed two (2) CNAs for 16 residents, reflecting an 8:1 resident to CNA ratio. At 01:36 PM, an interview was done with RN3 at the third floor nurses' station. RN3 reported that if there were no ventilator residents on the third floor, then the normal CNA to resident ratio is 7-8:1. Confirmed with RN3 and Respiratory Therapist (RT)3 that there were 2 ventilator residents on the third floor. With that in mind, RN3 agreed that 2 CNAs was not really enough for that resident acuity/load. Review of the Facility Assessment Tool, last updated 04/25/23, noted a determination of the total number of CNAs needed was "1 CNA to 5 residents' ratio on Respiratory Unit [second floor] and 1 CNA to 7 residents on SNF [skilled nursing facility] unit [third floor]."	F 725		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 756		

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F 756	Continued From page 41 §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to ensure that the drug regimen of each resident was reviewed once a month by a licensed pharmacist, and that recommendations	F 756		

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made by the licensed pharmacist were acted upon by the attending physician. The Medication Regimen Review (MRR) for the month of October 2022 was missing for four of the five residents (R) sampled for psychotropic medications (R26, R17, R21, and R20), and the physician failed to act upon recommendations for two of the five residents sampled (R26 and R17). As a result of this deficient practice, the residents were placed at risk of avoidable complications related to their medications. This deficient practice has the potential to affect all the residents in the facility taking psychotropic medications.

Findings include:

1) On 05/23/23 at 09:33 AM, conducted a review of R20's Electronic Health Records (EHR). List of medications included Lorazepam (sedative) 1 milligram (mg) every 6 hours as needed for restlessness and agitation, Quetiapine Fumarate (antipsychotic) 25 mg at bedtime for severe depression, and Lexapro (anti-anxiety) 5 mg one time a day for anxiety. Monthly MRRs were not found in the EHR so copies for the last 12 months were requested from the Director of Nursing (DON).

On 05/24/23 at 01:30 PM, DON brought copies of the MRR to the conference room. Noted that the MRRs for August 2022, October 2022, January 2023 and March 2023 were missing. DON was informed and he said he will check in his email since the reports are emailed to the DON monthly by the pharmacist. At 03:15 PM, DON provided three of the four missing MRRs requested. DON stated that he is not able to locate the MRR for October 2022.

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F 756	Continued From page 43 2) R21 is a 57-year-old male admitted on 06/22/22. R21's medication list includes the following psychotropic medications: Lorazepam and Lexapro. On 05/24/23 at 11:30 AM, while reviewing the MRR reports for R21, it was noted that October 2022 was missing. The Director of Nursing (DON) was asked to produce the October MRR. On 05/24/23 at 03:10 PM, the DON entered the conference room and stated that the October MRR could not be located for any of the residents at the facility. 3) R17 is an 88-year-old male admitted to the facility on 07/01/22. R17's medication list includes the following psychotropic medications: Lunesta and Ramelteon. On 05/24/23 at 11:30 AM, while reviewing the MRR reports for R17, it was noted that October 2022 was missing. The DON was asked to produce the October MRR. On 05/24/23 at 03:10 PM, the DON entered the conference room and stated that the October MRR could not be located for any of the residents at the facility. From the reports that were available, it was noted that the pharmacist had made a recommendation to consider a gradual tapering or gradual dose reduction (GDR) of the psychotropic medication Lunesta (classified as a sedative or hypnotic) on both 04/30/23 and 02/23/23. On 05/25/23 at 08:25 AM, an interview was done with the DON in his office. When asked about documentation of the provider's response(s) to the GDR recommendation/consideration made in February and April, the DON reported that he	F 756		

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F 756	Continued From page 44 could not find a provider response to those MRRs. During a concurrent review of the EHR, the DON confirmed that there was no GDR attempted, and that the order remained unchanged since its initial order on 07/01/2022. 4) R26 was admitted to the facility on 09/20/22. R26 is prescribed trazadone for insomnia. EHR review found no medication regime review for September, October, November, December, and February. On 05/24/23 at 03:15 PM, DON confirmed there was no medication review by the pharmacist for October 2022. Further review noted the pharmacist recommended to the physician to obtain labwork (TSH) as R26 receives synthroid via G-tube. DON was asked whether R26's physician disagreed or agreed to labwork. DON reported, there were no labs drawn and no documentation of the physician's response.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758		

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F 758	Continued From page 45 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to ensure two (Residents 20 and 17) of five residents sampled for medication review were free from unnecessary medications. The	F 758		

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PRN (as needed) order for a psychotropic medication (drugs affecting behavior, mood, thoughts or perception) for R20 was not limited to 14 days and reordered indefinitely without a rationale for continuance. Also, the facility failed to assure a gradual dose reduction for R17 as recommended by the pharmacist was done.

Findings include:

1) On 05/23/23 at 11:13 AM, conducted a review of R20's Electronic Health Records (EHR). R20 was admitted to the facility on 06/21/22. Diagnoses include history of psychoactive substance abuse, intracerebral hemorrhage (bleeding in the brain), anxiety, severe depression, and restlessness and agitation. List of medications included Lorazepam (sedative) 1 milligram (mg) every 6 hours as needed for restlessness and agitation. Review of current orders revealed that R20 had a PRN order for Lorazepam renewed on 05/23/23 without a stop date. Previous PRN order for Lorazepam was from 04/23/23 and 05/08/23 with an end date on the 14th day.

On 05/25/23 at 09:03 AM, concurrent interview and record review conducted with the Director of Nursing (DON) in his office. Reviewed current PRN order of Lorazepam with a start date 05/23/23. DON stated that since it is a PRN order, there should be a stop date after 14 days. DON also stated that the attending physician should have provided documentation of the rationale for extending the PRN order.

2) R17 was admitted to the facility on 07/01/22. R17's medication list includes the following

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F 758	Continued From page 47 psychotropic medications: Lunesta and Ramelteon. On 05/24/23 at 11:30 AM, while reviewing the MRR reports for R17, it was noted that October 2022 was missing. The DON was asked to produce the October MRR. On 05/24/23 at 03:10 PM, the DON entered the conference room and stated that the October MRR could not be located for any of the residents at the facility. From the reports that were available, it was noted that the pharmacist recommended consideration of gradual tapering or gradual dose reduction (GDR) of the psychotropic medication Lunesta (classified as a sedative or hypnotic) on both 04/30/23 and 02/23/23. On 05/25/23 at 08:25 AM, an interview was done with the DON in his office. When asked about documentation of the provider's response(s) to the GDR recommendation/consideration made in February and April, the DON reported that he could not find a provider response to those MRRs. During a concurrent review of the EHR, the DON confirmed that there was no GDR attempted, and that the order remained unchanged since its initial order on 07/01/2022.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		

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F 761	Continued From page 48 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure all medications used in the facility were securely stored in locked compartments. Proper storage and labeling of medications is necessary to promote safe administration practices, and to decrease the risk of medication errors and diversion of resident medications. Findings include: 1) On 05/22/23 at 10:58 AM, an observation was done of Registered Nurse (RN)22 leaving the medication cart designated for the male residents on the second floor unlocked while he left the floor. When he returned to the second floor, RN22 was observed going directly into room 206. Upon exit of room 206, RN22 was asked about the unlocked medication cart. RN22 stated "I'm sorry," and explained that he does not usually	F 761		

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leave it unlocked. Confirmed that the medication cart was solely assigned to him for the shift.

On 05/22/23 at 01:46 PM, observed the same medication cart (designated for the male residents on the second floor) unlocked and unattended with RN22 nowhere in sight. Certified Nurse Aide (CNA)2 noticed Surveyor opening medication cart to verify that it was unlocked, walked over a minute later, and locked the cart after Surveyor walked away from it.

On 05/24/23 at 07:40 AM, observed RN22 walk away from the medication cart designated for the male residents on the second floor, leaving it unlocked. Observed RN22 check Resident (R)19's blood sugar at his bedside, then returned to the medication cart. At 07:43 AM, RN22 acknowledged that he had forgotten to secure his medication cart while it was out of his sight.

A review of the facility policy and procedure, Administering Medications, last revised April 2019, noted the following:

" ... the medication cart is kept closed and locked when out of sight of the medication nurse ..."

2) On 05/24/23 at 09:20 AM, an unlocked medication cart was observed on the second-floor unit hallway. An interview was conducted on 05/24/23 at 09:34 AM with Registered Nurse (RN)2. RN2 stated, "it's supposed to be locked, I usually lock it. Sorry."

3) On 05/25/23 at 01:35 PM, a medication cart on the third-floor unit hallway was observed unlocked. A concurrent interview with RN3 was

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F 761	Continued From page 50 conducted and he stated, "the cart should be locked, she [registered nurse] forgot."	F 761		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide food that accommodates a resident's food allergies. Resident (R)190 was served food that contained an ingredient that she was allergic to placing her at risk for an adverse health condition. Findings include: On 05/24/23 at 08:06 AM while making observations on the third-floor unit, R190 waved at surveyor and made a hand gesture to enter the room. R190 stated that after she was done with her breakfast earlier that morning, she saw "Honey Nut Cheerios" documented on the meal ticket. R190 said she was concerned because she is allergic to almonds and peanuts and wanted to make sure the kitchen knows about her allergies. R190 also said that she was not having any allergic reactions at the moment and already notified the nurse on duty. Review of R190's	F 806		

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(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 806	Continued From page 51 Electronic Health Records (EHR) revealed that her allergies included lisinopril, almonds, peanuts, salmon, shellfish, mold, dust mites, grass pollen blade and weeds. Care plan also documented that R190 has a rash on her back related to allergies. On 05/24/23 at 08:13 AM, concurrent observation and interview conducted with the Director of Dietary Services (DDS) in the kitchen. There was a box of Honey Nut Cheerios by the food preparation area. Noted just below the ingredients in bold letters was "Contains Almonds ..." Asked DDS what the facility practice is for communicating food allergies to the kitchen staff. DDS replied that when a new resident is admitted, the dietitian fills out the "Diet Communication Form". Information on the form includes, diet order, diet texture, liquid consistency, resident's ability to select own menu, and comments where the allergies are noted. Dietitian would then provide a copy of the form to the dietary clerk, and they would transcribe the information unto the meal tickets. Dietary clerk would then print the meal tickets and give them to the DDS where he would place them in the holder by the food preparation area. Asked DDS if we could look the meal tickets in the food preparation area. Documented on R190's lunch meal ticket was, "Allergies: Salmon, Shellfish Products, Nuts." Informed DDS that R190 was served Honey Nut Cheerios for breakfast, and it contained almonds. DDS confirmed that R190 should not have been served Honey Nut Cheerios and that they "made a mistake."	F 806		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

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	125067	A. BUILDING _____ B. WING _____	05/25/2023

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F 812	Continued From page 52 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to provide a clean area to prepare food for the residents. This deficient practice has the potential to affect all residents, visitors and staff who have meals served by the facility with food-borne illnesses. Findings include: On 05/22/23 at 08:03 AM, initial tour and observation was done in the kitchen area with the Director of Dietary Services (DDS). Noted pipes for the sprinkler system that ran across the ceiling immediately above the food preparation area was covered with dust. On 05/24/23 at 08:13 AM, concurrent interview and observation conducted with DDS in the	F 812		

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F 812	Continued From page 53 kitchen area. Noted the pipes for the sprinkler system above the food preparation area were now free of dust. Asked DDS when the pipes were cleaned and how often they did it. DDS said the kitchen staff clean the sprinkler pipes once a month or as needed. Asked DDS if they have a log for when the task is completed, he said that they have a log they use daily to document tasks the kitchen staff completed at the end of the day, but it does not include the cleaning of the sprinkler pipes running across the food preparation area. DDS confirmed that the pipes were dusty on 05/22/23 and asked the staff to clean them that day.	F 812		
F 842 SS=E	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	F 842		

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F 842	Continued From page 54	F 842		

all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches 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;

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F 842	Continued From page 55 (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 record review, the facility failed to maintain accurate medical records for seven residents, physician progress notes were documented in the wrong record. This deficient practice has the potential to affect the medical care residents receive at the facility. Findings include: 1) On 05/25/23 at 08:59 AM, while reviewing the EHR for R17, three (3) physician progress notes in the last month had contained documented medical information for three different residents other than R17. One on 05/23/23 for R190. A second on 05/16/23 for R28. A third progress note on 04/28/23 for R9. 2) On 05/24/23 at 11:13 AM, conducted a review of R20's EHR. Under "Progress Notes", noted an entry from the attending physician done on 05/23/23 at 07:55 AM. Entry contained the name and medical information for R190. Further review revealed that the attending physician also made entries on 05/16/23 at 08:53 AM and on 05/12/23 at 08:11 AM that contained the name and medical information for R16. Notified Registered Nurse (RN)11 of attending physician's entry in R20's progress notes that contained other residents' information. RN11 said she will have the note removed and notify the attending physician to enter correct note.	F 842		

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F 880	Continued From page 56	F 880		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		

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F 880	Continued From page 57 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to prevent the possible spread of infectious illnesses to other residents. The facility failed to follow airborne precautions put in place for one resident (R) 189. This deficient practice has the potential to spread infectious illnesses to other residents in the facility.	F 880		

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F 880	Continued From page 58 Findings Include: On 05/22/23 at 09:18 AM, initial observation conducted on the second-floor unit. Room 208 is occupied by four residents, including R189. A sign outside of the room indicated that R189 was on droplet precautions and the following personal protective equipment were required when providing care: mask, gown and gloves. Registered Nurse (RN) 22 was observed entering room 208 wearing only a mask holding a medicine cup filled with liquid and an empty cup. RN22 then placed the items on the bedside table, performed hand hygiene, and donned gloves. RN22 proceeded to administer the medication to R189 through his gastrostomy tube without donning a gown. After he administered the medication, asked RN22 if a gown was required when proving care to R189. RN22 said a gown is only required when caring for R14, who is in bed next to R189. On 05/23/23 at 11:11 AM, conducted review of Electronic Health Record (EHR) for R189. Care plan revealed that R189 was on droplet precautions related to pneumonia. Interventions documented included, " ... Staff to adhere to droplet precautions: wearing gown ... prior to entering room ..." On 05/25/23 at 03:26 PM, interview conducted with Infection Preventionist (IP) in the conference room. Informed IP of observation with RN22 providing care for R189 without a gown. IP confirmed that staff need to wear a gown when caring for R189.	F 880		