STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125040	A. BUILDING _____ B. WING _____	11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HILO	944 WEST KAWAILANI STREET HILO, HI 96720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA). The facility was found not to be in substantial compliance with 42 CFR 483 Subpart B. The Aspen Complaints/Incident Tracking System (ACTS) complaint, 9307, and facility reported incidents (FRIs), 9387, 9480, 9481, 9589, 9859, and 9891, were also investigated. Survey Dates: 11/14/22 to 11/18/22 Survey Census: 207 Sample Size: 36	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	F 550		1/2/23

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

Electronically Signed | 12/16/2022

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F 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on a Resident Council interview and policy review, the facility failed to protect and promote quality of life for the residents by ensuring they were treated with respect and dignity. Specifically, the facility failed to ensure that English was consistently spoken in all resident care areas, exposing residents to frustrating and awkward situations that impede their ability to attain or maintain their highest practicable well-being. This deficient practice has the potential to affect all residents at the facility. Findings include: On 11/17/22 at 09:20 AM, an interview was done with two regularly-attending members of the Resident Council, and one former member and interested resident. The interview was conducted	F 550	F 550- Resident Rights Point 1 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Staff will be educated on the facilities language policy regarding speaking English in resident care areas. Point 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents who reside at the facility have the potential to be affected by deficient practice	

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F 550	Continued From page 2 in the second floor private Dining Room. All three residents complained that numerous kitchen staff, certified nurse aides (CNAs), and housekeepers speak to each other in front of the residents in their native language, a language other than English. It was reported that these staff members speak in their native tongue "all the time even though they know they not supposed to." One Resident Council member stated, "we don't know if they talking about us or what." All residents present at the interview reported that the deficient practice occurs on both the second and the third floor units. The residents also reported that when they ask staff not to speak in their native language in front of them, that they are reacted to with rudeness and "attitude." One of the residents reported that the housekeepers will leave the room in the middle of cleaning it, leaving it dirty, when he/she directs a request to staff to speak English in his/her room. On 11/18/22 at 1:24 PM, in the third floor Conference Room, the Administrator stated that she could not locate and was unaware of an English in the Workplace/Resident Care Areas Policy. However, she had contacted the Corporate Office and was waiting for further information. On 11/21/22 at 2:03 PM, the Administrator provided the State Agency with a copy of the undated corporate policy and procedure (P&P) titled: Language Guidelines, from the Facility Associate Orientation Manual. A review of the P&P revealed the following: " ... [facility] requires associates to speak English when working with or around a patient ..."	F 550	Point 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Upon initial orientation and as needed staff will be educated on the facilities language policy. Education will be provided to staff on the importance of speaking English in resident care areas unless otherwise requested by resident. Point 4 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes. The ED/designee will observe at least 3 associates on each shift (days, eves, noc) weekly, for the next 30 days, to ensure associates are following the facility language policy. Additionally, the Executive Director/designee will interview 5 residents weekly, for the next 30 days, to ensure associates are following the facility language policy. ED/designee will report the results, along with any corrective action taken, to the facility QAPI committee for review and recommendations. The QAPI committee will determine whether substantial compliance has been achieved and the frequency for ongoing monitoring. Point 5 January 2nd, 2023	

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F 550	Continued From page 3 "Associates who need to speak with a co-worker in another language for work-related reasons (on occasion) will walk away from the patient who may not understand ... it is sometimes helpful for an associate whose primary language is not English (but who does speak English) to talk in the primary language to clarify work-related direction. This communication, however, should be done away from the patient."	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		1/2/23

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F 561	Continued From page 4 interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to identify, support, and honor one Resident's (R) bathing schedule preference. As a result of this deficient practice, R98 did not have her needs met and was placed at risk of not attaining her highest practicable well-being. This deficient practice has the potential to affect all the residents at the facility. Findings include: On 11/14/22 at 2:44 PM, an interview was done with Resident (R)98. When asked about whether she is allowed to make choices that are important to her, R98 replied, "no." R98 explained that she can only shower twice a week, "it's something I just can't get used to, I like to shower every day." R98 stated she showers on her assigned days, Tuesday, and Saturday, and it is done when staff has the time. R98 also stated that she was never asked how often or what days she would like to shower, and when she does have a shower, she is rushed through it, "it feels like they're herding cattle, just in and out." On 11/14/22 at 3:00 PM, a review of R98's Minimum Data Set (MDS) Admission Assessment with an Assessment Reference Date (ARD) of 04/18/22 was done. Under Section F-Preferences for Customary Routine and Activities, the facility marked "Very important" under question F0400D: How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath?	F 561	F561: Self Determination Point 1 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #98 was interviewed to determine bathing preferences. The task record and care plan were updated to reflect her preference. Education was provided to nursing staff regarding the facility process for determining and honoring resident bathing preferences. Point 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. Bathing preferences were discussed with interviewable residents to determine if their current schedule met their needs. Changes were made to bathing schedules as needed, task records and care plans were updated. Point 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Residents are interviewed upon admission to determine their bathing preferences. A schedule is placed into the	

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F 561	Continued From page 5 On 11/15/22 at 12:19 PM, during a review of R98's Comprehensive Care Plan, it was noted that there was no documentation of R98's preferences with regards to bathing frequency, days, or type of bath.	F 561	task record and also reflected on the care plan. Schedules and choices are also reviewed quarterly during resident care conferences. If at any time, a resident expresses a desire to change bathing schedules, the task record and care plan is updated. Education is provided to nursing staff regarding the facility process for determining and honoring resident bathing preferences upon hire and as needed. Point 4 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes. The DON/designee will review the bathing schedule with interviewable residents within 24-72 hours of admission and compare to the schedule in the task record to determine if the residents preferences were accurately obtained and documented on the care plan. The nurse will correct the schedule as needed. This will be done following each admission for four weeks, then with 3-5 residents per week during quarterly reviews for the next 60 days. Results of the reviews, along with any corrective action taken, will be reported to the QAPI committee for review and recommendations. The QAPI committee will determine whether substantial	

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F 561	Continued From page 6	F 561	compliance has been met and the frequency for ongoing monitoring. Point 5 January 2nd, 2023	
F 575 SS=E	Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the required postings were placed in a manner accessible to all residents and resident representatives. Specifically, there were no postings observed on the first floor listing the contact information for pertinent State	F 575	F575 Required Postings Point 1 How corrective action will be accomplished for those residents found to have been affected by the deficient practice.	1/2/23

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F 575	Continued From page 7 agencies and resident advocacy groups, nor were there any postings observed on the first floor regarding a resident's right to file a complaint with the State Survey Agency (SA). In addition, despite the required postings being available on the second and third floor, not all residents residing there are aware where to find them. As a result, residents who have the capacity to comprehend their resident rights potentially are not aware of them, how to exercise them, or where they can find information about them. This deficient practice has the potential to affect all residents in the facility with the functional capacity to exercise their resident rights. Findings include: On 11/14/22 at 12:45 PM, observations were made on the One South unit that there were no postings found regarding resident rights or listing the contact information for any pertinent State agencies and/or resident advocacy groups. A tour of the first floor revealed no postings at the elevator, staircase, hallways, or on the One North unit. On 11/16/22 at 09:39 AM, an interview was done at the One South nurses' station (NS) with the Charge Nurse (CN) on duty, CN8. When asked to direct the SA to the required postings, CN8 could not find them. On 11/16/22 at 10:15 AM, a tour of the second floor revealed a resident rights posting next to the elevator behind a coffee table and two wicker chairs. The posting was printed in a small font and placed at a height unable to be read by a resident in a wheelchair who cannot put their face closer to it (due to the coffee table and wicker	F 575	Required postings will be placed throughout the facility Postings will be visually accessible for residents in wheelchairs Font size will be addressed to accommodate residents with visual impairments Point 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents in the facility. Point 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Required postings will be made on the first floor secure units in a manner accessible to all residents and resident representatives. Postings will list contact information for pertinent State agencies, resident advocacy groups, contain a statement regarding a residents right to file a Grievance and resident right posters. Residents and representatives are provided a copy and educated on their rights upon admission, quarterly and PRN Point 4 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued	

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F 575	Continued From page 8 chairs in the way). Long-term Care Ombudsman (LTCO) information, and other important phone numbers were observed posted directly outside the elevator on the second and third floors. On 11/17/22 at 09:20 AM, an interview was done with two regularly-attending members of the Resident Council, and one former member and interested resident. Two residents reside on the third floor and one on the second floor. The interview was conducted in the second floor private Dining Room. All three residents stated they have been told that the resident rights is posted on the second floor, but they haven't seen it, nor do they know where to find the phone numbers for the LTCO or the SA.	F 575	effectiveness of the systemic changes. The Social Services Director, or designee, at least bi-weekly, will ensure that required postings are accessible to all residents and resident representatives for the next 30 days by visually verifying the postings in the facility. The results of the reviews will be documented. In addition, the location of the postings, and of the resident right to file a complaint with the State Survey Agency, will be added to the resident council agenda and discussed/reviewed at the monthly resident council meeting. The social service audits and the resident council minutes will be reviewed at the monthly QAPI meeting. The QAPI committee will determine whether substantial compliance has been achieved and the frequency for ongoing monitoring. Point 5 January 2nd, 2023	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the	F 578		1/2/23

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F 578	Continued From page 9 requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review (RR), the facility failed to ensure valid Advance Health Care Directives were obtained and documented in two residents' medical records. As a result of this deficient practice, both Resident (R)98 and R162 were placed at risk of not having their (or their valid representatives') wishes honored for future health care decisions, should they become (or be determined) with diminished or no capacity. This deficient practice has the potential to affect all the	F 578	F 578 Advance Directives Point 1 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Advance Health Care Directive forms for residents #98 and #162 corrected. Surgency documentation was acquired for	

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F 578	Continued From page 10 residents at the facility. Findings include: 1) On 11/15/22 at 12:05 PM, during a review of Resident (R)98's electronic health record (EHR) and hard chart, documentation of a General (financial) Power of Attorney (POA) was found, but none for health care. On 11/16/22 at 2:28 PM, an interview was done with the Director of Social Services (DSS) at the 1 South nurses' station. The DSS confirmed that the facility did not have a Durable Power of Attorney (DPOA) for health care on file and she had only just realized that. The DSS stated she was trying to contact R98's POA. On 11/17/22 at 1:20 PM, during a review of R98's Comprehensive Care Plan (CP), the following documentation was noted: " ... [R98] has the following Advanced Directives on record: - Durable Power of Attorney for health care decisions." On 11/17/22 at 2:50 PM, during an interview with the DSS outside her office, the DSS confirmed that the CP is incorrect and that social services had misidentified the documentation that was on file. 2) On 11/15/22 at 12:37 PM, during a review of R162's EHR and hard chart, documentation of a DPOA for mental health was found, but none for health care. On 11/16/22 at 2:30 PM, during an interview with the DSS at the One South nurses' station, the	F 578	resident #98 November 17th of 2022. Advanced Health Care Directive was obtained for #162 November 17th of 2022. Education was provided to admissions, nurses and social services associates regarding the facility policy and procedure for obtaining/offering advance directives, care planning accurately for Advance Directives and or reflecting documentation of a legal representative that acts on behalf of a resident. Point 2 How the facility will identify other residents having the potential to be affected by the same deficient practice The Social Services Director (SSD)/designee will conduct a 100% audit of Advanced Health Care Directives to ensure they are complete and/or offered. Any missing documentation will be updated and placed in the medical record. Point 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Upon admission, residents and/or their responsible parties receive materials concerning their rights under applicable laws formulate advance directives. Documentation of advance directives are placed in the medical record. The residents attending physician is made aware of such, and the appropriate orders are incorporated into the residents care	

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F 578	Continued From page 11 DSS confirmed that the facility did not have a DPOA for health care on file and she had only just realized that. The DSS stated she was trying to contact R162's DPOA for mental health. On 11/17/22 at 1:24 PM, during a review of R162's CP, the following documentation was noted: " ... [R162] has the following Advanced Directives on record: - Durable Power of Attorney for health care decisions." On 11/17/22 at 2:52 PM, during an interview with the DSS outside her office, the DSS confirmed that the CP is incorrect and that social services had misidentified the documentation that was on file.	F 578	plan. If the resident has previous formulated an advance directive, the facility will request a copy of the directive and it will be placed in the medical record. If a resident is unable to make decisions regarding advance directives, the facility will obtain documentation to reflect decision-making authority of the designee. This documentation will be maintained in the medical record. Advance directives are reviewed upon admission, quarterly, and when a change in condition is noted in the resident condition. Any changes are reflected within the medical record and updates to the care plan. Point 4 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes. The SSD/designee will audit the medical record to determine if advance directives have been formulated and if the resident is unable to make decisions, there is documentation to reflect the decision-making authority of the designee. If the form is not complete or the appropriate documentation is not present, the SSD/designee will obtain the needed information. This will be done for each new admission for 90 days. The SSD/Designee will report the results,	

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F 578	Continued From page 12	F 578	along with any corrective action taken, to the facility QAPI committee for review and recommendations. The QAPI committee will determine whether substantial compliance has been met and the frequency for ongoing monitoring. Point 5 January 2nd, 2023	
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. §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	F 584		1/2/23

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F 584	Continued From page 13 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, the facility failed to assure comfortable sound levels for residents on a locked/secured dementia unit during dining and activities and for one resident (R)5 on another nursing unit. The residents residing on the secured unit are diagnosed with Alzheimer's disease and dementia with/without behavioral disturbances. R5 complained that the roommate's television was too loud. This deficient practice fails to provide a homelike environment and has the potential to affect all residents. Findings include: 1) Observation on 11/14/22 of lunch found residents seated in the multi-purpose room (activity/dining room). Music was being played. The volume was so loud, observed residents weren't talking to one another. The sound of the chairs being pulled out or dragged on the ground was startling loud. Second observation on 11/15/22, observed a resident shouting to another resident over the music. Observations during morning activities on	F 584	F584 SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT Point 1 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. For resident R5 accommodations will be made to reduce the sound level in her room by offering her roommate wireless personal body speaker DON/Designee will meet with staff and provided education regarding mealtime and activity preferences for dementia community. Point 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. Interviews will be conducted by the Activity Director/designee with residents and staff	

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F 584	Continued From page 14 11/14/22 and 11/15/22 found the volume of the videos being shown on the television was loud. The residents are provided with routine activities in the morning, singing of the national anthem, God Bless America, and Hawaii Pono'i. Then a video of chair stretches and exercises are played. The volume of the music is turned up so that you can't hear residents singing and the music can be heard at the nurses' station and down the hallway (approximately three-quarters down). 2) During an observation and interview with Resident (R)5 in her room on 11/15/22 at 09:07 AM, she stated to the state agency (SA), "it's so loud" and pointed at the roommate's television (TV). The television volume was up very loud requiring that SA had to speak louder for R5 to hear. SA stated to R5, oh, her TV is too loud, and R5 shook her head up and down and said its always loud. R5 self-propelled out of the room. SA asked Certified Nurse Aide (CNA)15 if R97's TV is always up this loud and if she is hard of hearing. CNA15 stated, yes and we always ask her to turn it down, but she just turns it right back up. On 11/17/22 at 10:00 AM, an observation was made outside of R5's room. SA noted the TV volume was up loud enough to be heard from the hallway. SA spoke to the Director of Nursing (DON) afterward and explained that the volume from R97's TV is loud enough to be heard outside and the roommate (R5) complained about it to SA on the previous day. The DON concurred that R97 turns the volume up very loud to be able to hear it and that perhaps she can follow up with rehab services for some assistance.	F 584	regarding activity preferences. Observation of dining, and resident rooms will be conducted to establish individual residents needs. Point 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. All nursing staff/activities educated on the rights of resident to have a safe/clean/comfortable/homelike environment Point 4 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes. Activity Director/designee will audit 1x week for the next 30 days which will include dining room observation, group activity areas and resident rooms for comfortable sound levels, and enjoyable programming. The results of the reviews will be presented at the Quality Assurance and Performance Improvement Committee (QAPI) meeting. The QAPI committee will determine whether substantial compliance has been met and the frequency for ongoing monitoring. Point 5 January 2nd, 2023	
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4)	F 585		1/2/23

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§483.10(j) Grievances.
§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for

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completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be

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F 585	Continued From page 17 taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to make information on how to file a grievance or complaint available to all residents. Specifically, there were no postings observed on the first floor providing information on how to file a grievance for the first two days of the survey, nor were there comment cards available on the first floor to assist a resident in filing a written complaint or grievance. As a result, the process of filing a grievance is unclear for residents and resident representatives residing on the first floor. This deficient practice has the potential to affect all residents with the functional capacity to file a grievance. Findings include: On 11/14/22 at 12:45 PM, observations were made on the One South unit that there were no postings found regarding how to file a grievance. A subsequent tour of the remainder of the first floor revealed no postings at the elevator, staircase, hallways, or on the One North unit.	F 585	F585- Grievances Point 1 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident 98 and 165 were educated on the facilities grievance program. Point 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents on the first floor secure units. Point 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Information regarding the facilities grievance program will be displayed at	

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F 585	Continued From page 18 Blue comment cards that assist residents in filing a written grievance, available in central areas on the second and third floor, could not be found on the first floor. On 11/16/22 at 09:39 AM, an interview was done at the One South nurses' station (NS) with the Charge Nurse (CN) on duty, CN8. A new sign was observed posted next to the NS regarding resident concerns, blue comment cards, and information on the facility Grievance Officer. Posting was a laminated 2-inch by 4-inch sign with one corner tucked into the top of another sign that was taped to the wall. Queried with CN8 when the sign had been posted as it was not observed the previous two days of survey, CN8 stated "it is constantly getting put up because residents keep pulling them down." On 11/16/22 at 2:45 PM, an interview was done with Resident (R)98 at her bedside. When asked if she was aware of how to formally file a complaint or grievance, R98 responded, "no." When asked if she had ever seen a blue comment card, or been offered one to voice a concern in writing, R98 responded, "no." On 11/16/22 at 2:50 PM, an interview was done with R165 at his bedside. When asked the same questions, R165 also reported that he was unaware of how to file a grievance or what a blue comment card was.	F 585	each nurses station on the first floor. Point 4 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes. The Social Services Director, or designee, at least bi-weekly, will ensure that information regarding the facilities grievance program is accessible to all residents and representatives on the first floor for the next 30 days by visually verifying the postings in the facility. The results of the reviews will be documented. The social service audits will be presented and reviewed at the monthly QAPI meeting. The QAPI committee will determine whether substantial compliance has been met and the frequency for ongoing monitoring. Point 5 Date completed: January 2, 2023	
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:	F 604		1/2/23

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F 604	Continued From page 19 §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interview with staff member, the facility did not ensure one (Resident 82) of one resident sampled was free from physical restraints. This deficient practice has the potential to affect the resident's psychosocial well-being. Findings include: Resident (R)82 was admitted to the facility on	F 604	F604: Free from Physical Restraint Point 1 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Upon notification of this concern, the Director of Nursing/designee provided education to nursing staff (days, eves and	

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F 604	Continued From page 20 07/30/18. Diagnoses include but not limited to, Alzheimer's disease, unspecified; dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance; other seizures; abnormal posture; muscle weakness (generalized); anxiety disorder due to known physiological condition; adjustment disorder with mixed anxiety and depressed mood; and personal history of healed traumatic fracture; and wandering in diseases classified elsewhere. On 11/14/22 at 12:33 PM, observed R82 seated in the multi-purpose room for lunch. R82 was in a wheelchair placed in the corner of the room, the back push handles were up against the wall and the table was placed in the front of the resident. Certified Nurse Aide (CNA)31 was assisting R82 with lunch. R82 remained in the corner and intermittently attempted to use the hand rims to propel herself. R82 was unable to move forward or backwards due to the proximity of the wall and table. Observation at 2:35 PM, R82 was still in the corner and had her head down on the table. Third observation at 2:52 PM, R82 was still seated in the corner. On 11/15/22 from 10:21 AM to 10:36 AM, observed R82 seated in her wheelchair, self-propelling up and down the hallway. On 11/16/22 at 09:53 AM, observed R82 self-propelling up and down the hall on the unit. R82 was observed in her wheelhair that was against the wall and she was unable to dislodge herself. CNA33 came to assist her and commented R82 will get stuck when she runs into the wall or doorways. Review of the annual Minimum Data Set (MDS) with assessment reference date of 10/15/22	F 604	nights) working on the secure unit for resident #82, regarding facility restraint policy. Resident #82 individual needs were identified, care plan and task record updated to reflect new interventions that will include 1. Allowing resident to self propel with visual oversite 2. Offer nature strolls when staff identify restlessness 3. Offer fidget blanket Point 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. The Director of Nursing/designee completed an audit of dining rooms/activity rooms on all units to determine if any other residents were being affected Interviews of residents and staff will be conducted to identify any other residents affected. Point 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Director of Nursing/Designee will provide nursing staff (days, eves, nights) on all units education regarding facility policy on restraints. If the deficient process is observed, it will be corrected immediately, and staff involved in the deficient process will be provided education to prevent a recurrence	

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F 604	Continued From page 21 notes R82 is not coded for restraints. A review of the care plan notes intervention for being at risk of break in skin integrity (resident experiences recurring bruises due to wandering behaviors, lack of safety awareness as she self-propels wheelchair to/from destinations), and when positioning resident in dining room via wheelchair allow for adequate spacing between wheelchair and other equipment due to resident's continuous movements. On 11/17/22 at 09:24 AM an interview was conducted with Charge Nurse (CN)5. The observation during lunch was shared with CN5. CN5 reported the dining room is small and there is concern of R82 wheeling herself and hitting another resident. CN5 reported R82 is positioned in the corner only for mealtimes. Inquired whether positioning R82 in the corner was assessed as a restraint. CN5 responded "no" and commented that staff are not supposed to leave R82 in the corner, that is a restraint. CN5 added, at the conclusion of the meal, staff are to let R82 go.	F 604	Point 4 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes. Director of nursing/designee will complete an audit of all unit dining rooms/activity rooms weekly for 60 days. The results of the reviews will be presented at the Quality Assurance and Performance Improvement Committee (QAPI) meeting. The QAPI committee will determine whether substantial compliance has been achieved and the frequency for ongoing monitoring. Point 5 January 2nd, 2023	
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at	F 607		1/2/23

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F 607	Continued From page 22 paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, in a sample of three residents (R), R454, R167, and R111, out of six residents, the facility failed to implement their abuse prohibition policies and procedures to: 1) screen employees for a history of abuse and, 2) to prevent abuse for two residents (R), R167 and R111, involved in a friendship/relationship. The facility's failure to follow their own abuse prohibition policies and procedures could potentially cause irreparable harm to their residents. Findings include: 1) A request of the facility's policy and procedures on abuse/neglect was done during the entrance interview on 11/14/22. With regards to screening, the facility provided a Human Resources policy entitled, "Background Screening Policy:	F 607	F607 Develop/implement Abuse/Neglect Policies Point 1 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Existing associate will be screened monthly. For resident #167 and #111 corrective action was taken to update care plan, involve family members/guardian, have SSD reassess residents and provide staff education on intimacy policy. Screening of Employee policy will be updated to reflect current practice at facility	

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F 607	Continued From page 23 Associates," with an effective date of 08/20/18 and revisions on 03/15/05, 07/06/12, 01/13/14, 06/12/14, and 11/22/16. The Purpose section documents the following, "This policy provides... supervisors and managers with the necessary guidance and instructions to conduct background investigations for all corporate and facility employed individuals in accordance with the applicable laws and regulations." The policy defines an Associate as, "... any person directly employed... For the purpose of this policy, any and all employed individuals will be called Associate(s)." The Scope of the policy documents the following, "This policy covers all Associates..." The Procedure section documents: "In accordance with... regulations, a facility will not employ or engage an individual who... has been found guilty of abuse ..." On 11/18/22 at 10:30 AM, while investigating a facility-reported incident (ACTS # 9480), an allegation of staff-to-resident abuse, involving R454, a review of the alleged perpetrator's (AP's) personnel file was done. It was noted that AP had been hired on 05/22/00 as a Certified Nurse Aide. No documentation was found that a criminal background check was done prior to AP's employment. During an interview with the Administrator at 1:24 PM in the third floor conference room, the Administrator reported that criminal background checks did not begin "until 2002" and that everyone who had been hired prior to that date had been "grandfathered in," meaning that background checks were not done for existing employees. On 11/23/22 at 2:05 PM, the facility provided the policy Abuse - Screening of Employees, issued 10/04/22. The Policy section documents the	F 607	Point 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents at the facility Interviews of residents and staff will be conducted to identify any other potential residents affected Point 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Existing associates will be screened monthly in accordance with the facility "Exclusion Screening for Associates, Vendors, and Contractors Policy." Social Services will document and care plan intimacy between residents upon admission, quarterly, observation and staff interviews Education provided to staff regarding Intimacy Policy Education provided to Human Resource Department for updated policy for screening of employees Point 4 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes. The Executive Director, designee, will verify with compliance monthly, for the	

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F 607	Continued From page 24 following, "It is the policy of this facility to screen staff (as defined in this policy) for a history of abuse..." The policy defines staff as "... includes employees, the medical director, consultants, contractors, volunteers. Staff would also include caregivers who provide care and services to residents on behalf of the facility..." The Procedure section documents the following, "1. Screening components include but are not limited to attempting to obtain information from previous employers... and checking with appropriate licensing boards, registries, and background checks." A review of the policy and procedure did not reveal any verbiage excluding existing employees from the screening requirement(s) and/or limiting the screening requirement(s) to new/prospective employees only. A review of the history of the Consolidated Medicare and Medicaid requirements for participation (requirements) for Long Term Care (LTC) facilities (42 CFR part 483, subpart B) noted that language dictating reasonable efforts to uncover information about any past criminal prosecutions in relation to abuse prevention and employee screening were published as early as February 2, 1989 (54 FR 5316) in the Federal Register. The link to the archived document can be found at https://www.federalregister.gov/citation/54-FR-5316. 2) A review of the facility's policy and procedure for Abuse Prevention (issued 10/04/22) documents under the heading of Procedure, "Establishing a safe environment that supports to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse, such	F 607	next 90 days, that screening has been conducted on all existing associates in accordance with the "Exclusion Screening for Associates, Vendors, and Contractors Policy." The Executive Director will document verification and report results at the monthly QAPI committee meeting. The QAPI will determine if substantial compliance has been achieved and the frequency of ongoing monitoring. Human Resources/or designee will audit new employees background checks for 90 days to ensure screening policy is being followed SSD/or designee will audit weekly for 30 days. This audit will include observation and staff interviews to inquire about possible intimate relationships among residents Results of the observations, along with any corrective action taken, will be reported to the QAPI committee for review and recommendations. The QAPI will determine if substantial compliance has been achieved and the frequency of ongoing monitoring.	

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as identify when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relations; Refer to the Intimacy Between Residents/Sexual Consent Policy."

The policy and procedure of "Intimacy Between Residents/Sexual Consent" issued 08/25/21 and revised 09/28/22 was reviewed. The definition of intimacy is "an expression of the natural desire of human persons for connection; a state of reciprocated physical closeness to, and emotional honesty with another. Physical closeness to another includes physical touch as demonstrated by nongenital, nonsexual touching, hugging, and caressing. Intimacy is not a synonym for sex; however, sexual activity frequently occurs with an intimate relationship."

The procedure for intimate contact between residents notes it is important for an associate to be aware of different acts of intimacy between residents, subtle contact such as hand holding may progress to kissing and even sexual intercourse. The procedure includes once the facility is aware of the desire of two or more individuals wanting to pursue an intimate relationship (i.e., hand holding, kissing, sexual intercourse), all individuals will be assessed by the Social Services Director, or other clinical manager to determine the ability of the individuals to consent". Upon completion of assessment, the person conducting the assessment will document the findings in each respective resident's medical record. The attending practitioner should be

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notified, and the interdisciplinary team will meet to discuss the abilities of the residents to consent to sexual activity and the residents' plan of care will be updated to reflect consent and education as well as any specific intervention required.

On 11/14/22 at 11:22 AM observed Resident (R)167 and R111 in R167's room. They were sitting on the bed together talking. Second observation saw them holding hands and walking down the unit hall to the dining room for lunch. R167 and R111 ate lunch together on the same table. At 2:20 PM observed the door to R167's room was closed with the call light on, R167's roommate (R174) was in the room. A staff member went in and both residents emerged from the room together. Throughout the afternoon, R167 and R111 would ambulate in the hall, holding hands going back and forth to R167's room and the multi-purpose room.

On 11/15/22 at 07:59 AM residents were eating breakfast together in the dining room. At 08:39 AM, the door to R167's room was closed. At 09:30 AM they were observed coming out of the room together, holding hands. No staff were available to ask residents to leave the door open. They sat in activities then at 09:49 AM then returned to R167's room.

On 11/16/22 at 09:54 AM, R111 was in R167's room sitting on the bed together, R174 (roommate) was observed laying in his bed. Subsequent observation at 09:58 AM found the three walking together down the hall to the activity room. R111 and R167 were holding hands and R174 stood close to the couple following them up and down the hall.

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Record review was done on 11/16/22 at 8:19 PM. R167 was admitted to the facility on 12/09/21. Diagnoses include unspecified dementia, unspecified severity, with agitation; depression, unspecified; alcohol abuse, uncomplicated; other stimulant use, unspecified with stimulant-induced psychotic disorder, unspecified; anxiety disorder; sleep disorder; metabolic encephalopathy; personal history of transient ischemic attack (TIA); and cerebral infarction without residual deficits.

A review of the quarterly Minimum Data Set (MDS) with assessment reference date (ARD) of 09/15/22 notes R167 yielded a score of 5 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS). There was no documentation R167 was assessed to have capacity for consent or a care plan with parameters for this relationship. The care plan for exhibits fluctuating mood, behavior with limited social interaction related to cognitive, hearing, vision, communication deficits, restlessness, and history of rummaging/hoarding includes intervention of "Resident prefers to hold hands with another Resident," revision date was 11/15/22. R167's family, son, and daughter-in-law act as the resident's representative.

There is a progress note entry for 12/19/21 documenting, R167 was found lying in 125-B bed (male occupants) with only a shirt on. He attempted to use the privacy curtain as a blanket. When staff offered assistance, he became physically aggressive. Staff were able to redirect him.

Record review was done on 11/16/22 at 8:42 PM.

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R111 was readmitted to the facility on 10/19/20. Diagnoses include unspecified dementia, unspecified severity, with other behavioral disturbance; muscle weakness; generalized anxiety disorder; and wandering in diseases classified elsewhere.

A review of R111's quarterly MDS with an ARD of 08/13/22 notes she yielded a score of 4 (severe cognitive impairment) on the BIMS. There was no documentation of an assessment to determine R111's capacity for consent or a care plan with parameters for this relationship. The care plan included a focus area for communication problem related to impaired cognition secondary to dementia and co-morbidities. The intervention includes Resident prefers to hold hands with another Resident, date initiated was 11/15/22. Further review found R111 has a public guardian.

Review of progress note for 10/22/22 notes R111 stayed in R167's room for dinner. Also documented, R167 wears one shoe of R111 and one of his own. And R111 wears footwear the same way.

On 11/17/22 at 09:08 AM, an interview was conducted with Charge Nurse (CN)5. CN5 reported R167 and R111 are comfortable with each other and will hold hands while walking in the hall. CN5 reported to separate them may hurt them. Inquired when did R167 and R111's relationship begin. CN5 replied, it may be months. Further queried if the interdisciplinary team discussed this "friendship." CN5 is not aware. CN5 was asked if it is acceptable for the friends to spend time in the room together with the door closed, CN5 responded staff will check if they are okay. CN5 confirmed the facility did not

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develop a care plan for this friendship. CN5 reported R111 had another male friendship, however, this resident has expired. CN5 was asked if it is okay for this couple to enter a sexual relationship, CN5 responded only holding hands is acceptable. CN5 reported she does not think R167 and R111 bothers the roommate, R174.

On 11/17/22 at 09:57 AM an interview was conducted with the Unit Manager (UM)4. UM4 reported the residents have a care plan to hold hands. They are not allowed to close the door to the bedroom so that they can be constantly monitored. UM4 further reported R167's family is aware of the relationship and the public guardian for R111 is aware.

On 11/17/22 at 10:21 AM interviewed Certified Nurse Aide (CNA)18. CNA18 reported residents are only allowed to hold hands and are not to go into the room and close the door. CNA further reported when staff redirect residents and ask R111 to leave, R167 will say it's okay, we are married. R111 reportedly attempts to sleep in the vacant bed in R167's room.

On 11/16/22 at 10:30 AM interviewed the Director of Social Services (DSS). DSS reported awareness of the residents' relationship and that they are holding hands. DSS reported the residents will comment that they are married. DSS also reported R167's family (Power of Attorney) and R111's guardian is aware of their relationship. Further queried if facility determined the residents' capacity for consensual intimacy and if they don't have capacity, what are the parameters for their expressions of intimacy. Also, inquired when did the residents relationship begin. DSS was agreeable to follow-up.

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F 607	Continued From page 30 On 11/18/22 at 09:45 AM a follow-up interview was conducted with DSS. DSS reported the residents' POA and guardian are aware of the relationship, however, the conversations with the involved parties were not documented. DSS stated yesterday (11/17/22 she contacted the residents' representatives and consulted the Medical Director) which she documented. DSS believes the residents' relationship started in September/October. DSS confirmed the care plan including holding hands was added on 11/15/22. Inquired whether the DSS was aware of the facility's policy and procedures titled, "Intimacy Between Residents/Sexual Consent?" Reviewed the policy and procedure with DSS and asked if the residents' representatives and interdisciplinary team determined the extent of the residents' capacity for consent for intimate contact (i.e., is it okay for them to have sexual intercourse). DSS responded the facility has not made this determination.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve	F 609		1/2/23

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F 609	Continued From page 31 abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to appropriately protect two Residents (R), R199 and R454, out of a sample of three residents, from further abuse by failing to report to Adult Protective Services (APS) incidents that involved alleged staff-to-resident abuse. R454's staff-to-resident abuse incident was not reported to the Administration and state agency (SA) within the prescribed timeframes deemed by federal and state regulations. This deficient practice may result in the failure to identify abuse and can potentially affect all residents. Findings include: 1) On 11/14/22 at 07:30 AM, reviewed from the Aspen Complaints/Incidents Tracking System (ACTS) the completed "Office of Health Care Assurance (OHCA) Event Report" document dated 10/28/22 for ACTS #9859. The document described an alleged staff-to-resident abuse with	F 609	F609: Reporting of Alleged Violations Point 1 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Reports were made to Adult Protective Services (APS) regarding events for residents #199 Education was conducted with the Executive Director (ED), Director of Nursing (DON), and nursing leadership regarding reporting incidents to APS along with the timeframe requirements for reporting abuse to the state agency for resident #454. Point 2 How the facility will identify other residents having the potential to be affected by the same deficient practice.	

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F 609	Continued From page 32 an ensuing investigation involving Certified Nurse Aide (CNA)80 who assisted R199 roughly when he helped her to the restroom. R199 sustained a bruise on her left hand. A police report was filed, but no report was made to APS. The facility's internal investigation of the abuse allegation was found to be unsubstantiated. On 11/18/22 at 09:04 AM, the Director of Nursing (DON) was interviewed. DON stated that historically the Social Services (SS) department would notify APS for a facility-initiated discharge and if there was a concern about a visitor causing harm to resident(s). All alleged abuse incidents were reported to the local police department. DON stated that she needed to clarify with the corporate office whether abuse allegations were also reported to APS. Reviewed the facility's "Abuse - Reporting and Response - No Crime Suspected" policy issued 10/04/22. It stated, " ... 4. All alleged violations, whether oral or in writing, must be reported to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency and adult protective services where State law provides for jurisdiction in long-term care facilities) ..." 2) On 11/18/22 at 08:22 AM, while investigating a facility-reported incident (ACTS #9480), an allegation of staff-to-resident abuse, an interview was done with the Director of Nursing (DON) in her office. During a concurrent review of the completed investigation report and corresponding progress notes, the DON agreed that the abuse allegation was not reported to the Nurse Supervisor and the DON "immediately" in	F 609	Incidents that were reported to the state agency in the past 30 days were audited to determine if APS had been notified and if they had been reported timely. APS was contacted and notified of events as needed and there were no other issues identified related to timeliness of reporting. Point 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Alleged or suspected violations abuse, and incidents involving serious injury of a resident are immediately reported to the ED and/or DON. For alleged violations of abuse or if there is resulting serious bodily injury, the facility will report the allegation immediately, but no later than 2 hours after the allegation is made. These notifications are made to the state agency, APS, police, etc. Education is provided to staff regarding reporting requirements related to abuse upon hire and as needed. Point 4 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes. The ED/designee will audit Incidents that were reported to the state agency to	

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F 609	Continued From page 33 accordance with facility policy. A Nursing Progress Note documented assessment of the resident injury/alleged abuse occurred at 12:40 AM on 04/27/22, but notification to the Registered Nurse (RN) on call (Nurse Supervisor) and the DON was documented as done at 05:05 AM. When asked about notifying Adult Protective Services (APS), the DON confirmed that APS was not notified about the abuse allegation. The DON stated that she was not aware that it needed to be reported to APS. When asked what types of incidents would be reportable to APS, the DON stated since she took over as the DON in February 2022, she had not been trained of any situations that needed to be reported to APS. When asked about reporting abuse allegations to the State Survey Agency (SA) within 2 hours, the DON acknowledged that because she was notified late, that delayed the SA notification as well. On 11/18/22 at 08:50 AM, during a review of the facility's policy and procedure (P&P) Abuse-Reporting and Response-No Crime Suspected, issued on 10/04/22, the following was noted: "Procedure Reporting 2. All alleged or suspected violations involving mistreatment, abuse, neglect, injuries of unknown origin... will be immediately reported to the administrator and/or director of nursing... 3. When an incident of resident abuse is suspected, the incident must be reported to the supervisor regardless of the time lapse since the	F 609	determine if APS had been notified and if they had been reported timely. This will be done with each incident for 90 days, and then re-evaluated. Based on the findings of the audits, the ED will take corrective action as needed. Results of the audits, along with any corrective action taken, will be reported to the QAPI committee for review and recommendations. The QAPI will determine if substantial compliance has been achieved and the frequency of ongoing monitoring. Point 5 January 2nd, 2023	

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F 609	Continued From page 34 incident occurred... 4. All alleged violations, whether oral or in writing, must be reported to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency and adult protective services...). See reporting timeframes for additional details... Reporting Time Frames Initial Report - a. For alleged violations of abuse... the facility must report the allegation immediately, but no later than 2 hours after the allegation is made..."	F 609		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services.	F 655		1/2/23

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F 655	Continued From page 35 (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to develop a care plan that addressed the behavioral and emotional health needs of one newly admitted resident (R), R406, out of a sample of three residents. This deficient practice fails to provide non-pharmacological interventions for the behavioral and emotional health needs of a newly admitted resident and can potentially affect all incoming residents suffering from behavioral and emotional health issues. Finding includes:	F 655	F655: Baseline Care Plan Point 1 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The care plan for resident #406 was updated to reflect behavioral and emotional needs, along with non-pharmalogical interventions. Education was done with nurse managers	

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F 655	Continued From page 36 On 11/15/22 at 1:23 PM, an observation of R406 was done. R406 lay in bed with his eyes closed wearing a hospital gown and tubing into his nostrils that delivered oxygen from an oxygen compressor next to his bed. R406 opened his eyes when the state agency (SA) approached him. SA tried to initiate a conversation with R406, but his eyelids kept drooping closed. R406 spoke with a flat affect and soft tone. Reviewed R406's electronic health record (EHR). The "Admission Record" document revealed that R406 was admitted on 11/08/22 for pneumonia. The discharge summary from the acute care facility dated and timed 11/08/22 at 09:02 AM was read. R406 had an extensive medical cardiac history and was found unresponsive following vascular surgery to correct narrowed blood vessels in the leg. R406 was also identified as having depression and was started on an antidepressant on 10/31/22 after he was taken off the ventilator and the breathing tube removed. R406's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/14/22 was reviewed. R406's cognition was assessed with the Brief Interview for Mental Status (BIMS) under Section C, Cognitive Patterns. R406 scored "09," meaning his cognition was moderately impaired. R406's "Order" showed that he continued the same dose of antidepressant as when he was discharged from the acute care facility. Reviewed R406's care plan. There was no focus to address his depression specifically and no non-pharmacological interventions. On 11/16/22 at 09:10 AM, R406 was interviewed. R406 lay in bed wearing a hospital gown with the	F 655	and admission nurse regarding the facility procedure for developing Baseline care plans for residents and ensuring it is reflective of the resident needs. Point 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. An audit of residents admitted in the last 7 days was done to determine if a baseline care plan was implemented and if it addressed the behavioral and emotional needs of the resident and if it included non-pharmalogical interventions. Care plans were updated as needed. Point 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The completion and implementation of the baseline care plan is done within 48 hours of the resident□s admission to the facility. Residents and their representative, if applicable, are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan. The baseline care plan includes the minimum health care information necessary to properly care for each resident and includes the initial goals of the resident, a summary of the resident's medications and dietary instructions, services, and treatments to be	

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F 655	Continued From page 37 television on and his call device in his hand. R406 spoke with a flat affect and soft tone. He infrequently made eye contact with SA during the conversation. R406 stated that he was depressed and that he wanted to go home. He denied any suicidal ideation or self-harm. Both of his feet were elevated on pillows that were covered with a blanket. He complained of 9 out of 10 pain to his left foot. R406 further stated that he would like to go outside. On 11/16/22 at 09:40 AM, licensed nurse (LN)45 was interviewed about R406's depression. LN45 did not confirm R406's depression and stated that R406 had endured "a lot" medically and is "suprisingly getting better after all he has been through." LN45 further stated that R406 is on an antidepressant medication and wants to go home. On 11/18/22 at 10:52 AM, interviewed the Medical Director (MD) about R406's depressive state. MD stated that he just increased his antidepressant medication. Reviewed the facility's policy, "Behavioral Health Services," issued on 08/29/22. It stated, " ...4. The facility must provide necessary behavioral health care and services which include: a. Ensuring that the necessary care and services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. b. Ensuring direct care staff interact and communicate in a manner that promotes mental and psychological well-being. c. Providing an environment and atmosphere that is conducive to mental and psychosocial well being.	F 655	administered by the facility, etc. Education is done with nurse managers and admission nurse upon hire and as needed regarding the facility procedure for developing Baseline care plans for residents and ensuring it is reflective of the resident needs. Point 4 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes. The DON/designee will audit baseline care plans within 48 hours of admission to determine if reflective of the resident's behavioral and emotional needs and non-pharmalogical interventions. This will be done with each new admission for 30 days, then will be done for 3-5 residents per week for 30 days and then 10 residents per month for 30 days. Based on the findings of the audits, care plans will be updated as needed and additional education will be provided. Results of the audits, along with any corrective action taken, will be reported to the QAPI committee for review and recommendations. The QAPI will determine if substantial compliance has been achieved and the frequency of ongoing monitoring.	

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F 655	Continued From page 38 d. Providing meaningful activities which promote engagement, and positive meaningful relationships between residents and staff, families, other residents and the community. Meaningful activities are those that address the resident's customary routines, interests, preferences, etc. and enhance the resident's well-being. e. Ensuring that pharmacological interventions are only used when nonpharmacological interventions are ineffective or when clinically indicated."	F 655	Point 5 January 2nd, 2023	
F 656 SS=E	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	F 656		1/2/23

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F 656	Continued From page 39 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §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 ensure that the care plans for nine residents (R), R131, R152, R151, R180, R55, R98, R169, R26 and R76, out of a sample of 36 residents, were appropriately developed and/or implemented to promote the highest practicable physical, mental, and/or psychosocial well-being of these residents. This deficient practice has the potential to affect all residents. Findings includes: 1) During an observation and interview with R131 on 11/15/22 at 10:33 AM noted resident with right lower extremity swelling and redness. R131 was	F 656	F656: Comprehensive Care Plans Point 1 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The care plan for resident #131 was updated to reflect skin care. The care plan for resident #152 was updated to reflect bed mobility assistance. The care plan for resident #151 was updated to reflect activity needs.	

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F 656	Continued From page 40 lying in bed with her right lower leg elevated onto the pillow, her eyes were closed. On 11/15/22 at 10:45 AM, state agency (SA) asked the Charge Nurse (CN)6 why her right lower leg is swollen and red. Per CN6, she scratches her leg, and she would rather be up in her chair watching television, which doesn't help with the swelling of her leg. On 11/16/22 at 08:04 AM, an interview with licensed nurse (LN)5 was done. Asked her to describe why the right leg is swollen and red. LN5 explained that R131's right and left lower extremities have some scabs with some swelling. Her nails are long, and she won't allow the staff to cut them. She scratches the lower legs because the skin is dry and breaks open the scabs. We are rinsing with normal saline, drying, and elevating her legs on pillows while she is in bed. On 11/17/22 at 09:13 AM, reviewed R131's electronic health record (EHR). Physician orders reviewed: "Saline Wound Wash Solution 0.9 %. Apply to right lateral lower leg topically every day shift for dry scabs & abrasion to right lower extremity (RLE), until healed. Monitor for pain, drainage, or signs and symptoms (s/s) of infection. AND apply to left calf, topically every day shift for intact blisters two times until healed. Monitor for pain, drainage, or s/s of infection. Notify supervisor if ruptures for further treatment orders. AND apply to bilateral LE topically every day shift for multiple pink dry lesions, until healed. Monitor for pain, drainage, or s/s of infection, start 09/29/22." Diabetic Foot Check. Every day shift for diabetes mellitus (DM) type 2. No directions specified for	F 656	The care plan for resident #180 was updated to reflect behavioral symptoms and interventions. The care plan for resident #55 was updated to reflect activity needs and interventions for behavioral symptoms and wandering. The care plan for resident #98 was updated to activity needs. The care plan for resident #169 was updated to reflect activity needs and interventions for behavioral symptoms and wandering. The care plan for resident #26 was updated to reflect and interventions for behavioral symptoms and wandering. The care plan for resident #76 was updated to reflect and interventions for behavioral symptoms and wandering. Education was done with the Interdisciplinary Team (IDT), nurses and MDS Coordinators regarding the facility procedure for developing comprehensive care plans for residents and ensuring they are reflective of the resident needs. Point 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. An audit of care plans was done to determine if comprehensive care plans reflected skin care, mobility, and activity	

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F 656	Continued From page 41 order. Care plan dated 10/29/2022 reviewed. Noted care plan skin care interventions were generalized and vague. No specific interventions regarding the skin care to the wounds on the right lateral leg nor the treatment interventions. Care plan focus: "Resident has actual impairments to her skin integrity related to (r/t) pain, mobility challenges, self-care deficits, diabetes, incontinence, etc. Goal: Resident's skin impairment will resolve/heal and will not show signs of infection through next review. Interventions/ tasks. No intervention for wound treatment to the right lower extremity noted." During an interview with Assistant Director of Nursing (ADON) on 11/18/22 at 09:55 AM SA discussed the problem and wound treatment with the ADON, explained that the care plan interventions for skin impairment prevention do not include the wound treatment to the right lower leg. ADON, acknowledges the skin care interventions, and stated that the resident doesn't want her nails trimmed so it is difficult to keep the skin free of scratches. 2) On 11/15/22 at 07:58 AM, R152 was observed to be sitting up in his wheelchair in his room. R152 stated that he did not eat breakfast yet. Staff was noted to be in the hallways passing out breakfast trays to the residents. On 11/15/22 at 10:19 AM and 11:27 AM, R152 was observed to be sitting up in his wheelchair in his room in the same position. On 11/16/22 at 08:29 AM, observed R152 lying on his back with the head of bed raised at a	F 656	needs and behavioral symptoms and interventions. Care plans were updated as needed. Point 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The comprehensive care plan is developed by the IDT after the MDS Assessment is completed in order to implement a comprehensive person-centered plan for each resident. It includes measurable objectives to meet a residents medical and psychosocial needs. The comprehensive care plan is reviewed by the Interdisciplinary Team (IDT) and updated quarterly, with significant change of condition and as needed. Education is done with IDT, nurses and MDS Coordinators regarding the facility procedure for developing comprehensive care plans for residents and ensuring they are reflective of the resident needs upon hire and as needed. Point 4 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes. The DON/designee will audit 10% of comprehensive care plans to determine if	

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F 656	Continued From page 42 45-degree angle. R152 wore a hospital gown, his breakfast tray finished on his bedside table pushed to the side of his bed. On 11/16/22 at 10:19 AM and 11:14 AM, R152 was lying in bed on his back in the same position as 08:29 AM. On 11/16/22 at 1:21 PM, R152 was eating lunch lying in the same position as he was in at 08:29 AM. R152's lunch tray on his bedside table in front of him. On 11/16/22 at 2:30 PM, R152 was lying in bed in the same position he was in since 08:29 AM. Reviewed R152's electronic health record (EHR). "Admission Record" revealed that R152 is a 72-year-old resident admitted to the facility on 09/02/22 for right-sided weakness following a stroke. R152's Minimum Data Set (MDS) admission assessment with Assessment Reference Date (ARD) of 09/08/22 revealed under Section G, Functional Status that R152 needed "extensive assistance" with "two+ [plus] persons physical assist" for "Bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed...)" R152's care plan was reviewed. A problem identified included, "At risk for break in skin integrity r/t [related to] incontinent episodes, use of suprapubic catheter and co-morbidities." An intervention to be provided by staff included, "Reposition resident upon rising, after breakfast, before lunch after lunch before dinner, after dinner and as needed." A review of R152's "Bed Mobility" task flowsheet for 11/16/22 showed that R152 was provided extensive assistance with one person helping him for bed mobility at 10:25 AM	F 656	reflective of the resident's current status, goals, and interventions. Based on the findings of the audits, care plans will be updated as needed and additional education will be provided. Results of the audits, along with any corrective action taken, will be reported to the QAPI committee for review and recommendations. The QAPI will determine if substantial compliance has been achieved and the frequency of ongoing monitoring. Point 5 January 2nd, 2023	

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F 656	Continued From page 43	F 656		

and 6:44 PM.

Read the facility's Activities of Daily Living (ADLs) policy and procedure reviewed on 08/22/22. It stated, " ...Procedure For Bed/Wheelchair Mobility, the following procedure will be followed: 1. Assist residents with bed/wheelchair repositioning as necessary to promote good body alignment and to prevent skin breakdown ..."
3) Cross Reference to F679, Activities Meet Interest/Needs of Each Resident. Resident (R)151 resides on a locked dementia unit. Observations found R151 seated in the multi-purpose room during group activities. R151 was not engaged in the group activity, she was observed with eyes closed. R151 assessment included 1:1 engagement for activities. Observations found no consistency of implementation of R151's care plan or whether R151's activity assessment needs to be updated.

4) Cross Reference to F744, Treatment/Service for Dementia. R180 resides on a locked dementia unit and receives four psychotropic medications. The care plan found the identified behaviors being monitored for the use of the medications and non-pharmacological interventions to address R180's behavior were not included in the R180's care plan.

5) Cross-reference to F679, Activities Meet Interest/Needs of Each Resident. The facility failed to ensure there was an ongoing resident-centered activities program that fully identified and met the residents' needs, for three residents in the sample, Resident (R)55, R98, R169. Specifically, the facility failed to act on the residents' need for social engagement, failed to identify activities the residents found meaningful,

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F 656	Continued From page 44 and failed to develop and/or implement a person-centered activities program. 6) Cross-reference to F689, Accident Hazards. The facility failed to ensure four residents (R) in the sample were free from accident hazards by thoroughly assessing and developing/implementing a plan to keep them safe once they had been identified as elopement risks with wandering and at times aggressive behavior. As a result of this deficient practice, the residents (R55, R169, R26, and R76) were placed at risk of an avoidable accident, interpersonal altercation, and/or injury..	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		1/2/23

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F 657	Continued From page 45 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 observation, interview and record review, the facility failed to update the care plan with treatment of one Resident (R)131 osteoarthritis of the left wrist. The deficient practice increased the resident's pain and discomfort, and updated interventions improve outcomes of the treatment plan for residents' osteoarthritis. Findings include: On 11/14/2022 at 10:50 AM, surveyor reviewed the completed incident report that was received by the state agency (SA) via fax on 11/03/22 at 4:18 PM. Resident complained of right wrist pain and was noted to have bruising. Resident was taken to acute care for an X-ray. During an observation and interview with R131 on 11/14/22 at 1:30 PM, when asked about her injured wrist, she held up her hand and said, "I had a brace for my sore wrist, but it's better now and I don't need it." When asked what happened to cause her sore wrist, she shrugged her shoulders and said she didn't remember. The facility internal investigation report for the unknown injury to the resident's wrist was reviewed on 11/16/22 at 12:38 PM. Report made to Police Department Report # 22-097895. Reviewed the fax report. On November 3, 2022,	F 657	F657: Care Plan Timing and Revision Point 1 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The care plan for resident #131 was updated to reflect treatment for the left wrist. Point 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. An audit of care plans for residents involved in incidents within the last 30 days was done to determine if updates to the care plans were done to reflect new interventions. Care plans were updated as needed. Point 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Care plans are reviewed following an incident to update with new nursing, psychosocial, behavioral, etc. interventions as appropriate. This can	

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F 657	Continued From page 46 a reportable incident report was faxed to the state agency for R131. She was complaining of left wrist pain and a portable x-ray done on 11/03/22 showed an acute fracture of the distal radius. A follow up x-ray was done on 11/04/22 at the emergency department (due to concerns of the accuracy related to portable x-ray result) which came back negative for left wrist fracture, with finding of osteoarthritis. Based on these findings a report for injury of unknown source is not required at this time. On 11/17/22 at 09:30 AM electronic health record (EHR) reviewed. On 11/17/22 at 10:30 AM Reviewed the care plan dated 10/29/22: Did not find an update on the care plan after the incident occurred on 11/03/22 with swelling of the wrist. Assistant Director of Nursing (ADON) interviewed on 11/18/22 09:48 AM. When asked if the care plan was updated for R131 after the incident ADON responded that no, the care plan had last been updated on 10/29/22. ADON stated that the physician (MD) diagnosed her with Osteoporosis of the left wrist. When asked if the resident's diagnosis was updated, she replied, R131 was not diagnosed with osteoarthritis of wrist until after the X-ray results, but the MD did not update it yet.	F 657	include the development of new problems and interventions or adding to existing problems. Adding a short-term problem, goal and interventions is done to address a time-limited condition. The comprehensive care plan is reviewed by the Interdisciplinary Team (IDT) and updated quarterly, with significant change of condition and as needed. Education will be provided with IDT, nurses and MDS Coordinators regarding the facility procedure for developing comprehensive care plans for residents and ensuring they are reflective of the resident needs upon hire and as needed. Point 4 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes. The DON/designee will audit care plans for residents who have had an incident in the past 30 days to determine if reflective of the resident's current status, goals, and interventions. Based on the findings of the audits, care plans will be updated as needed and additional education will be provided. Results of the audits, along with any corrective action taken, will be reported to the QAPI committee for review and recommendations. The QAPI will determine if substantial compliance has	

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F 657	Continued From page 47	F 657	been achieved and the frequency of ongoing monitoring. Point 5 January 2nd, 2023	
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that there was an ongoing resident-centered activities program that fully identified and met the residents' needs for four residents, Resident (R)55, R98, R169, and R151, out of a sample of 12 residents, and for over half of the total of 26 residents in a secured dementia unit. Specifically, the facility failed to act on the residents' need for social engagement, failed to identify activities the residents found meaningful, and failed to develop and/or implement a person-centered activities program. Residents on the dementia unit were not engaged in group activities, they were not singing along or exercising and there were residents sitting in the multi-purpose (room for dining and activities) with their eyes closed. As a result of this deficient practice, these residents	F 679	F679: Activities Meet Interest/Needs Each Resident Point 1 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The activity programming for residents #55, 98, 169 and 151 were reviewed and corrected Education was done with activity and nursing staff regarding meaningful and resident-centered activities that engage residents. Associates received information on the updated activity programs along with other options for providing activity	1/2/23

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were placed at risk of experiencing a decline in their psychosocial well-being, self-esteem, and comfort. This deficient practice has the potential to affect all residents at the facility.

Findings include:

1) Resident (R)55 is a 73-year-old female admitted to the facility on 10/14/15 and resides in a locked unit with one long hallway. R55's diagnoses include dementia, schizoaffective disorder, bipolar type, wandering, depression, and psychotic disorder with delusions.

On 11/14/22 at 10:57 AM, observations were made of R55 in her room. R55 was sitting alone wearing bright lipstick, a head wrap covered by a large hat, a bright pink outfit, pretty socks, and a pair of old shoes that were falling apart. When asked how she was doing, R55 responded that "someone got into my moon dress and ruined it." R55 continued on to state that when she finds out who did it, "they're going to get it in the neck, that's what happens to people who steal, they always get it in the neck." At 12:15 PM, R55 was observed in the dining room sitting alone. One staff member was observed leading a mealtime activity. No observations were made of staff member attempting to engage or include R55 as she sat alone with her back to the staff member. Consumed 50% of her lunch, then got up and began wandering the hall.

On 11/15/22 at 08:35 AM, observed R55 standing by the foot of her bed facing the wall and talking to herself. Throughout the survey period, numerous observations were made of R55 wandering alone in the hallway, or alone in her room. When other residents attempted to

pursuits for the residents.

Point 2 How the facility will identify other residents having the potential to be affected by the same deficient practice.

The activity programming for residents on the secured dementia unit was evaluated. Activity assessments, along with the cognitive and functional status and behavioral symptoms of the residents was reviewed. Based on the information obtained, resident-centered activity programming was updated and implemented.

Point 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

Residents activity preferences are evaluated upon admission, quarterly, with significant change of status and as needed.

Activity offerings are resident centered and incorporate the interests, hobbies and cultural preferences in order to maintain and/or improve the physical, mental and psychosocial well-being and independence of the residents. Cognitive and functional abilities, along with behavioral symptoms are also considered when creating an activity plan. This can be done with both group and individual activities and programming.
Planned activity programming is conducted with and communicated to all

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approach or engage with her, R55 was observed rolling her eyes and walking away and/or becoming verbally aggressive. No observations were made of staff attempting to engage R55 in any activity or to include her in the group. No residents were observed being offered or assisted on nature strolls. More than 90% of the observations made of R55 wandering, sitting, or standing alone, there were no staff members in sight.

On 11/15/22 at 10:48 AM, an interview was done at the One South nurses' station (NS) with the Charge Nurse (CN) on duty, CN8. When asked about how the residents interact with each other, CN8 stated R55 in particular is "a challenge" because she can and does physically act out towards other residents at times. CN8 acknowledged part of the challenge with R55 is she is "very mobile."

On 11/17/22 at 2:13 PM, a review of R55's electronic health record (EHR) was done. During a review of her comprehensive care plan (CP), the following was noted in relation to activities' goals:

"... shall attend an average of 2-4 group programs/activities daily for social contact/interaction..."

"... shall pursue her self initiated [sic] activities such as socializing with staff, relaxing in her room, beautifying her appearance, and exploring the hallway..."

With regards to planned interventions, the following was noted:

departments to ensure coordination of schedules, need for refreshments, cleaning activity areas, family and community involvement, transportation, etc.

Education is done with activity and nursing staff regarding meaningful and resident-centered activities that engage residents upon hire and as needed.

Point 4 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes.

The Activity Director/designee will observe the activity programming on the secured unit 3-5 times a week for 60 days, then weekly for 30 days. Based on the observations, adjustments will be made to the programs based on the resident needs and response to activity offerings. This will also include observations of associate engagement with residents. Additional education will be provided to associates as needed.

Results of the observations, along with any corrective action taken, will be reported to the QAPI committee for review and recommendations. The QAPI will determine if substantial compliance has been achieved and the frequency of ongoing monitoring.

Point 5 January 2nd, 2023

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"Invite and assist to group activities/programs especially beauty bar, group exercises, movie time/you tube videos, musical programs, sing along, and mealtime socials."

"Offer/provide nature strolls as tolerated."

2) R98 is a 70-year old female admitted to the facility on 04/11/22 with admitting diagnoses that include dementia, epilepsy, history of falling, and anxiety.

On 11/14/22 at 2:44 PM, an interview was done with R98 at her bedside. When asked about activities, R98 stated that she preferred to stay in her room writing letters to friends and family, reading, or sometimes coloring. When asked if she was invited to activities outside her room, R98 stated that she did not know why she was "in the lockdown [locked/secured unit]," and that she had no interest in participating in the activities offered on the unit because they were "too simple." "Why would I want to sing songs and sit around doing children's puzzles?" Several times during the interview, R98 stated her belief that she did not belong on the secured unit with the "crazy people." Throughout the survey period, R98 was found to be an alert and oriented, high-functioning, articulate, and cognizant individual. R98 answered all questions asked of her appropriately and intelligently, in a manner that demonstrated linear and logical thought. Several times throughout the survey period, R98 shared portions of the letters she was writing, and her handwriting was clear and legible, writing in complete sentences that also demonstrated linear and logical thought.

On 11/15/22 at 12:25 PM, during a review of

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R98's EHR, an Activity Participation Note from 10/18/22 at 3:55 PM documented the following:

"Note Text: ... was assessed for Quarterly review. She remains the same and continued to be alert, able to engage in simple conversation and make some of her needs known by making eye contact with clear speech. She attended an average of 3-5 group activities for social interaction especially bingo, arts [sic] and craft (coloring) tabletops, movies/videos, group exercises, sing along, music programs and mealtime socials... She had her meals in the dining area 3 times daily for social contact. Care plan was reviewed and updated..."

Documentation noted to be inconsistent with observations for the survey period. Surveyor observed R98 briefly leave her room only once during the survey period, and that was for a shower the morning of 11/15/22.

During a review of her CP, the following revision was noted on 10/20/22 in relation to activities' focus:

"... has expressed a preference of remaining in her room and has refused group activities."

With regards to activities' goals, the following was noted initiated on 10/18/22:

"... shall receive/accept/respond to an average of 3-5 one to one visits weekly ..."

Initiated on 10/20/22: "... shall attend group activities as interested..."

There was no documentation found on 10/18/22

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or 10/20/22 to indicate why R98 had refused group activities, or that an activities assessment had been conducted as a result of the refusal.

3) R169 is a 58-year-old male admitted to the facility on 01/19/22 with admitting diagnoses that include early onset Alzheimer's Disease, unspecified psychosis, and dementia.

On 11/14/22 at 11:34 AM, observations were done of R169 as he wandered along the hallway and into the day room. Attempts to interview R169 found him to have unintelligible speech, both eyes very red, no sense of personal space, and as a result, a large, somewhat intimidating presence to this female observer. Over the span of the next hour, observed R169 several times standing in the doorway of other residents' (sometimes female) rooms.

On 11/15/22 at 10:00 AM, observed R169 enter a room that was not his own and sit on a male resident's bed. At 10:15 AM, observed R169 enter a female residents' room with one of the females asleep on her bed. At 11:21 AM, observed R169 enter the same room again, this time sitting on a chair and rummaging through the drawers of a nightstand. Throughout the survey period, numerous observations were made of R169 wandering alone. Several observations were made of R169 attempting to interact with other residents, and the residents responding with frustration or indifference due to his close proximity to them and his communication barrier. No observations were made of staff attempting to engage R169 in any activity or to include him in the group. More than 90% of the observations made of R169 wandering, entering other residents' rooms, touching their property, sitting,

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or standing alone in the quiet, empty day room, there were no staff members in sight.

On 11/17/22 at 2:13 PM, a review of R169's EHR was done. During a review of his CP, the following was noted in relation to activities' goals:

" ... shall attend an average of 2-3 group activities daily for social contact/interaction ..."

With regards to planned interventions, the following was noted:

"Invite, encourage, and assist to group activities such as musical programs, tabletop and movies/videos."

"Offer/provide nature strolls as tolerated."

"Monitor if needed his time in the day room. Put on a show/movie of interest while he is relaxing in there."

4) On 11/15/22 at 09:11 AM, residents of the secured/locked dementia unit were observed in the multi-purpose room (dining and activity room). There was one activity staff present. A video of a young child singing Christian music was on the television at the front of the room. At 09:27 AM, the national anthem video was on until the snacks arrived. The next video was of a hula dancer, observed two residents were asleep. At 10:12 AM a video of chair exercise was provided. At 10:27 AM there were eleven residents in the room, five of the residents had their eyes closed, seemingly asleep. At 10:32 AM residents were encouraged to sing "Que Sera Sera", three residents were actively singing, and five residents were asleep. R73 was seated under the

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television and was unable to see the screen. R185 and R151 were asleep.

On 11/16/22 at 08:34 AM, there was music playing in the multi-purpose room. There was one activity staff present. R73 was seated under the television, asleep and dropped her false teeth that she was holding in her hand on the floor. R73 was unable to benefit from the visual picture. At 09:20 AM, residents in the room were informed the activity program would begin. R73, R111, and R82 had their eyes closed. R180 entered the room and requested a snack, ate, and left six minutes later. The group activity moved on to singing of "Hawaii Pono'i" and "God Bless America." There were eleven residents in the room and only two residents were engaged, singing. There was a male resident seated toward the back of the room sitting in a chair with both legs hanging over arms of the chair.

On 11/16/22 at 09:33 AM, observed R180 with R108 in the hall together. R180 was heard to say, she didn't like that song. R180 asked the Assistant Social Services Director (ASSD) if there was somewhere else they could go. ASSD redirected residents by informing them it was snack time. ASSD was asked whether the unit has another room for residents' activities, ASSD responded there is only one room, and the other room is used for visitors. At 09:50 AM, it was announced that this would be the last song, there were nine residents present and only two residents were engaged (R106 and her tablemate). Subsequently, at 10:34 AM a video of Englebert Humperdink singing was provided to the group. Observed R167 and R111 continuously walking in and out of the room.

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On 11/16/22 at 2:12 PM, the residents in the multi-purpose room with music playing, residents were provided with magazines and newspaper. R180 was sitting to the side of the room reading a newspaper. R151 was seated at the back corner of the room asleep. R106 was speaking loudly to another resident, stating "I'm a good person, you making trouble to me again?" No intervention to this behavior was observed. R13 was observed sitting at a table in the front looking at her baby doll.

On 11/17/22 at 09:00 AM an interview was conducted with the Charge Nurse (CN)5 regarding the activity program on the unit. CN5 reported sometimes music/program is loud and will aggravate residents. At times residents don't do table top activities in the multi-purpose room as it is too loud. However, as long as the music is calm the residents are okay. CN5 recognizes some residents have difficulty hearing. CN5 recalled there was an incident when the music was so loud, it was vibrating and it aggravates the residents more. They try to encourage residents to participate but for some, its dependent on their mood.

On 11/17/22 at 1:40 PM an interview was conducted with the Activities Director (AD). Observations of the unit were shared with the AD. AD responded she would like to "ramp up" the activity program downstairs to include more 1:1 group activity, having staff available to go from table to table. AD explained the scheduled activities are repetitive to provide structure for residents with dementia. Inquired whether the activity department is provided with in-service regarding creating an activity program for residents with dementia. AD replied previously

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they had more in-service and training. AD envisions having more staff on this unit, ability to provide activities for the "passive people on one table and more alert on another table" and would like to utilize the "day room" that is not being used.

The loud volume of the music and videos were discussed with the AD. Inquired whether loud music/talking would be too much stimulation for residents, causing them to shut down (closing their eyes) or not stay for activities. AD responded the volume is to accommodate residents with hearing deficits.

5) Cross Reference to F656, Develop/Implement Comprehensive Care Plan

R151 was admitted to the facility on 12/02/21. Diagnoses include, Parkinson's disease, unspecified dementia, unspecified severity, without behavioral disturbance; psychotic disturbance, mood disturbance, and anxiety; dysphagia, oropharyngeal phase; bipolar disorder, unspecified; and wandering in diseases classified elsewhere.

On 11/15/22 at 08:02 AM observed R151 seated in a wheelchair in the back right corner of the multi-purpose room. R151 had her eyes closed. At 08:45 AM observed R151 still in the dining room with a magazine in front of her. Subsequent observations at 09:32 AM found R151 with her head hanging down with patriotic sing along activity going on. Observed R151 at 09:54 AM at the table with an activity placed in front of her. There were vertical wooden dowels for R151 to string wooden beads on the dowels. The activity staff came over to assist R151 in

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activity, providing hand over hand assist. A bead was placed on the dowel and activity staff left. R151 did not continue in activity, the residents head was down, and eyes were closed. At 10:31 AM, Charge Nurse (CN)5 was observed spoon feeding R151 (yogurt). R151 would not open her mouth to accept the yogurt. CN5 tried to rouse R151 but was unsuccessful.

Record review on 11/16/22 at 12:56 PM found an admission Minimum Data Set with an assessment reference date of 12/08/21. R151 yielded a score of 4 (severe cognitive impairment). Review of an admission Activities Evaluation dated 12/10/21 documents R151 can make simple conversation with eye contact and clear verbal speech. Past/current activities noted as somewhat important includes, current events, movies, music, reading, and social/parties. Resident coded for 1:1 engagement for these activities. Also noted, R151 exhibits limited social interaction and activity participation related to cognitive deficits.

R151 has a care plan for limited social interaction and activity participation. Interventions include, discuss topics of interest such as family, past job, hobbies, religion; invite, assist, and encourage resident to attend group activities especially beauty bar, movie time, trivia, musical programs, socials, and tabletops; during group programs offer one to one attention and companionship; and encourage conversation and ask trivia questions. There were no observations of consistent implementation of R151's care plan. R151 attended group activities, however, was observed not to be engaged (asleep or head down).

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F 689	Continued From page 58	F 689		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure four residents (R), R55, R169, R26, and R76, in a sample of five residents were free from accident hazards by thoroughly assessing and developing a plan to keep them safe once they had been identified as elopement risks with wandering behavior. As a result of this deficient practice, the residents (R55, R169, R26, R76) were placed at risk of an avoidable accident, interpersonal altercation, and/or injury. This deficient practice has the potential to affect all the residents at the facility displaying wandering behavior. Findings include: 1) Cross-reference to F679 Activities Meet Interest/Needs of Each Resident. The facility failed to ensure there was an ongoing resident-centered activities program that fully identified and met the residents' needs, for two residents in the sample, Resident (R)55 and R169. Specifically, the facility failed to act on the residents' need for social engagement and activities despite identifying them with wandering and periodic verbally and/or physically aggressive	F 689	F689 Free of Accident Hazards Point 1 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The behavioral symptoms of residents #55, 169, 26 and 76 were reviewed by the IDT to determine resident-centered interventions to promote engagement and safety to minimize the risk for accidents, altercations and/or injury. Care plans were updated with identified interventions. Education was done with the activity and nursing staff related to activity programming and care of the patient with dementia that demonstrates wandering. Point 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. The activity programming for residents on the secured dementia unit was evaluated.	1/2/23

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F 689	Continued From page 59 behavior. 2) R26 is a 75-year-old male admitted to the facility on 07/20/20 with admitting diagnoses that include anxiety disorder, insomnia, history of falling, Alzheimer's disease, wandering, and depression. On 11/14/22 at 10:39 AM, observations were done of R26 wandering in the hallway barefoot. R26 had a severely unsteady, almost waddling gait, with a tall, large, and intimidating stature and a loud, booming voice. At 11:39 AM, observed R26 wander into a female resident's room with one resident asleep on one of the beds. At 12:15 PM, observed R26 staring angrily, yelling at, and scolding a female resident across the dining room who seemed oblivious to him. On 11/17/22 at 1:50 PM, a review of R26's electronic health record (EHR) noted that the facility had identified R26 as a wanderer with aggressive behavior. A review of the Nurse Progress Notes noted numerous documentations of consistently disruptive and aggressive behavior that was resistant to redirection. A review of R26's comprehensive care plan (CP) noted the following four planned interventions for the identified problem of " ... risk for elopement": "1. Complete Elopement Risk Assessment. 2. MD ordered special care unit. Elder resides on special care unit. 3. Provide escort whenever off unit. 4. When ...[R26] exhibits altered sleep pattern, social withdrawal, altered thoughts, restlessness, resistiveness with care, physical/verbal behavior, repetitive health and non-health concerns, validate in actions and words. Assess for basic	F 689	Activity assessments, along with the cognitive and functional status and behavioral symptoms of the residents was reviewed. Based on the information obtained, resident-centered activity programming was updated and implemented. Care plans were updated with identified interventions as needed. Point 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Residents that demonstrate wandering behavior are monitored by staff and attempts to engage in activities that minimize the risk for accidents, altercations and/or injury are implemented. Care plans are developed by the IDT for residents with dementia to reflect target behavioral symptoms and interventions in order to implement a comprehensive person-centered plan for each resident. It includes measurable objectives to meet a residents medical and psychosocial needs. Safety measures are also identified and communicated to associates. The care plan is reviewed by the Interdisciplinary Team (IDT) and updated quarterly, with significant change of condition and as needed. Education is done with the activity and nursing staff upon hire and as needed related to activity programming and care of the patient with dementia that demonstrates wandering.	

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F 689	Continued From page 60 needs of hunger, thirst, toileting, activity, companionship, touch, comfort. Provide for basic needs. Distract to activity or compatible Elder. Call wife; talk about surfboards." Further review of R26's CP noted that the identified problem of " ... exhibits altered thoughts. DX [diagnosis]: Dementia with psychosis ...," had the following one intervention: "When ...[R26] exhibits altered sleep pattern, social withdrawal, altered thoughts, restlessness, resistiveness with care, physical/verbal behavior, repetitive health and non-health concerns, validate in actions and words. Assess for basic needs of hunger, thirst, toileting, activity, companionship, touch, comfort. Provide for basic needs. Distract to activity or compatible Elder. Call wife; talk about surfboards." Continued review noted that the identical intervention is used for three other problems identified in R26's CP. In addition, it was noted that R26's CP did not address his wandering behavior or what to do when he is found in other residents' rooms, particularly female. 3) R76 is 93-year-old female admitted to the facility on 08/23/22 with admitting diagnoses that include sleep disorder, anxiety disorder, and restlessness and agitation. On 11/16/22 at 2:58 PM, observed R76 in a male resident's room [R165]. Observed R165 quietly but firmly ask R76 to leave several times while she silently stared at him. R76 eventually turned and left, then entered another male residents' room, got into one of the beds, pulled a male resident's blanket up over her, and closed her	F 689	Point 4 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes. The Activity Director (AD) and/or DON/designee will conduct observations of residents that demonstrate wandering behaviors and staff interactions to determine if interventions are effective. Based on the results of the observations, additional training will be provided as needed. This will be done 3-5 times per week for 30 days and then weekly for 30 days and then twice a month for 30 days. Results of the observations, along with any corrective action taken, will be reported to the QAPI committee for review and recommendations. The QAPI will determine if substantial compliance has been achieved and the frequency of ongoing monitoring. Point 5 January 2nd, 2023	

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eyes.

On 11/16/22 at 3:00 PM, an interview was done with R165 at his bedside. R165 stated "lots of residents [including R76]" walk into his room, "sometimes they get cocky and don't want to leave," so he calls the nurse. At times R165 stated he will return to his room and find other residents "going through my stuff, and I don't like that." R165 confirmed that R76 is one of the residents he has found touching his property. Approximately five minutes later, R76 returned to R165's room and he had to ask her repeatedly to leave again. R76 was assisted out of R165's room and back to her own room by state agency (SA).

On 11/17/22 at 11:47 AM, observed R76 asleep in R149's [a male resident] bed, covered with his blanket. SA called Certified Nurse Aide (CNA)6's attention to R76 as she assisted another resident down the hall. CNA6 stated "yeah, that's what she does." CNA6 explained that staff usually let her go unless there are other residents in the room.

On 11/18/22 at 11:00 AM, a review of R76's CP noted the following three planned interventions for the identified problem of "... risk for elopement... history of wandering":

"1. MD ordered special care unit. Elder resides on special care unit.
2. Provide escort whenever off unit.
3. When ...[R76] exhibits wandering nvalidate [sic] in action or words. Assess for basic needs of hunger, thirst, toileting, activity, companionship, touch, comfort. Provide for basic needs. Distract to activity or compatible Elder."

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F 689	Continued From page 62 In addition, it was noted that R76's CP did not specifically identify her wandering behavior as a problem, or what to do when she is found in other residents' rooms and/or touching/using their belongings.	F 689		
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 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:	F 725		1/2/23

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F 725	Continued From page 63 Based on observations and interviews, the facility failed to ensure there was sufficient nursing staff to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, in addition to their physical, mental, and psychosocial well-being. As a result of this deficient practice, the residents experienced a decreased quality of life and were unable to attain their highest practicable well-being. Findings include: 1) Cross-reference to F679 Activities Meet Interest/Needs of Each Resident. The facility failed to provide staff to adequately monitor and redirect residents identified with wandering behavior. 2) On 11/14/22 at nbh2:39 PM, an interview was done with Resident (R)98 at her bedside. When asked about staffing levels, R98 stated that she feels "they could do with more staff." R98 explained that staff seem to be rushing all the time, no matter what shift. R98 gave one example about her shower schedule. R98 stated she showers on her assigned days, Tuesday, and Saturday, and it is done "when staff has the time." R98 also stated that she was never asked how often or what days she would like to shower, and when she does have a shower, she is rushed through it, "it feels like they're herding cattle, just in and out." 3) On 11/17/22 at 09:20 AM, an interview was done with two regularly-attending members of the Resident Council, and one former member and interested resident. Two residents reside on the third floor and one on the second floor. The	F 725	F725 Sufficient Nursing Staffing Point 1 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Recruitment efforts by management have been proposed and approved to include salary adjustments, incentives for picking up shifts and sign on bonuses. Recruitment for traveling staff has been proposed and approved to fill licensed positions to meet staffing needs. The facility has collaborated with community partners to provide services for CNA certification. Point 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. Staff and resident interviews will be conducted to identify customer service needs. Point 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Weekly meetings will be conducted with DON, ED, SDC and HR to review current candidates, new hires, and any potential resignations. Point 4 How the facility will monitor its	

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F 725	Continued From page 64 interview was conducted in the second floor private Dining Room. When asked about staffing on their units, Resident (R)130, who has to be assisted to the restroom and uses a wheelchair, stated she always has to wait a long time for someone to assist her to the bathroom, and that she frequently gets her medications late. R130, who is also on hemodialysis, explained that she has dialysis medications that she knows she is supposed to take before breakfast, but even when she asks for it, the medications are always brought late. This results in R130 frequently eating her breakfast late as well. R130 stated sometimes she is so hungry that she forgets and starts eating breakfast and has to stop and call for her medications. R47 also complained about frequently getting his medications late. R47 stated when he calls and asks for his medications, the nurse "gives me attitude and still brings it late." All three residents stated that their food is often cold, "not sometimes, like all the time." All three also agreed that the facility is short-staffed on all shifts, and it has affected their care and comfort. In addition, R47 stated that he also waits a long time to be assisted to the bathroom, stating that he sometimes waits half an hour or longer. R47 stated that he also must press his call light for his roommate, who is bed-bound, when his adult brief needs to be changed. R47 complained that if his roommate sits too long in his bowel movement, he will start to play with it and spread it all over his bed. R47 stated he will press his call light as soon as he smells feces, but that staff frequently take so long that he has to leave the	F 725	corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes. ED/or Designee will be conducting monthly audits for 90 days to track new hires, terminations and resignations. Results of the audits, along with any corrective action taken, will be reported to the QAPI committee for review and recommendations. The QAPI will determine if substantial compliance has been achieved and the frequency of ongoing monitoring. Point 5 January 2nd, 2023	

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F 725	Continued From page 65 room because the smell is so bad. 4) On 11/17/22 at 11:44 AM, a confidential interview was done with a staff member on a secured dementia unit. The staff member stated there should be four Certified Nurse Aides (CNA)s scheduled for the day shift, but frequently (like that particular day), there are only three. 5) On 11/16/22 at 2:30 PM a confidential interview was conducted with a staff member. The staff member reported their unit does not have enough staff members which has an impact on the residents. The staff member clarified due to lack of staff members, there are times residents have to wait for response to call light and staff do not have time to talk with the residents.	F 725		
F 732 SS=E	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data	F 732		1/2/23

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F 732	Continued From page 66 specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure its nurse staffing information was prominently posted in a clear and visible place accessible to all residents and visitors. Specifically, the facility posted the nurse staffing information at the central nurses' station (fishbowl) on the second floor only, in a place not readily accessible to residents and visitors of the first and third floors. Moreover, the residents of the first floor reside in secured units, making the second floor posting completely inaccessible to them. This deficient practice has the potential to affect all residents and visitors to the first and third floors. Findings include: 1) On 11/14/22 at 12:45 PM, observations were made on the One South unit that there were no	F 732	F732 Posted Nurse Staffing Information Point 1 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The nurse staffing data posted at the fish bowl will be posted on both secure units on the first floor and at the nurses station on the third floor. Point 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents on the first and third floors of the facility	

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F 732	Continued From page 67 postings found regarding nurse staffing. A subsequent tour of the remainder of the first floor revealed no postings at the elevator, staircase, hallways, or on the One North unit. On 11/16/22 at 09:39 AM, an interview was done at the One South nurses' station (NS) with the Charge Nurse (CN) on duty, CN8. When asked about the nurse staff posting, CN8 stated "I think it's only at the fishbowl on the second floor." On 11/16/22 at 02:28 PM, a tour of the second floor confirmed a framed posting, approximately 8-inches by 12-inches in size, propped up in the second floor fishbowl window facing the private dining room. Placement of the staff posting required the viewer to walk around the fishbowl to a side not visible from the entrance to the second floor or from the elevator area. Subsequent tour of the third floor observed no nurse staffing information postings. 2) Observations on 11/16/22 and 11/17/22 found no posting of the nurse staffing information on One North unit. On 11/18/22 at 10:45 AM interviewed Charge Nurse (CN)5 to inquire if the nurse staffing information is posted on their unit. CN5 responded, it is not posted on their unit, the posting is on the second floor. Observation of the signage on the second floor found posting was not in a prominent place and readily accessible to all residents and visitors. Visitors to North unit on the first floor would not pass the posting while using the elevators or stairs to go the first floor. 3) Observations done on the third floor nursing units during the survey period of 11/14/22 to 11/18/22 revealed no nuse staffing information was posted and/or visible to the state agency	F 732	Point 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The facility will post nurse staffing data on the secure units and each floor of the facility to ensure that staffing data is readily accessible to all residents and visitors. Point 4 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes. The DON/ or designee, will conduct a weekly audit for the next 30 days to ensure that staffing data is posted daily on the secure units and each floor of the facility. The audits will be documented and reviewed at the monthly QAPI meeting. The QAPI committee will determine whether substantial compliance has been achieved and the frequency for ongoing monitoring. Point 5 January 2nd, 2023	

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F 732	Continued From page 68 (SA).	F 732		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff members, the facility did not assure a resident with dementia received appropriate interventons to attain or maintain her highest practicable psychosocial well-being. Findings include: Resident (R)180 was admitted on 04/26/22. Diagnoses include, unspecified dementia, unspecified severity with agitation; depression (06/23/22); psychotic disorder with delusions due to known physiological condition (04/26/22); mood disorder due to known physicaological condition with depressive features (04/26/22); anxiety disorder (04/26/22); and restlessness & agitation (04/26/22). Record review notes R180 is prescribed psychotropic medications (used to treat mental health disorders): alpralozam, 1 mg (miligram), give one tablet three times a day for anxiety disorder; risperdal tablet 0.5 mg, give 0.25 mg by mouth one time time a day for dementia with psychosis; citalopram hydrobromide, 20 mg, give 20 mb by mouth one time a day for depressive disorder secondary to dementia; and mirtazapine	F 744	F744: Treatment/Service for Dementia Point 1 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The care plan for resident #180 was updated to reflect target behaviors and interventions, including non-pharmalogical, to address behavioral symptoms. Education was done with the Social Services and MDS Coordinators regarding the facility procedure ensuring care plans reflect specific target behaviors for residents with behavioral symptom, along with interventions. Point 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. An audit of care plans for residents with dementia was done to determine if they reflected target behavioral symptoms and	1/2/23

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F 744	Continued From page 69 tablet 15 mg, give one tablet by mouth at bedtime for mood disorder with anorexia. A review of the admission Minimum Data Set (MDS) with assessment reference date of 05/02/22 notes physical behaviorial symptoms directed toward others, verbal behavioral symptoms directed towards other; and other behavioral sympotoms not directed towards others occurred on to three days during the assessment period. R180 was also coded as receiving antispsychotic, antianxiety and antidepressant medications daily. A review of the behavior note dated 06/19/22 documents, R180 was reviewed at the behavioral enhancement committee meeting with the interdisciplinary team (IDT), Director of Nursing, pharmacist, and physician (MD). Target behaviors identified on behavioral monitoring form includes restlessness, disruptive behavior, tearfulness, irritability, wandering, repetitive statements/questioning, and anxiousness. There were 11 behaviors exhibited from admission 04/26/22 to 06/16/22. Non-pharmacological interventions includes providing snacks, active listening, positive distraction, help resident become more comfortable, and assess for physical needs. Resident currently on Alprazolam for anxiety disorder, Risperdal for dementia with psychosis, and Bupropion for depression secondary to dementia, Mirtazapine for mood disorder with anorexia. IDT and MD recommending to consider discontinuing Bupropion and initiating Citalopram at this time. Subsequent behavioral enhancement committee meeting dated, 11/04/22 notes . Resident is currently on risperdal for dementia with	F 744	interventions, including non-pharmalogical. Care plans were updated as needed. Point 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Care plans are developed by SS and/MDSC and or Nurse/designee for residents with dementia to reflect target behavioral symptoms and interventions in order to implement a comprehensive person-centered plan for each resident. It includes measurable objectives to meet a residents medical and psychosocial needs. The care plan is reviewed by the Interdisciplinary Team (IDT) and updated quarterly, with significant change of condition and as needed. Education is done with the Social Services and MDS Coordinators upon hire and as needed regarding the facility procedure ensuring care plans reflect specific target behaviors for residents with behavioral symptom, along with interventions. Point 4 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes. The DON/designee will audit 10% of care plans for residents with dementia to determine if reflective of the resident's	

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F 744	Continued From page 70 psychosis. Target behaviors includes repetitive statements/questioning/non-health concerns, and anxiousness. There were 7 behaviors exhibited from 08/05/22 to 11/03/22. Non-pharmacological interventions includes active listening, positive distraction, offering snacks, and assessing resident for physical needs. Review of the care plan does not include the interventions identified by the behavioral enchancement committee. Also, a review of the Certified Nurse Aides' Kardex (instructions for aides to follow) does not include these interventions. On 11/17/22 at 09:00 AM interview was done with Charge Nurse (CN)5. Inquired what are the identified behaviors she is monitoring for R180. CN5 responded verbal aggression, sarcasm, resists care, and reported there has been a dose reduction of risperdal so she is closely monitoring R180. Inquired what are the interventions utilized to address behaviors. CN5 responded to offer snacks and talk to her, distract her, listen to what she wants to say, encourage her to attend activites (mostly likes to watch news and talk to other residents). On 11/17/22 at 1:17 PM an intereview was conducted with the Director of Nursing (DON). Inquired what are the non-pharmacological interventions to address R180's behaviors. DON responded it should be care planned under social services. Further queried whether the identified target behaviors and non-pharmacological interventions were included in the resident's care plan. DON acknowleged the targeted behaviors and non-pharmacological interventions were not included in the resident's care plan.	F 744	target behaviors and interventions. Based on the findings of the audits, care plans will be updated as needed and additional education will be provided. Results of the audits, along with any corrective action taken, will be reported to the QAPI committee for review and recommendations. The QAPI will determine if substantial compliance has been achieved and the frequency of ongoing monitoring Point 5 January 2nd, 2023	

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F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to adequately monitor one resident (R)131 for pain management out of a sample of three residents. R131 was prescribed a stronger form of the medication (opioid) versus acetaminophen without indication for its use and for an excessive duration. The deficient practice potentially increases the likelihood for an adverse medication effect. Findings include: Cross reference to F657 Care Plan Timing and	F 757	F757: Unnecessary Medication Point 1 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #131 was assessed for pain, including type and level, and the interventions that help alleviate pain. The assessment findings, along with the residents current pain regimen orders, were reviewed with the physician. New	1/2/23

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F 757	Continued From page 72 Revision. During record review on 11/17/22 at 9:30 AM, noted in the Physician orders, R131 had Norco Tablet (Hydrocodone-Acetaminophen) 7.5-325 mg (milligram) give 1 tablet by mouth at bedtime for pain. Ace Wrap to left wrist, no directions specified for order, 11/03/2022. Resident is at risk for falls related to (r/t) chronic bilateral knee pain, generalized weakness, etc. ...administer pain medications as ordered, evaluate pain med's effectiveness. Reviewed MDS quarterly assessment dated 10/25/22. Section J. Resident assessed for pain. Ask resident: "Have you had pain or hurting at any time in the last 5 days?" Answer coded as "No". Medication administration record (MAR) reviewed on 11/18/22 at 07:44 AM. MAR dated 10/01/22 - 10/31/2022. Hydrocodone-Acetaminophen, give 1 tablet by mouth at bedtime for knee pain. Pain level noted a "0" indicating no pain on 10/01/22 to 10/30/22 then "5" indicating moderate pain, on 10/31/22. Hydrocodone given nightly 10/01/22 to 10/31/22. Acetaminophen was ordered for R131 although it was not given on any of the dates reviewed. Further review of the MD orders revealed that R131 started taking the Norco-Acetaminophen on 01/2021. Assistant director of nursing (ADON) interviewed on 11/18/22 at 09:52 AM, when asked how is R131's pain being monitored and what are the parameters on the zero to ten pain scale for giving the pain medication? ADON replied they look at her pain scale every shift. Questioned the ADON why the resident was not given acetaminophen instead of the Hydrocodone	F 757	order were obtained. The care plan was updated. Education was done with nurses upon hire and as needed regarding assessing pain and interventions for residents, and monitoring for efficacy and adverse effects to determine an appropriate regimen to promote management of pain. Point 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. An audit of residents receiving opioid pain medications was done. Pain assessments findings were reviewed to determine if changes to the current pain management regimen was needed. The physician was contacted as needed and reviewed results of audits and new orders were obtained as appropriate. The care plan was update for those residents with changes. Point 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The facility will ensure only medications required to treat the resident's assessed condition are being used, reducing the need for and maximizing the effectiveness of medications are important considerations for all residents and use non-pharmalogical approaches designed to meet the individual needs of each resident. Based on the comprehensive assessment of a resident, the facility will ensure that	

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F 757	Continued From page 73 since she has so many low scores on her pain scale. ADON replied that in the past she was taking the Hydrocodone up to three times per day. Now she only takes it one time per day. She does tend to be somebody who needs to be on the medication.	F 757	residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. The facility will assess the resident's underlying condition, current signs, symptoms, and expressions, and preferences and goals for treatment. This will assist the facility in determining if there are any indications for initiating, withdrawing, or withholding medication(s), as well as the use of non-pharmacological approaches. The facility process will support the selection and use of medications in doses and for the duration appropriate to each resident's clinical conditions, age, and underlying causes of symptoms and based on assessing relative benefit and risks to, and preferences and goals of, the individual resident. Education is done with nurses upon hire and as needed regarding assessing pain and interventions for residents, and monitoring for efficacy and adverse effects to determine an appropriate regimen to promote management of pain. Point 4 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes.	

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F 757	Continued From page 74	F 757	The DON/designee will audit pain assessments for residents receiving opioid pain medications to determine if changes to the current pain management regimen was done, if needed. Based on the results of this audit, additional training will be done with nurses as indicated. This will be done weekly for 30 days, then monthly for 60 days and then re-evaluated. Results of the audits, along with any corrective action taken, will be reported to the QAPI committee for review and recommendations. The QAPI will determine if substantial compliance has been achieved and the frequency of ongoing monitoring. Point 5 January 2nd, 2023	
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. §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	F 761		1/2/23

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F 761	Continued From page 75 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 and biologicals used in the facility were labeled, stored, and/or disposed of in accordance with professional standards. Proper labeling and storage of medications and biologicals is necessary to promote safe administration practices and decrease the risk for medication errors. This deficient practice has the potential to affect all residents in the facility receiving medications or biologicals. Findings include: 1) On 11/16/22 at 09:14 AM, an inspection of a medication storage room was done with the Charge Nurse (CN) on duty, CN8. While inspecting the treatment cart, two opened and undated medicated gauze 4x4 packets were found with unused gauze remaining. The first one found, CN8 stated he had just used a portion of it to conduct a dressing change, and he "should have thrown it [the unused portion] away." In the opened pack used by CN8, observed three tiny squares, approximately 1-centimeter by 1-centimeter in size, of unused gauze remaining	F 761	F761: Label/Store Drugs and Biologicals Point 1 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The opened gauze packets and the bottles of docusate sodium and calcium were discarded. Education was done with nurses regarding the following: Discarding unused dressing supplies once opened Removing outdated medications from the medication cart Facility process for checking and documenting findings of medication refrigerators Point 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. Each medication cart was checked for	

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F 761	Continued From page 76 in the foil packet. When asked, CN8 stated that the facility protocol is to date the foil packet when opened and to use it "only for a couple days." A copy of the facility protocol was requested from CN8. After being unable to locate the protocol on the unit, CN8 stated it should be available on the second floor in the "fishbowl [central nurses' station]." On 11/16/22 at 11:25 AM, an interview was done with the Director of Nursing (DON) near the second floor fishbowl. The DON reported that she could not locate the existing process/protocol being used with regards to the medicated gauze, but the facility had just initiated a process of discarding the opened medicated gauze after one use, until she could find supportive evidence specifying clear usage parameters. The DON agreed that the facility needed to find a process to standardize usage and ensure resident safety. 2) On 11/16/22 at 10:20 AM, an inspection of the a medication cart was done with CN9. An unopened bottle of docusate sodium 100 mg [milligrams] was found with a manufacturer's expiration date of 8/22. CN9 stated that it should have been pulled from the cart and discarded. A bottle, dated as opened on 08/07/22, of calcium 600 mg plus vitamin D 10 mcg [micrograms] was found with six (6) tablets remaining. The manufacturer's expiration date was 10/22. CN9 stated that should have also been pulled from the cart and discarded. An interview was done with CN9 at 10:50 AM in front of the unit's medication cart. CN9 stated she was unsure what the facility protocol was for checking the medication carts as she had only been employed at the facility for not quite a	F 761	open, unused dressing supplies and expired medications. If observed, these were removed from the carts and discarded. Each medication refrigerator was checked to ensure a temperature log was present.. A temperature log was placed with each medication refrigerator if needed. Point 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Dressing supplies are used for individual residents. Once a dressing package is opened, any remaining supply is discarded. Expiration dates for medications are checked by the nurse prior to administration of medications. If a medication is expired, it is removed from the cart and discarded per facility protocol. Medication refrigerator temperatures are checked daily and as needed. The results of this check is documented on the refrigeration log. Education is done with nurses upon hire and as needed regarding the following: Discarding unused dressing supplies once opened Removing outdated medications from the medication cart Facility process for checking and documenting findings of medication	

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F 761	Continued From page 77 month. CN9 looked in the narcotic logbook for some type of inspection log but could not find one. On 11/16/22 at 11:15 AM, an interview was done with Nurse Supervisor (NS)1 at the second floor nurses' station. NS1 produced a routine nursing task list/log for October 2022 that she located in the second floor nursing unit's narcotic logbook. One of the tasks listed specified that the day shift was responsible to check the medication cart for expired items weekly. There were eight other tasks listed on the log with tasks ranging from daily, weekly, to every shift, with squares to initial in to attest that the task had been completed. Not one square for the entire month had been initialed off for any of the tasks. NS1 could not explain why the October 2022 task list was completely blank. 2) During an observation of medications on 11/15/22 at 08:20 AM, a bottle of Docusate Sodium was affixed with a label dated 11/09/21. The affixed label also read to discard after one year of opening. During staff interview on 11/15/22 at 09:35 AM, the Director of Nursing (DON) acknowledged that the Docusate Sodium medication should have been discarded as labeled. Review of facility policy on "Disposal of Medications, Syringes and Needles," copyright 2007 read the following: "Disposal of Medications ... Procedures 7. Outdated medications contaminated or deteriorated medications, and the contents of containers with no label shall be destroyed according to the above policy."	F 761	refrigerators Point 4 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes. The DON/designee will conduct medication cart audits to determine if there are opened dressing supplies and/or expired medications. If these are identified, they will be removed and additional education will be done with nurses. This will be done once weekly for 30 days and then monthly for 60 days. The DON/designee will conduct audits of medication refrigerator temperature logs to determine if complete. If missing information identified, follow-up will be done with the nurse responsible for checking and additional education will be completed as needed. This will be done daily for two weeks, then 3-5 time per week for 2 weeks and then weekly for 60 days. Results of the audits, along with any corrective action taken, will be reported to the QAPI committee for review and recommendations. The QAPI will determine if substantial compliance has been achieved and the frequency of ongoing monitoring. Point 5 January 2nd, 2023	

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F 761	Continued From page 78	F 761		

3) During an observation on 11/15/22 at 08:30 AM of the medication refrigerator on the second-floor nursing unit, the temperature checklist log for the month of November '22 was missing daily checks for the following dates: 11/09/22, 11/11/22, 11/12/22. Two medications were being stored in the refrigerator; Acetaminophen Suppositories and Bisacodyl Suppositories.

During staff inquiry on 11/15/22 at 08:30 AM, licensed nurse (LN)5 acknowledged that the temperatures for the medication refrigerator were not being monitored on the dates as previously mentioned.

Review of facility policy on "Medication Storage, Storage of Medication," copyright 2007 read the following: "...Policy, Medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. ... Procedures, 11. Medications requiring "refrigeration" or "temperatures between 2 [degree]C [celcius] (36 [degree] F [Fahrenheit]) and 8 [degree]C (46 [degree] F) are kept in a refrigerator with a thermometer to allow temperature monitoring. Medications requiring storage "in a cool place" may be refrigerated unless otherwise directed on the label as "cool" temperatures are those between 8 [degree] C (46 [degree] F) and 15 [degree] C (59 [degree] F). A temperature log or tracking mechanism is maintained to verify that temperature has

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F 761	Continued From page 79 remained within accepted limits. The temperature of any refrigerator that stores vaccines should be monitored and recorded twice daily ... 16. Medication storage conditions are monitored on a regular basis as a random quality assurance ("QA") check. As problems are identified, recommendations are made for corrective action to be taken." 3) On 11/16/22 at 09:42 AM, an observation and concurrent interview with licensed nurse (LN)45 was done of the medication room on a nursing unit. There were two refrigerators containing medications with a "Refrigerator Checklist..." for November 2022 on each refrigerator. The dates for November 5, 6, 7, 11, and 14 on both checklists were not checked for refrigerator temperatures to be between 38 to 41 degrees F (Fahrenheit), to be clean and orderly, and to be without any expired medications. LN45 stated that he was unsure of the protocol for checking the refrigerator temperatures and further stated that "the night shift is responsible." On 11/17/22 at 10:21 AM, a follow-up observation and concurrent interview with the Director of Nursing (DON) were done of the same two medication refrigerators and checklists. DON confirmed that the refrigerator checklists should be completed daily by the night shift staff.	F 761		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities	F 790		1/2/23

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F 790	Continued From page 80 A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide assistance in obtaining emergency dental care for pain and bleeding gums for one Resident (R)188 of two	F 790	F790: Dental Services Point 1 How corrective action will be accomplished for those residents found to	

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F 790	Continued From page 81 residents investigated. The deficient practice potentially increases risk of illness due to the severity of R188's gingivitis (inflamation of the gums) and has the potential to affect all residents in the facility. Findings include: During an observation and interview with R188's spouse on 11/14/22 at 12:06 PM when asked if she has any concerns about her husband's care since he was admitted to the facility, responded, he has very bad gingivitis, we have been asking them to take him to the dentist. Sometimes when I come in his gums are bleeding. I had to brush his teeth and clean all around his gums. I asked them a few times if he can get a dental appointment, but they never got back to me. Observed an electric toothbrush on top of R188 dresser. Spouse stated, since my husband has been here, I come in to visit him every day to help feed him and take care of his teeth. Electronic health record (EHR) reviewed on 11/16/22 at 2:44 PM. R188 is a 78-year-old resident here for Rehab services following a cardiovascular accident (CVA-stroke). R188 has diagnosis of Hemiplegia and hemiparesis following Cerebral infarction affecting right dominant side. Dysphagia, muscle weakness, anorexia, hx of transient ischemic attacks (mini strokes)with no residual deficits. Reviewed minimum data set (MDS) quarterly assessment dated 09/14/22 section L oral and dental. A. Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose) Coded "No" F. Mouth or facial pain, discomfort, or difficulty with chewing	F 790	have been affected by the deficient practice. The resident was discharged from the facility on 11/18/22. Education was done with nursing and Social Services associates regarding the facility procedure for obtaining dental services for residents upon identification of dental issues and/or request from a resident and/or family member. Point 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. Interviews were done with nurses and CNAs to determine if there were other residents in need of dental services. None were identified. Point 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The facility will assist a resident in obtaining needed dental services, including routine dental services. The facility will provide or obtain from an outside resource routine and emergency dental services to meet the needs of each patient. The dental status of the resident is assessed upon admission, quarterly and as needed.	

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F 790	Continued From page 82 Coded "No" Certified Nurse Aide, (CNA)21 was interviewed on 11/18/22 at 08:40 AM when asked to describe the personal hygiene routine, stated that she starts care early in the morning. I get the resident up and help them with their oral care. If they can't do it on their own, I provide it for them. If they don't want to brush their teeth, we come back later. Sometimes they don't want to brush their teeth until after lunch. R188 had a problem with his gums bleeding. Last month I noticed that his gums were bleeding and reported to the nurse. Charge Nurse (CN)7 interviewed 11/18/22 08:40 AM. When asked if R188 was having any problems with his teeth or gums? When he first was admitted he had some issues, with dental caries and bleeding, now the plan is he is being discharged to the family today and will follow up with his issues with his own dentist. I remember that we asked the family members if they wanted to see our dentist and they declined. State agency (SA) requested if there was any documentation to show that the facility offered to assist with a dental appointment, CN7 replied I think there was, I'd have to look in the chart to find it. When asked what the process is for assisting a resident with a dental referral once a problem is identified, CN7 explained, when anyone has a report of discomfort we get orders from the doctor, and the unit clerk who does the transport will call to make the appointment. No documentation of a dental referral for R188 was provided by the nursing staff.	F 790	If a need for dental services is identified either through assessment, routine care or by request of the resident and/or family member, the physician is notified. Assessments findings are communicated to the physician in order to determine the urgency of the dental referral. Referrals are made to a dentist for consultation and treatment based on the resident needs. Assessment findings, requests, communication with the physician and dentist, and referral information is documented in the resident's medical record. Education is done with nursing and Social Services associates upon hire and as needed regarding the facility procedure for obtaining dental services for residents upon identification of dental issues and/or request from a resident and/or family member. Point 4 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes. The DON/designee will audit the progress notes and will speak with nursing staff during rounds to determine if there are residents with needs for dental services and if services have been arranged. Services will be arranged and/or additional education provided to staff as	

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F 790	Continued From page 83	F 790	needed. This will be done 3-5 times per week for 30 days, then weekly for 60 days, and then re-evaluated. Results of the audits, along with any corrective action taken, will be reported to the QAPI committee for review and recommendations. The QAPI will determine if substantial compliance has been achieved and the frequency of ongoing monitoring. Point 5 January 2nd, 2023	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §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:	F 812		1/2/23

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F 812	Continued From page 84 Based on observations, interviews with staff members, and review of the facility's policy and procedures, the facility did not assure food was stored under sanitary conditions and did not ensure staff members were accurately checking chemical ratio for sanitizing of dishes in the three-compartment sink, the staff member inaccurately identified the parts per million (ppm) of the solution and the new test strips were expired. This deficient practice encourages food-borne illnesses and has the potential to affect all residents, visitors, and staff who receive meals from the kitchen. Findings include: 1) On 11/14/22 at 10:30 AM an initial brief tour of the kitchen was done with the Food Services Director (FSD). Observation of the walk-in refrigerator found an opened bottle of horseradish with a disposal date of 09/30/22, an opened bottle of mustard with no label, six unopened containers of buttermilk with a manufacturer's expiration date to use by 09/09, and there was a clear plastic container of blueberry compote with lid ajar that was labeled 09/28/22. FSD stated the facility's practice is to label when the item is opened. Observed the labels adhered to the food items are marked to document date opened and date to discard. Discard dates were either missing or items were pass the expiry date. Observation of the walk-in freezer found a box of frozen butter croissants and a box of jumbo round cheese ravioli stored on the floor of the freezer. Further observation of the walk-in refrigerator found four stacks of plastic crates containing small cartons of milk (whole and skim). The bottom crates were placed on the floor of the	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary Point 1 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Items that were identified that were undated and/or expired were discarded, and removed from the floor & stored properly. Expired 3 compartment quaternary test strips were thrown away. Point 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents who eat in the facility are presumed at risk for alleged deficient practice. Point 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Use by date reference tools were place in all food storage areas for staff to reference. A colored chart was laminated and put above the 3 compartment sink for staff to reference to verify actual PPM's with acceptable ranges. Dietary staff were educated on the related importance and policy on preparing storing, distributing and ware washing to ensure food safety. The dietary manager will routinely check for expired test strips during morning quick rounds. In addition, the Ecolab was	

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F 812	Continued From page 85 refrigerator. FSD acknowledged food items are not to be stored directly on the floors. Review of the policy and procedures titled "Food Safety" was provided by the FSD on 11/18/22 at 11:28 AM. The policy and procedures note under subheading of procedure, "1. Food is stored a minimum of six inches off the floor" and "2. Pre-packaged food is placed in a leak-proof, pest-proof, non-absorbent, sanitary (NSF) container with a tight fitting lid. The container is labeled with the name of the contents and date (when the item is transferred to the new container). 'Use by Date' is noted on the label or product when applicable. The 'use by date' guide is easily accessible to all associated involved with resident food storage". Under the subheading for receiving, "6. Food is labeled with the date received, if date received is not on the item". 2) On 11/16/22 at 08:13 AM, requested staff to check the sanitizing solution of the three-compartment sink. Dietary Aide (DA)2 began to drain the compartment with the sanitizing solution. Inquired why is the sink being drained. There was no response, DA1 stopped the solution from completely draining. Requested staff check the solution. DA2 brought out a roll of strips from a plastic bin affixed to the wall next to the sink. The strip was dipped for a count of 10 (ten) then compared with the manufacturer's color guide. The strip was observed to be green, however, DA2 placed it on the manufacturer's color guide (yellow) and stated it was 200 ppm. Observed green on the color guide is 400 ppm. Queried DA2 again, stating the strip is green, not yellow so is it 200 ppm or 400 ppm. Again, DA2 stated it is 200 ppm. Reviewed the facility's log and all entries read 200 ppm. Informed FSD that	F 812	educated to verify test strips are not expired during his routine monthly visits. Point 4 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes. Dietary Manager or/designee will audit 3 x per week for 30 days to ensure foods are stored, prepared and distributed safely, specifically dating of foods and food storage and staff are monitoring PPM's correctly. Audits will be reviewed at QAPI meeting. The QAPI committee will determine whether substantial compliance has been achieved and the frequency for ongoing monitoring. Point 5 January 2nd, 2023	

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F 812	Continued From page 86 the sanitizing solution was at 400 ppm and inquired whether this is an acceptable ratio. Also, inquired whether the strips were expired. There was no expiration on the container. FSD brought out several unopened containers of test strips. FSD not aware whether the strips have an expiration date. FSD was agreeable to research whether 400 ppm is a safe ratio and follow-up on expiration dates of the strips. On 11/16/22 at 10:57 AM a follow-up interview was done with the FSD. FSD stated the minimum level is 200 ppm. Review of the online manufacturer's instructions found that one brand of strips has an expiration date and the other does not. FSD found the unopened container of strips and noted there was an expiration date of 05/30/16.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 842		1/2/23

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F 842	Continued From page 87 (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches 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	F 842		

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F 842	Continued From page 88 provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff member, the facility failed to assure a medical record was maintained in accordance with accepted professional standards and practices to ensure accurate documentation. This deficient practice has the potential to affect all residents in the facility. Findings include: Record review found documentation of a power of attorney document in the "misc" tab for Resident (R)151. The document was very dark, and the name of the resident and the identified power of attorney (POA) was difficult to read. The left side of the pages were darker, making that information illegible. On 11/16/22 interview and concurrent record review was done with the Assistant Director of Social Services (ADSS). The ADSS reviewed the document and stated this was sent to the facility by the POA and acknowledged the clarity of the document was hindered by the dark shading. We were able to decipher the POA's name. ADSS commented that parts of the document cannot be read as it is too dark.	F 842	F842: Resident Records Identifiable Information Point 1 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. A new copy of the Power of Attorney documentation was requested for resident #151 and placed in the medical record. Education was done with Social Services, Admissions associates and medical records regarding obtaining copies of legal documents are legible prior to placing them into the medical record. Point 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. An audit of legal representative documentation was done for each resident to ensure that the information was legible. There were no other issues identified. Point 3 What measures will be put into	

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place or systemic changes made to ensure that the deficient practice will not recur.

The facility obtains legible documentation of the legal authority of a decision-maker for the resident. These copies are placed in the resident's medical record for reference.

If a copy of a legal document is not legible, the facility will contact the legal representative and request an updated copy of the documentation.
Education is done with Social Services, Admissions and medical record associates upon hire and as needed regarding obtaining copies of legal documents are legible prior to placing then into the medical record.

Point 4 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes.

The Medical Records Director or/designee will audit documentation regarding legal representatives for residents to ensure it is legible. If it is not, the legal representative will be contacted for an updated copy. This will be done following every new admission for 90 days and then re-evaluated.

Results of the audits, along with any

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LIFE CARE CENTER OF HILO	944 WEST KAWAILANI STREET HILO, HI 96720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 90	F 842	corrective action taken, will be reported to the QAPI committee for review and recommendations. The QAPI will determine if substantial compliance has been achieved and the frequency of ongoing monitoring. Point 5 January 2nd, 2023	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 883		1/2/23

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F 883	Continued From page 91 §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure one resident (R)131 of five residents in the sample had the pneumococcal vaccine. The deficient practice has the potential to increase the resident's risk for illness and may potentially affect all residents. Finding includes: On 11/17/22 at 2:58 PM electronic health record reviewed for R131.	F 883	F883: Influenza and Pneumococcal Immunizations Point 1 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The pneumococcal vaccine was offered to resident #131 and refused 12/15/2022 documentation placed in medical record	

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F 883	Continued From page 92 Vaccine information reviewed. R131received the following vaccines: Influenza vaccine 11/04/2022. SARS-COV-2 (COVID-19) (Dose 1) 01/6/2021 Complete SARS-COV-2 (COVID-19) (Dose 2) 02/3/2021 Complete SARS-COV-2(COVID-19) Moderna Booster 05/18/2022 Complete On 11/17/22 at 3:07 PM, requested the Pneumococcal vaccine information for R131 from the Unit Manager (UM)4, who stated that it is in the hard chart, and she provide the information to the surveyor. At 3:48 PM the Nursing Manager/ Supervisor, informed surveyor there was no documentation that R131 had the Pneumococcal vaccine in her hard chart, and there was no documentation that she had a history of having the pneumococcal vaccine.	F 883	Education was done with nursing staff regarding the facility policy and procedure related to Pneumococcal Immunizations. Point 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. An audit of each resident's pneumococcal immunization status was done. Residents without current immunization were offered the pneumococcal vaccine. With the result documented in the medical record. Point 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On admission the facility determines the vaccination history of the resident and if the resident has previously been vaccinated with one or both of the Pneumococcal vaccines. If the resident has previously received one or the other vaccine prior to admission or after admission, the facility should consult with the primary provider to determine if a second vaccination is needed and which vaccine that should be. Education is provided to the resident and/or the resident's responsible party regarding benefits and potential side effects of immunization. The resident or resident's representative has the opportunity to refuse immunization.	

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F 883	Continued From page 93	F 883		

The resident and/or responsible party is provided with the vaccine information statement (VIS) for the vaccine to be administered.

Residents will be offered the vaccines, unless the immunization is medically contraindicated, or the resident has already been immunized and the resident Immunization Record is updated.

Education is done with nursing staff regarding the facility policy and procedure related to Pneumococcal Immunizations. Upon hire and as needed.

Point 4 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes.

The Infection Preventionist (IP)/designee will audit the medical records of residents upon admission to determine if they have had or declined the pneumococcal vaccine. Follow-up will be done as needed. This will be done for each new admission for the next 30 days, then weekly for 60 days and then re-evaluated.

Results of the audits, along with any corrective action taken, will be reported to the QAPI committee for review and recommendations. The QAPI will determine if substantial compliance has been achieved and the frequency of

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F 883	Continued From page 94	F 883	ongoing monitoring. Point 5 January 2nd, 2023	
F 920 SS=D	Requirements for Dining and Activity Rooms CFR(s): 483.90(h)(1)-(4) §483.90(h) Dining and Resident Activities The facility must provide one or more rooms designated for resident dining and activities. These rooms must-- §483.90(h)(1) Be well lighted; §483.90(h)(2) Be well ventilated; §483.90(h)(3) Be adequately furnished; and §483.90(h)(4) Have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to provide one or more rooms designated for resident dining and activities, ensuring enough space is available and adaptable for a variety of uses and meet resident's needs. Findings include: On 11/14/22 during the lunch meal, observed there were 22 residents in the multi-purpose room seated at six tables. The dining area did not allow spaces to walk through the dining room. There were three residents that required assistance with their meals resulting in 25 people seated at the tables (including staff members). There was one set of chairs that were	F 920	F920: Requirements for Dinning and Activity Rooms Point 1 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. A plan was implemented that allows for both the dining area and the day room on the affected unit to be utilized during meals and for activities. Setup of each room reviewed, and tables/chairs adjusted to allow for easy mobility of residents in/out of chairs and a clear path into/out of room.	1/2/23

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F 920	Continued From page 95 back-to-back with the spacing too small to walk between. There were three tables placed against the wall resulting in three residents seated alongside the wall. On 11/15/22 observed Resident (R)82 self-propelling up and down the hall in a wheelchair. At 10:25 AM, R82 was assisted by Certified Nurse Aide (CNA)33 into the multi-purpose room. R82 started to wheel herself in the room, however, was redirected and removed from the room. CNA stated there is not enough room in there for R82 to wheel around. On 11/16/22 at 09:33 AM observed R180 and R108 in the hall, asking the Assistant Director of Social Services (ADSS) if there was somewhere else they could go, they did not like the music. Residents were re-directed to the multi-purpose room as snacks were going to be served. Residents went into the multi-purpose room and ate their snacks. After R180 consumed her snack and left the room. Observed a door labeled as the "day room", however, the door was locked. On 11/17/22 at approximately 09:30 AM, interviewed Charge Nurse (CN)5. CN5 reported the day room was primarily used for family visits. Also, the unit discontinued the use of this room for activities as residents became territorial and did not want to allow other residents to enter. CN5 also commented the multi-purpose room is small and doesn't allow for R82 to propel around the room.	F 920	Point 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. Facility dining rooms reviewed during mealtime and group activity programs to identify any deficient practice. Point 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Staff will be educated on dining room placement, clear pathways for residents who are able to ambulate and or self-propel wheelchairs. Point 4 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes. Weekly audits of all dining areas/activity areas will be completed by Director of Nursing/Designee for 90 days. The results of the reviews will be presented at the Quality Assurance and Performance Improvement Committee (QAPI) meeting. The QAPI committee will determine whether substantial compliance has been achieved and the frequency for ongoing monitoring.	