STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(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. Two facility reported incidents (FRI) #9365 and #9425, from the Aspen Complaints/Incidents Tracking System (ACTS), were found to be unsubstantiated. Survey Dates: June 6 to June 9, 2022 Survey Census: 53 Sample Size: 18	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review, the facility failed to ensure that one resident (R)27, out of a sample of 18 residents, was able to use his call light appropriately to alert staff for assistance. The facility did not ensure that R27's call light was within reach for his use and did not assess if R27's current call light was still appropriate for his use and mentation. This deficient practice has the potential to affect all residents suffering from Alzheimer's disease in the facility and who rely on staff for assistance.	F 558	Corrective Action: Resident #27□s call light was assessed for appropriateness with consideration to mental capabilities. Resident #27□s call light was placed within reach. Identification of Others: On 7/24/2022 the DOR/Designee audited all resident□s call lights for appropriateness with consideration to mental capabilities. On 7/24/2022 the DOR/Designee audited all resident□s call	7/30/22

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

Electronically Signed | 07/29/2022

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

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F 558	Continued From page 1 Finding includes: On 06/06/22 at 11:12 AM, an initial observation of R27 was done. R27 was lying in bed and his call light control was not nearby. R27 was queried as to how he would call for assistance and he stated, "I don't know how to communicate (with staff)." On 06/07/22 at 08:21 AM, R27 was lying in bed with his call light clipped to the bedsheet to the right of him. His roommate, R32, stated that R27 forgets that he has his call light. R27 stated, "No one told me that I had a call light", and he places the cord from his left to right, behind his neck, so that the call light trigger button rested on his right shoulder. On 06/08/22 at 08:10 AM, R27's call light was on a wheelchair to the left of his bed and out of his reach. licensed practical nurse (LPN)3 was queried about R27's use of his call light an LPN3 stated that R27 does not usually use it because he forgets to use it and he calls out for assistance. LPN3 further stated that the call light should be within R27's reach in case he does remember to use it. On 06/08/22 at 10:00 AM, R27's electronic health record (EHR) was reviewed. R27 is a 96-year-old resident admitted to the facility on 07/17/21 for Alzheimer's disease (most common cause of dementia which is a loss of cognitive functioning). R27's Brief Interview for Mental Status (BIMS) score on his quarterly Minimum Data Set (MDS) assessment, dated 04/12/22, scored his cognition as "10" or being moderately impaired. R27's care plan included a "Focus" for "[R27] is at risk for falls r/t immobility, Alzheimer's Disease, Hallucinations, Legal Blindness, wears hearing	F 558	lights to ensure they were within reach of the resident. Systemic Measures: On 7/25/22 through 7/29/22 the DON/SDC educated staff that residents must periodically be assessed to ensure call light is appropriate with consideration to mental capabilities and the call light should be placed within the reach of the resident. All new staff will be educated upon orientation that residents must periodically be assessed to ensure call light is appropriate with consideration to mental capabilities and the call light should be placed within the reach of the resident. Monitoring: The DOR will audit 5 residents weekly to ensure that their call light is appropriate with consideration to mental capabilities and is placed within their reach for the next 90 days or until substantial compliance is met. The DOR will track and trend results of the audits for the next 90 days or until substantial compliance is met and present it to the Performance Improvement Committee monthly for input and review.	

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F 558	Continued From page 2 aids, Hx [history] of falls, Major Depressive Disorder," revised on 03/21/22. "Interventions" included "Call light within reach ([R27] prefers call light to be placed behind the back of his neck). The facility's "Resident Call System," reviewed on 04/22/22, was read. It stated under " ...Procedure: ...5. The call light should be positioned within reach of the resident. Return demonstration must be used when educating the resident about call light use. If the resident is unable to demonstrate appropriate call light use, the nurse must be notified to determine an adequate alternative." On 06/09/22 at 3:10 PM, the facility's guidance, "Major neurocognitive disorder (dementia), care of resident, long-term care," revised on 02/18/22 was reviewed. It stated that in the care of residents with dementia "ongoing assessment is essential," care should be "person-centered" and a daily routine should be maintained so that residents are able to recall daily activities.	F 558		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral	F 622		7/30/22

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F 622	Continued From page 3	F 622		

status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:

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F 622	Continued From page 4 (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that a transfer summary detailing R50's medical history was completed by his physician and sent to the local area hospital he was transferred to. This deficient practice failed to communicate important information about R50's acute illness that may have hindered	F 622	Corrective Action: No corrective actions taken. Resident no longer resides at the facility. Identification of Others: This deficiency has the potential to affect all residents who transfer or discharge to	

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F 622	Continued From page 5 continuity of his care. This has the potential to affect all residents who transfer to a hospital for treatment. Findings include: On 06/07/22 at 2:32 PM, R50's EHR was reviewed. R50 is a 62-year-old resident that was initially admitted to the facility on 06/20/20 for complicated diabetes and chronic obstructed pulmonary disease (an inflammatory lung disease that causes obstructed airflow from the lungs). A physician encounter with date of service 05/17/22 was read. It stated that R50 was transferred to a local area hospital on 05/10/22 for difficulty breathing and decreasing oxygen levels in his blood. "Given his rapid decline and his expressed desire to be fully treated, it was felt that he would benefit from a higher level of care ..." Further review of progress notes revealed that R50 was transferred back to the same local area hospital on 05/29/22 for low blood oxygen levels in his blood again. No transfer summary for this hospitalization was found in R50's chart. On 06/08/22 at 08:30 AM, a request for R50's transfer summary to the local area hospital on 05/29/22 was made with the facility. On 06/08/22 at 1 p.m., a progress note from the physician was given to the State Agency (SA) by the director of nursing (DON). The DON stated that there was no transfer summary made at the time of R50's transfer to the hospital on 05/29/22 and the progress note provided to SA was the transfer summary. As indicated on the progress note, the physician created the document on 06/08/22 at 12:23 PM.	F 622	the hospital for treatment. Systemic Measures: On 7/24/22 through 7/29/22 the DON/Designee educated nursing staff that pertinent medical record documentation detailing a resident□s medical history must be completed and sent with the resident to the hospital. All new staff will be educated upon orientation that pertinent medical record documentation detailing a resident□s medical history must be completed and sent with the resident to the hospital. The physician will write a summary of the resident transfer/discharge to an acute setting describing the specific needs the facility could not meet. Monitoring: The HIM/Designee will audit discharged/transferred resident□s records weekly to ensure that pertinent medical record documentation detailing the resident□s medical history was completed and provided to the resident upon transfer for the next 90 days or until substantial compliance is met. The HIM/Designee will track and trend results of the audits for the next 90 days or until substantial compliance is met and present it to the Quality Assurance Performance Improvement Committee monthly for input and review.	

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F 622	Continued From page 6 On 06/09/22 at 08:55 AM, medical doctor (MD)1 was interviewed at the nursing station. MD1 stated that a transfer summary was not made because he was unsure if R50 was going to be admitted to the hospital. MD1 stated that facility's process needed to be improved. On 06/09/22 at 12:00 PM, the facility's "Transfers and Discharges" policy, reviewed 05/11/21, was read. A document must be made by the physician and provided if the " ...transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility ..." This document should include " ...appropriate information is communicated to the receiving health care institution or provider ...to ensure a safe and effective transition of care ..."	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice.	F 623		7/30/22

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F 623	Continued From page 7	F 623		

(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State

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F 623	Continued From page 8 Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the appropriate notifications	F 623	Corrective Action: No corrective actions taken. Resident #34	

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F 623	Continued From page 9 were done when R34 was transferred to a hospital for emergent care, a facility-initiated transfer. This deficient practice fails to protect residents from involuntary discharge and has the potential to affect all residents in the facility. Finding includes: On 06/07/22 at 1:32 PM, R34's EHR was reviewed. The "Progress Notes" from 04/07/22 to 04/13/22 were read. On 04/08/22, R34 had medical changes that included right sided facial drooping, incontinence of urine that was new, and low blood pressure. R34 was transferred to a hospital for evaluation and was admitted to the hospital. There was no documentation that a written notification of R34's facility-initiated transfer was sent to his family and to the Ombudsman. The hospital discharge summary was reviewed, and R34 was admitted to the facility on 04/08/22 for a heart condition and discharged back to the facility on 04/13/22. On 06/09/22 at 09:00 AM, the DON was interviewed. The director of nursing (DON) stated that R34's representative was notified verbally of his transfer to the local area hospital. On 06/09/22 at 10:17 AM, the Medical Records Director (MRD) was interviewed. MRD stated that a written notification of residents sent to the hospital is not sent to the Ombudsman. On 06/09/22 at 12:00 PM, the facility's "Transfers and Discharges" policy, reviewed 05/11/21, was read. Under "Emergency Transfers" it stated, "When a resident is temporarily transferred on an emergency basis to an acute care facility, notice of the transfer may be provided to the resident	F 623	was re-admitted to the facility. Identification of Others: This deficiency has the potential to affect all residents who transfer or discharge to the hospital for treatment. Systemic Measures: On 07/25/22 through 07/29/22 the DON/Designee educated licensed nursing staff that appropriate verbal and written notifications must be made when transferring any resident to the hospital to protect residents from involuntary discharge. Education will continue until all licensed nursing staff and new hires have completed the education that appropriate verbal and written notifications must be made when transferring any resident to the hospital to protect residents from involuntary discharge. Monitoring: The HIM/Designee will audit discharged/transferred resident□s records weekly to ensure that appropriate notifications were made when transferring any resident to the hospital to protect residents from involuntary discharge. The HIM/Designee will track and trend results of the audits for the next 90 days or until substantial compliance is met and present it to the Quality Assurance Performance Improvement Committee monthly for input and review.	

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F 623	Continued From page 10 and resident representative as soon as practicable...Copies of notices for emergency transfers must also still be sent to the ombudsman..."	F 623		
F 657 SS=E	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 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, record review, and interview, the facility failed to review and revise	F 657	Corrective Action: Facility reviewed and revised the care	7/30/22

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F 657	Continued From page 11 the Comprehensive Care Plan (CP) for five residents (R) (R11, R46, R19, R48, and R13) in a sample of 18 residents, to effectively address their status, condition, and needs. As a result of this deficient practice, staff did not have the information necessary to adequately care for these residents so that they could meet their highest potential of physical and psychosocial well-being. This deficient practice has the potential to affect all the residents at the facility. Findings include: 1) Cross Reference to F684. R11 was with moisture-associated skin damage (MASD) for approximately one month and eventual development of a Stage 2 pressure ulcer. R11 was admitted to the facility on 04/14/21. Diagnoses includes but not limited to personal history of transient ischemic attach and cerebral infarction without residual deficits, fistula of vagina to large intestine, dementia with behavioral disturbance, and history of urinary tract infections. A review of the weekly skin assessments from 04/07/22 through 06/03/22 revealed that R11's skin was intact on 04/07/22, On 04/15/22 documentation stated that R11's skin was assessed with blanchable redness and open area/wound caused by moisture-associated skin damage (MASD) to the groin and coccyx. The director of nursing (DON) and minimum data set coordinator (MDSC) were notified. The documentation from weekly assessments from 04/22/22 to 05/28/22 noted continued MASD to groin and coccyx, noting it "comes and goes."	F 657	plans for resident #s 11, 46, 19, 48, and 13 to effectively address their status, condition, and needs. Identification of Others: From 07/22/22 to 07/29/22 the DON/Designee audited resident care plans to ensure they effectively addressed their status, condition, and needs. Any issues were corrected immediately upon discovery. Systemic Measures: On 07/25/22 through 07/29/22 the DON/Designee educated nursing staff that resident care plans must effectively address their status, condition, and needs to ensure that staff have the information necessary to adequately care for the residents so that they can meet their highest potential of physical and psychosocial well-being. All new staff will be educated that resident care plans must effectively address their status, condition, and needs to ensure that staff have the information necessary to adequately care for the residents so that they can meet their highest potential of physical and psychosocial well-being. Monitoring: The DON/Designee will audit 5 care plans weekly to ensure they effectively addressed their status, condition, and needs for 90 days or until substantial compliance is met. The DON/Designee will track and trend results of the audits for the next 90 days or until substantial compliance is met and	

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	125052	A. BUILDING _____ B. WING _____	06/09/2022

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F 657	Continued From page 12 On 06/08/22 at 2:39 PM a concurrent interview and record review was done with the MDSC. R11's care plan included the following interventions to prevent skin breakdown: Perform Braden Scale assessments, weekly skin checks, notifying of skin breakdown, pressure reducing mattress, diet as ordered, and treatment as ordered (use skin barrier, A&D ointment). MDSC confirmed that R11 had MASD documented in his record on 04/22/22 through 05/28/22. Asked the MDSC whether the facility changed R11's treatment/interventions. MDSC reviewed the electronic health record (EHR) and responded that she didn't see any change from A&D ointment and further stated a change in ointment is not always helpful. MDSC reported A&D is an ointment which creates a moisture barrier. Further queried if there are other ointments that are used for MASD, for example calmoseptine (ointment to treat and prevent skin irritation). MDSC responded calmoseptine contains zinc which aides in treatment of skin. On 06/09/22 at 09:07 AM an interview was conducted with the DON and Infection Preventionist (IP). The DON reported R11 has a long fistula so that stool comes out of her vagina, with continual seepage which makes it difficult to keep R11 "clean and dry" to prevent MASD. DON also reported resident has behavior of repetitively wiping herself, resulting in irritation of her skin. Inquired if the facility changed R11's ointment/treatment in response to development of MASD. DON stated she does not believe anything beyond A&D ointment was used. DON reported there are three ointments used to create moisture barrier and treat skin, A&D ointment, calmoseptine and triad. Requested documentation different ointments/treatments	F 657	present it to the Quality Assurance Performance Improvement Committee monthly for input and review.	

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were tried. DON reported the facility would change the treatment if it were not working and then go from there. The IP confirmed there is no documentation other treatments were tried.

2) Cross Reference to F689. R46 fell on 02/26/22 at 06:30 AM. The facility conducted a root cause analysis. The five why(s) of contributory factors included: she was reaching for her Reacher that was by her calf; because she has limited mobility and uses a Reacher to extend her personal space area; she uses the Reacher to give herself independence; she keeps items on her bed along both sides of her legs and uses two bedside tables; and she is on an air mattress and prefers to stay in bed. The root cause identified, R46 is unable to recover her balance after reaching forward for her Reacher and the air mattress may have further aided her losing her balance. Inquired whether it would be helpful to revise the resident's care plan to include keeping her Reacher within reach so that she can independently have access to her belongings. The Administrator responded she is not sure whether this intervention has been included in R46's care plan.

3) Cross-reference to F689 Free of Accident Hazards/Supervision/Devices. The facility failed to ensure R19 was free from accident hazards by thoroughly assessing and developing a plan to keep her safe once an elopement risk had been identified.

R19 is an 82-year-old female admitted on 07/31/21 for long-term care. R19's admitting diagnoses include, but are not limited to, dementia, osteoporosis, rheumatoid arthritis, and

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a history of falls and stroke with residual weakness.

On 06/07/22 at 12:17 PM, during a review of R19's electronic health record (EHR), it was noted that R19 had been placed on "alert charting" on 06/02/22 for behaviors, restlessness, and confusion. Progress notes beginning on 06/03/22 document R19 exhibiting exit-seeking behavior and verbalizations, " ... Res [R19] very difficult to deal with ... perseverating ideations ... insisting she needs to get "on the elevator to go to Disneyland!" R19's family was notified of the exit-seeking behavior and verbalizations on 06/04/22. On 06/06/22 at 06:23 PM, a Nursing Behavior Note documented, "Resident exit seeking. Attempting to open both entrance door and Rehab door." The last Elopement Risk Assessment, done on 03/23/22, determined R19 was at no risk for elopement. A review of R19's comprehensive care plan noted no interventions or care plan initiated for exit-seeking behavior and/or risk for elopement.

On 06/08/22 beginning at 3:15 pm, observations were made of R19 sitting in her wheelchair facing the visitor entrance doors, staring intently at the doors. Several staff members walked past with no attempts to re-direct her. The facility receptionist posted near the visitor entrance stated, "she's been having some sundowning," but made no attempts to speak to R19 or inform unit staff that she was near the entrance. At 3:23 PM, another resident observed R19 at the door and stated, "you gotta watch her, she's going to try to get out, she did yesterday." At 3:24 PM, R19 was observed trying to open the visitor door, which set off the alarm. At this point, the receptionist approached R19 and unsuccessfully

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tried to redirect her. This behavior continued for several minutes with R19 repeatedly trying to open the visitor door and setting off the alarm. At 3:28 PM, the receptionist alerted a staff member on the unit by phone of the behavior, stating, "if someone can come talk to ... [R19] over here, she keeps setting off the alarm."

On 06/09/22 at 08:49 AM, an interview was done with the Minimum Data Set Coordinator (MDSC) in her office. The MDSC stated R19's last quarterly assessment was completed on 03/31/22, and she had not been exhibiting exit-seeking behavior at that time. The MDSC reported that the exit-seeking behavior and verbalizations were "pretty new," but had been identified, discussed in Interdisciplinary Team (IDT) meetings, and reviewed with R19's family, both in person and over the phone. During a concurrent review of R19's EHR, the MDSC stated the earliest documentation she could find regarding exit-seeking behavior was on 05/26/22, which she confirmed was when the issue was first discussed with the IDT. After reviewing R19's comprehensive care plan, the MDSC also confirmed that the care plan had not been revised to include any interventions for the identified problem, but it should have been.

4) R48 is a 69-year-old male admitted to the facility on 11/30/18 for long-term care. R48's admitting diagnoses include, but are not limited to, high blood pressure, difficulty in walking, right-sided weakness following a stroke, and aphasia (loss of ability to express speech).

On 06/06/22 at 10:55 AM, observed R48 yelling gibberish out of his room. When surveyor entered, R48 was sitting up in bed with his bed

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set at a very high position. The bed had no bed rails, and his call light was noted to be hanging off the bed out of his reach and sight. It took several minutes of him yelling before a staff member entered to attend to his needs.

On 06/08/22 at 10:00 AM, an interview was done with Certified Nurse Aide (CNA)3 outside of R48's room. CNA3 stated R48 is very particular and likes things a certain way, he will object loudly if he is not happy. Regarding the height of his bed, CNA3 stated R48's bed is left at the highest level per his preference and request.

On 06/09/22 at 08:49 AM, an interview was done with the Minimum Data Set Coordinator (MDSC) in her office. During a concurrent review of R48's comprehensive care plan (CP), the MDSC confirmed that his CP includes to "Provide a safe environment: Call light in reach, Adequate low glare light, Bed in lowest position and wheels locked ..." The MDSC stated she is aware that R48's bed is left in the highest position per his preference and agreed that his CP should have been revised to include that preference.

5) R13 is a 73-year-old female admitted to the facility on 04/26/21 for skilled services but has since been changed to long-term care. Since 05/21/22, R13 has been on isolation related to COVID-19 exposure, then on 05/31/22 tested positive for COVID-19 herself.

On 06/09/22 at 07:34 AM, during a review of R13's CP, it was noted that there was no revision to her CP to address the social isolation and changes in needs resulting from her quarantine since 05/21/22.

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F 657	Continued From page 17 On 06/09/22 at 08:49 AM, an interview was done with the MDSC in her office. During a concurrent review of R13's CP, the MDSC confirmed it had not been revised since 04/10/22 and agreed that her needs would have changed when she went into quarantine. When asked why R13 did not have a COVID-19 isolation care plan, the MDSC stated "I have no good answer as to why not."	F 657		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and	F 661		7/30/22

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F 661	Continued From page 18 non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff members, the facility failed to ensure a discharge summary with an accurate and current description of the clinical status of the resident and sufficiently detailed, individualized care instructions, to ensure that care is coordinated and the resident transitions safely from one setting to another was done. The discharge summary may help reduce or eliminate confusion for the continuum of care. Findings include: Record review done on 06/07/22 at 2:24 PM noted R54 was admitted to the facility on 04/05/22 and discharged on 05/14/22. A review of the progress note dated 05/14/22 documents the family decided to take resident home today due to financial issue. The physician was notified. The family signed form for discharge against medical advice. Medications were released to the family. R54 was discharged with her family with recommendation to see her primary community physician as soon as possible. Further review found no documentation of a discharge summary. Requested a copy of the discharge summary. On 06/08/22 at 09:22 AM, the facility provided a copy of the "Against Medical Advice Discharge Form" and the progress note of 05/14/22. On 05/14/22 at 10:00 AM requested the Administrator provide a copy resident's discharge	F 661	Corrective Action: No corrective actions. Resident discharged. Identification of Others: All discharging residents have the potential to be affected by this deficiency. Systemic Measures: On 07/25/22 through 07/29/22 the DON/Designee educated nursing staff that a discharge summary with accurate and current description of the clinical status of the resident and sufficiently detailed, individualized care instructions, to ensure that care is coordinated and the resident transitions safely from one setting to another, must be completed upon the resident□s discharge. This may help reduce or eliminate confusion for the continuum of care. All new staff will be educated that a discharge summary with accurate and current description of the clinical status of the resident and sufficiently detailed, individualized care instructions, to ensure that care is coordinated and the resident transitions safely from one setting to another, must be completed upon the resident□s discharge. This may help reduce or eliminate confusion for the continuum of care. Monitoring: The HIM/Designee will audit resident	

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F 661	Continued From page 19 summary. The Administrator responded a discharge summary is not done as this was an unplanned discharge.	F 661	discharges weekly to ensure that a discharge summary with accurate and current description of the clinical status of the resident and sufficiently detailed, individualized care instructions, to ensure that care is coordinated and the resident transitions safely from one setting to another, was completed upon the resident□s discharge. for 90 days or until substantial compliance is met. The HIM/Designee will track and trend results of the audits for the next 90 days or until substantial compliance is met and present it to the Quality Assurance Performance Improvement Committee monthly for input and review.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff members, the facility failed to monitor, and evaluate Resident (R)11's response to interventions, and/or revise the interventions as appropriate to facilitate the healing of moisture-associated skin damage (moisture-associated skin damage is the general	F 684	Corrective Action: On 6/10/22, a wound observation tool was completed, the area was resolved. Identification of Others: On 07/21/22 through 07/29/22 the DON/Designee evaluated the response to	7/30/22

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F 684	Continued From page 20 term for inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva, or mucus). This deficient practice compromised R11's skin and possibly a contributory factor to the development of a Stage 2 pressure injury. Findings include: Cross Reference to F657. The facility failed to revise care plan interventions to treat moisture-associated skin damage (MASD). Cross Reference to F686. Resident (R)11 had compromised skin and developed a Stage 2 pressure injury. R11 was admitted to the facility on 04/14/21. Diagnoses includes but not limited to personal history of transient ischemic attack and cerebral infarction without residual deficits, fistula of vagina to large intestine, history of falling, anxiety disorder, dementia with behavioral disturbance, and history of urinary tract infections. R11 was observed on 06/07/22 at 10:11 AM asleep, lying on her back with a pillow to right lower extremity. On 06/07/22 at 11:13 AM, R11 was asleep on her back. No air mattress and bedside commode placed next to her bed. On 06/08/22 at 08:52 AM, R11 was observed in the hallway wheeling herself back to her room. Review of the annual Minimum Data Set with assessment reference date of 03/15/22 documents R11 requires extensive assist with two person physical assist for bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or	F 684	interventions of all residents with MASD to ensure the intervention was facilitating healing, and/or revise the interventions as appropriate to facilitate the healing of moisture associated skin damage. All issues discovered were corrected at the time of the audit. Systemic Measures: On 07/25/22 through 07/29/22 the DON/Designee educated nursing staff that the facility must monitor and evaluate resident□s response to interventions, and/or revise the interventions as appropriate to facilitate the healing of moisture associated skin damage (MASD). All new staff will be educated that the facility must monitor and evaluate resident□s response to interventions, and/or revise the interventions as appropriate to facilitate the healing of moisture associated skin damage (MASD). Monitoring: The DON/Designee will audit 5 residents with MASD weekly to ensure the intervention was facilitating healing, and/or revise the interventions as appropriate to facilitate the healing of moisture associated skin damage for 90 days or until substantial compliance is met. The DON/Designee will track and trend results of the audits for the next 90 days or until substantial compliance is met and present it to the Quality Assurance Performance Improvement Committee	

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alternate sleep furniture). R11 also noted to be frequently incontinent of bowel and bladder, requiring extensive assist with two person physical assist for toilet use (how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad).

A review of the weekly skin assessments from 04/07/22 through 06/03/22 notes on 04/07/22, R11's skin was intact. On 04/15/22, R11's skin was not intact, blanchable redness and open area/wound caused by moisture-associated skin damage (MASD) to the groin and coccyx were noted. The DON and MDS were notified. The weekly assessments from 04/22/22 to 05/28/22 documents continued MASD to groin and coccyx, noting it "comes and goes." The assessment of 06/03/22 notes a Stage 2 pressure ulcer to the coccyx.

On 06/08/22 at 2:39 PM an interview and record review was done with the Minimum Data Set Coordinator (MDSC). MDSC reported in the last couple of weeks, R11 seems to be declining. Review of the Braden Scale (predicts pressure sore risk to foster early identification of patients at risk for forming pressure sores) of 05/12/22 notes R11 was at mild risk for developing a pressure ulcer.

MDSC reviewed R11's care plan for interventions to prevent skin breakdown. The interventions included performing Braden Scale assessments, weekly skin checks, notifying of skin breakdown, pressure reducing mattress, diet as ordered, and treatment as ordered (use skin barrier, A&D ointment). MDSC confirmed R11 documented with moisture-associated skin damage and

monthly for input and review.

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F 684	Continued From page 22 acknowledged MASD from 04/22/22 through 05/28/22. Queried whether the facility changed R11's treatment. MDSC reviewed the electronic health record (EHR), responded she didn't see any change from A&D ointment and further stated a change in ointment is not always helpful. MDSC reported A&D is an ointment creates a moisture barrier. Further queried if there are other ointments that are used for MASD, for example calmoseptine (ointment to treat and prevent skin irritation). MDSC responded calmoseptine contains zinc which aides in treatment of skin. On 06/09/22 at 09:07 AM an interview was conducted with the DON and IP. The DON reported R11 has a long fistula so that stool comes out of her vagina with continual seepage which makes it difficult to keep R11 "clean and dry" to prevent MASD. DON also reported resident has behavior of repetitively wiping herself, resulting in irritation of her skin. Inquired if the facility changed R11's ointment/treatment in response to the development of MASD. DON stated she does not believe anything beyond A&D ointment was used. DON reported there are three ointments used for moisture barrier and treat skin, A&D ointment, calmoseptine and triad. Requested documentation different ointments/treatments were tried. DON reported the facility would change the treatment if it is not working and then go from there. The IP confirmed there is no documentation other treatments were tried.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity	F 686		7/30/22

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F 686	Continued From page 23 §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview with staff members, facility failed to prevent the formation of pressure ulcers [localized damage to the skin and/or underlying soft tissue usually over a bony prominence) for one, R11, of two residents sampled. A resident assessed at mild risk for developing a pressure ulcer developed a Stage 2 pressure ulcer and this deficient practice has the potential to affect all residents dependent on staff for care. Findings include: Cross Reference F684. Resident (R)11 with compromised skin, moisture-associated skin damage to the groin and coccyx for approximately one month with no change in interventions/treatment possibly contributed to the development of a Stage 2 pressure ulcer to the coccyx/sacrum. R11 was admitted to the facility on 04/14/21. Diagnoses includes but not limited to personal history of transient ischemic attack and cerebral	F 686	Corrective Action: Wound resolved on 6/10/22, the day after survey exit. Identification of Others: On 07/21/22 through 07/29/22 the DON/Designee audited all residents to ensure that their pressure ulcer prevention interventions were appropriate according to their risk for developing a pressure ulcer utilizing the BRADEN risk scale. Any issues identified were corrected immediately upon discovery. Systemic Measures: On 07/25/22 through 07/29/22 the DON/Designee educated nursing staff that residents must have appropriate interventions in place to prevent pressure ulcers according to their risk level (using BRADEN risk scale). All new staff will be educated that residents must have appropriate interventions in place to prevent pressure	

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F 686	Continued From page 24 infarction without residual deficits, fistula of vagina to large intestine, history of falling, anxiety disorder, dementia with behavioral disturbance, and history of urinary tract infections. R11 was observed on 06/07/22 at 10:11 AM asleep, lying on her back with a pillow to right lower extremity. On 06/07/22 at 11:13 AM, R11 was asleep on her back. No air mattress and bedside commode placed next to her bed. On 06/08/22 at 08:52 AM, R11 was observed in the hallway wheeling herself back to her room. Record review done on 06/08/22 at 11:53 AM found physician order with start date of 06/02/22 for treatment to coccyx, cleanse and apply skin prep and foam dressing, every day shift, Tuesday and Saturday related to pressure ulcer of sacral region. Review of the annual Minimum Data Set with assessment reference date of 03/15/22 documents R11 requires extensive assist with two person physical assist for bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture). R11 also noted to be frequently incontinent of bowel and bladder, requiring extensive assist with two person physical assist for toilet use (how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad). A review of the weekly skin assessments notes on 04/07/22, R11's skin was intact. The assessment of 04/15/22 R11's skin was not intact, blanchable redness and open area/wound caused by moisture-associated skin damage	F 686	ulcers according to their risk level (using BRADEN risk scale). Monitoring: The DON/Designee will audit 5 residents weekly to ensure that their pressure ulcer prevention interventions are appropriate according to their risk for developing a pressure ulcer utilizing the BRADEN risk scale for 90 days or until substantial compliance is met. The DON/Designee will track and trend results of the audits for the next 90 days or until substantial compliance is met and present it to the Quality Assurance Performance Improvement Committee monthly for input and review.	

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F 686	Continued From page 25	F 686		

(MASD) to the groin and coccyx was noted. The DON and MDS were notified. The weekly assessments from 04/22/22 to 05/28/22 documents continued MASD to groin and coccyx, noting it "comes and goes." The assessment of 06/03/22 notes a Stage 2 pressure ulcer to the coccyx.

On 06/08/22 at 2:39 PM an interview and record review was done with the Minimum Data Set Coordinator (MDSC). MDSC reported in the last couple of weeks, R11 seems to be declining. MDSC reported R11 has been spending more time in bed and has a preference to be on her back. MDSC recalled in the past, R11 would get out of bed several times a day. Inquired when would staff reposition R11, MDSC replied when doing rounds staff will check and turn/reposition residents. Review of the Braden Scale (predicts pressure sore risk to foster early identification of patients at risk for forming pressure sores) dated 05/12/22 notes R11 was at mild risk for developing a pressure ulcer.

MDSC reviewed R11's care plan for interventions to prevent skin breakdown. The interventions included performing Braden Scale assessments, weekly skin checks, notifying of skin breakdown, pressure reducing mattress, diet as ordered, and treatment as ordered (use skin barrier, A&D ointment). MDSC reported all the mattresses in the facility are pressure reducing. MDSC confirmed R11 has moisture-associated skin damage. MDSC confirmed after a month, there was no change in treatment/intervention following the identification of MASD.

The progress note of 06/02/22 at 04:22 PM documents the Certified Nurse Aide (CNA)

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F 686	Continued From page 26 informed the nurse and Director of Nursing (DON) of an open wound to the resident's "butt." DON assessed and determined it is a Stage 2 pressure injury. Also noted, resident prefers to lay in bed more as she has back pain and does not like to lay on her side. Staff were reminded to try and reposition/shift her weight on every round. The Wound Observation Tool done on 06/02/22 documents the facility-acquired Stage 2 pressure ulcer to the sacrum with both sides of the coccyx with open area, the left was measured at 1.5 cm (length) x 1 cm (width) x 0.1 cm (depth) and right at 1 cm x 0.6 cm x 0.1 cm. On 06/09/22 at 09:07 AM an interview was conducted with the DON. The DON reported it is difficult to prevent MASD as R11 has a long fistula so that stool comes out of her vagina and it is difficult to keep the resident clean and dry. DON also reported R11 has back pain so prefers to stay on her back. Inquired whether there is documentation of refusals to reposition in bed, DON responded R11 can reposition herself and can sit up in bed. DON reported the MASD is at the top of the "butt crack" and the pressure ulcer is on the sacrum. DON also reported the wound came on quickly and there were no signs of it prior. At the end of the interview, DON was asked if the pressure ulcer was avoidable. DON responded, the pressure ulcer probably could have been avoidable, however, has not done an evaluation.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		7/30/22

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F 689	Continued From page 27 §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 observation, interview, and record review, the facility failed to ensure that two residents, R46 and R19, in the sample were free from accident hazards by thoroughly assessing and developing interventions consistent with their needs. As a result of this deficient practice, R46 and R19 were placed at risk of an avoidable accident and/or injury. This deficient practice has the potential to affect all the residents at the facility who are at a high risk for falls or display exit-seeking behavior. Findings include: 1) Cross Reference to F657. Based on the root cause analysis, the facility did not revise the resident's care plan to include factors contributing to the resident's fall. Resident (R)46 was admitted to the facility on 09/26/90 with diagnoses including but not limited to anxiety disorder; displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing; unspecified nondisplaced fracture of first cervical vertebra, subsequent encounter for fracture with routine healing; unspecified nondisplaced fracture of second cervical vertebra, subsequent encounter for fracture with routine healing; and history of falling.	F 689	Corrective Action: Care plans for residents #46 and #19 were reviewed and updated to reflect interventions consistent with their needs with emphasis on falls and exit-seeking behaviors. Identification of Others: On 07/21/22 through 07/29/22 the DON/Designee audited all resident care plans to ensure they reflected interventions consistent with the resident□s needs with emphasis on falls and exit-seeking behaviors. Any identified issues were corrected upon discovery. Systemic Measures: On 07/25/22 through07/29/22 the DON/Designee educated nursing staff that resident care plans must reflect interventions consistent with the resident□s needs with emphasis on falls and exit-seeking behaviors. All new staff will be educated that resident care plans must reflect interventions consistent with the resident□s needs with emphasis on falls and exit-seeking behaviors. Monitoring: The DON/Designee will audit 5 residents	

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F 689	Continued From page 28 On 06/06/22 at 10:43 AM observed R46 asleep in bed, she had a neck brace on, call light was placed on her stomach, overbed tray was placed along the left side of the bed, and her Reacher (mechanical tool to increase the range of a person's reach when grabbing objects) was next to her. Subsequent observation at 1:37 PM observed R46 sitting up in bed with her lunch on the overbed tray. The overbed tray was placed to her left and she had to turn to feed herself. A staff member was observed to enter R46's room, saw the overbed tray placed to the resident's left, and repositioned the overbed tray to the front. On 06/07/22 at 08:13 AM and 09:04 AM observed R46 sitting up in bed eating breakfast. The overbed tray was placed to the front. Subsequently on 06/07/22 at 11:12 AM and 0609/22 at 07:39 AM, R46 observed asleep in bed. On 06/08/22 at 08:49 AM, R46 awake and eating breakfast. R46 observed with an air mattress. On 06/07/22 at 09:04 AM an interview was conducted with R46. R46 recalled that she had fallen by the corner of her bed and broke her neck. She further reported she had dropped something, leaned over to try and get it, but could not get up until someone came to help her. She states that she is not as limber and the facility refuses to allow her to walk. The facility submitted an "Event Report" notifying the State Agency (SA) of R46's fall on 02/26/22 at 06:30 AM. R46 was found on the floor to the right side of her bed. Record review was done on 06/07/22 at 11:53 AM and 06/08/22 at 10:56 AM. The progress note of	F 689	weekly to ensure that their care plans reflected interventions consistent with the resident□s needs with emphasis on falls and exit-seeking behaviors for 90 days or until substantial compliance is met. The DON/Designee will track and trend results of the audits for the next 90 days or until substantial compliance is met and present it to the Quality Assurance Performance Improvement Committee monthly for input and review.	

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02/26/22 at 11:37 AM documents at 06:30 AM, R46 was found on the floor. She was on the right side of the bed with her blanket in left lateral position. R46 reported "I was reaching for my Reacher by my foot and leaned forward then lost balance and fell to the ground." Resident had pain to her head, neck, back, and right hip. She was assessed and found with a lump to the top of her head. She was assisted back to bed and later sent to emergency department. Upon return, R46 diagnosed with C1 and C2 fracture with a cervical collar.

The facility developed a care plan identifying R46 at risk for falls related to weakness and impaired mobility. The care plan was initiated on 09/27/20 and revised on 06/04/22. Interventions prior to R46's fall included: assist with activities of daily living as needed; call light within reach, complete fall risk assessment; orient resident to room; provide adaptive equipment or devices as needed (wheelchair and walker); and Physical Therapy evaluate and treat as ordered or PRN. On 02/26/22, the care plan was revised to include, provide concave (air) mattress (bolsters until concave can be placed). On 06/04/22 the care plan was revised to include call light within reach, adequate lighting, and clutter free room.

On 06/07/22 at 10:38 AM, an interview was conducted with R46's representative via telephone call. The representative confirmed she was notified by the facility of the fall and was sent to emergency. R46's representative reported she thinks R46 fell as she was trying to reach for something by getting out of bed..

On 06/08/22 at 12:00 PM an interview was conducted with the Administrator. The root cause

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F 689	Continued From page 30	F 689		

analysis was reviewed with the Administrator. A copy of the document was requested, however, the Administrator reported this document is not a part of the medical record and would not provide a copy of the document to the State Agency. The Administrator reported R46 may have lost her balance due to the air mattress. Review of their root cause analysis included the five why(s). The responses include: she was reaching for her Reacher that was by her calf; because she has limited mobility and uses a Reacher to extend her personal space area; she uses the Reacher to give herself independence; she keeps items on her bed along both sides of her legs and uses two bedside tables; and she is on an air mattress and prefers to stay in bed. The root cause identified, R46 is unable to recover her balance after reaching forward for her Reacher and the air mattress may have further aided her losing her balance. The Administrator reported an air mattress with bolsters (concave) has been provided to R46. Inquired whether it would be helpful to include keeping R46's Reacher within reach as an intervention. The Adminsitrator responded she did not "look through every word" of the care plan so is not sure whether this intervention has been included in the care plan revision.

2) R19 is an 82-year-old female admitted on 07/31/21 for long-term care. R19's admitting diagnoses include, but are not limited to, dementia, osteoporosis, rheumatoid arthritis, and a history of falls and stroke with residual weakness.

On 06/07/22 at 12:17 PM, during a review of R19's electronic health record (EHR), it was noted that R19 had been placed on "alert

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charting" on 06/02/22 for behaviors, restlessness, and confusion. Progress notes beginning on 06/03/22 document R19 exhibiting exit-seeking behavior and verbalizations, " ... Res [R19] very difficult to deal with ... perseverating ideations ... insisting she needs to get "on the elevator to go to Disneyland!" R19's family was notified of the exit-seeking behavior and verbalizations on 06/04/22. On 06/06/22 at 06:23 PM, a Nursing Behavior Note documented, "Resident exit seeking. Attempting to open both entrance door and Rehab door." The last Elopement Risk Assessment, done on 03/23/22, determined R19 was at no risk for elopement. A review of R19's comprehensive care plan noted no interventions or care plan initiated for exit-seeking behavior and/or risk for elopement.

On 06/08/22 beginning at 3:15 pm, observations were made of R19 sitting in her wheelchair facing the visitor entrance doors, staring intently at the doors. Several staff members walked past with no attempts to re-direct her. The facility receptionist posted near the visitor entrance stated, "she's been having some sundowning," but made no attempts to speak to R19 or inform unit staff that she was near the entrance. At 3:23 PM, another resident observed R19 at the door and stated, "you gotta watch her, she's going to try to get out, she did yesterday." At 3:24 PM, R19 was observed trying to open the visitor door, which set off the alarm. At this point, the receptionist approached R19 and unsuccessfully tried to redirect her. This behavior continued for several minutes with R19 repeatedly trying to open the visitor door and setting off the alarm. At 3:28 PM, the receptionist alerted a staff member on the unit by phone of the behavior, stating, "if someone can come talk to ... [R19] over here,

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F 689	Continued From page 32 she keeps setting off the alarm." On 06/09/22 at 08:11 AM, an observation was made in the medical records room near the nurses' station of a posting of R19's picture with her name, age, gender, and room number written on it. The posting was titled "Elopement Risk." On 06/09/22 at 08:49 AM, an interview was done with the Minimum Data Set Coordinator (MDSC) in her office. The MDSC stated R19's last quarterly assessment was completed on 03/31/22, and she had not been exhibiting exit-seeking behavior at that time. The MDSC reported that the exit-seeking behavior and verbalizations were "pretty new," but had been identified, discussed in Interdisciplinary Team (IDT) meetings, and reviewed with R19's family, both in person and over the phone. During a concurrent review of R19's EHR, the MDSC stated the earliest documentation she could find regarding exit-seeking behavior was on 05/26/22, which she confirmed was when the issue was first discussed with the IDT. After reviewing R19's comprehensive care plan, the MDSC also confirmed that the care plan had not been revised to include any interventions for the identified problem, but it should have been.	F 689		
F 732 SS=F	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	F 732		7/30/22

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F 732	Continued From page 33 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 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 appropriately inform their staff, residents, and visitors of the staffing pattern in the facility. This deficient practice failed to inform all staff, residents, and visitors of the current staffing conditions in the facility. Finding includes:	F 732	Corrective Action: The Nurse Staffing Information Board was moved to a more prominent location in the facility to increase visibility by staff, residents and visitors. Education was provided to the Staffing Coordinator and back-up designees regarding the process for updated the	

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LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

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F 732	Continued From page 34 On 06/06/22 at 11:12 AM, upon initial entry and observations of the facility, no posted staffing information was noted. Subsequent and continued observations in the facility for the required posted staffing information on 06/07/22, 06/08/22, and 06/09/22 did not reveal any such posting. On 06/07/22 at 09:17 AM, certified nurse aide (CNA)4 was interviewed at the nursing station. CNA4 directed the surveyor to the staff scheduling book when asked where the posted nurse staff information with the total amount of hours of staff working per shift and total resident census was located. No document containing that specific information was found in the staff scheduling book. On 06/09/22 at 10:00 AM, the Administrator was asked where the posted nurse staffing information was located. The Administrator stated that it was located on the closed unit.	F 732	information on the board each day. Identification of Others: No other staffing boards are located in the facility. Systemic Changes: The facility posts the following information on a daily basis: " Current date " Total number and the actual hours worked by the RNs, LPNs and CNAs " Resident Census The facility posts the nurse staffing data in a clear and readable format. The staffing board is located in a prominent place that is readily accessible to residents and visitors. Monitoring: The SC/designee will update the staffing board each day and ensure that the board remains in a prominent location which is readily visible by residents and visitors. If the board is moved from the current location, the SC/designee will notify the Executive Director. The ED will check the staffing board weekly for 90 days to ensure posted in visible place. The SC/designee will review the status of the staffing posting board in QAPI monthly for three months. The QAPI committee will determine the frequency of ongoing monitoring.	
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d)	F 745		7/30/22

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F 745	Continued From page 35 §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record reviews, the facility failed to ensure that medically related social services were provided to one resident (R)32, out of a sample of two residents. This deficient practice failed to provide emotional support to R32 and ensure the highest practicable mental and psychosocial well-being is maintained. The deficient practice has the potential to affect all residents in the facility who suffer from depression. Finding includes: On 06/07/22 at 08:30 AM, an initial observation and query was done with R32. R32's bed was by the window, and he was watching television. R32 had a depressed affect. R32 stated that there was no social worker (SW) in the facility, that the staff are too busy to talk to him, and that State Agency (SA) had been the only one to come into his room to converse. On 06/07/22 at 12:24 PM, R32's electronic health record (EHR) was reviewed. R32's PHQ-9 (Patient Health Questionnaire; a nine-question survey to assess for the presence and severity of depression) dated 01/17/22 was scored at zero or minimal depression. PHQ-9 assessment done on 04/19/22 was scored at 12 indicating moderate depression. On 06/08/22 at 08:21 AM, R32 stated with a depressed affect, that he wanted to die. R32 laid	F 745	Corrective Action: A PHQ-9 was completed for resident #32 to assess the current level of depressive symptoms. The IDT discussed appropriate interventions to address depressive symptoms and updated the care plan based on the preferences of the resident. Education was provided to the staff regarding interacting and communicating with the residents in a manner that promotes mental and psychosocial well-being and providing meaningful activities for residents displaying mood symptoms. Identification of Others: A review of each resident□s most recent PHQ9 assessment was completed to determine their level of mood/depressive symptoms. Resident identified with a PHQ9 score >4, based on the review results, the plan of care was reviewed and updated, as needed, and education was provided to the staff regarding resident-centered interventions. Systemic Changes: Residents are assessed for psychosocial needs upon admission, quarterly, change of condition and as needed. Based on assessment findings, a plan is developed to address psychosocial	

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F 745	Continued From page 36 in bed with the television on. On 06/08/22 at 08:30 AM, a query was made with licensed practical nurse (LPN)3 about R32's statement of wanting to die and LPN3 stated that R32 sometimes makes comments like that, but that he is okay. On 06/08/22 at 1:51 PM, R32's EHR was reviewed. Progress notes from 02/16/21 to 06/07/22 were reviewed. The last "Psychosocial Note" found was dated 01/24/22. It stated that he had a Brief Interview for Mental Status Interview (BIMS) score of 15, which meant that he was cognitively intact, and he was able to communicate his needs and wants to the staff. The resident and staff reported "no negative changes in demeanor nor onset of new bx at this time." "Mood/PHQ-9" progress note dated 04/19/22 for 2:51 PM stated that "...he feels down every day. That he feels like he let his daughter down. And that he has difficulty concentrating (sic) on things. That he has thought that he would be better off dead, but he has no plan of hurting himself..." No follow up progress notes addressing his depressive symptoms or any attempts to provide emotional support were found after the entry on 04/19/22 at 2:51 PM. R32's care plan with last review date of 05/06/22 was reviewed. Focus "BEHAVIOR: [R32] exhibits s/sx [signs and symptoms] r/t [related to] depressed mood ..." Interventions included " ...Offer [R32] non-pharmacological options during times of emotional distress: utilize active listening, 1-1 [one to one] validation of his concerns - offering realistic solutions to his concerns ..." On 06/09/22 at 11:46 AM, registered nurse (RN)1 was interviewed at the nursing station. RN1	F 745	needs. This may include medication regimen changes and/or consultation with mental health professionals. Behavior Monitoring is initiated upon admission and includes monitoring for mood indicators. This documentation is reviewed during clinical rounds and as needed. The SSD/designee will meet with residents experiencing increase mood symptoms routinely to determine if the plan of care is effective or if changes are needed. Education is provided to staff regarding the following: " Monitoring the resident closely for expression or indications of distress, including changes in mood " Accurately document mood and behavioral changes " Share concerns with the IDT to determine underlying causes and ensure appropriate follow-up assessment, if needed " Interacting and communicating with residents in a manner that promotes mental and psychosocial well-being " Providing an environment and atmosphere that is conducive to mental and psychosocial wellbeing " Meaningful activities which promote engagement and positive, meaningful relationships between residents and staff Monitoring: The SSD/designee will review the PHQ-9 assessment results with each quarterly assessment and as needed to identify changes. If the findings show an increase	

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F 745	Continued From page 37 stated that R32 had been very depressed in the past but he improves after the SW speaks with him. RN1 stated that the facility's SW left in March. RN1 stated that R32 had been depressed again and that the SW duties had been divided among three of the facility's staff but doesn't know who provides the emotional support for the residents. On 06/09/22 at 3:00 PM, the facility's "Behavioral Health Management" policy and procedure, revised on 05/09/22 was reviewed. Stated under "Policy": " ...The facility will provide medically related social services for highest practicable well- being as necessary for each resident. The facility will identify the need for medically- related social services and ensure that these services are provided. It is not required that a qualified social worker necessarily provide all of the services ..."	F 745	in mood/depressive symptoms, the IDT will review the status of the resident and develop a person-centered plan of care. This will be done for 3 months and then re-evaluated. The SSD/designee will report the results of the PHQ-9 audits, along with any corrective action taken, to the QAPI committee for 90 days. The QAPI team will determine if compliance has been achieved and the frequency of ongoing monitoring.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, and record review, the facility failed to ensure a medication error rate of less than 5%, as evidenced by two medication errors observed out of twenty-eight opportunities for errors, for an error rate of 7.14%. Safe medication administration practices are essential for the health and well-being of the residents. As a result of this deficient practice, two residents	F 759	Corrective Action: Residents #48 and #41 were evaluated to determine if there were adverse effects from the medications they received. None were noted. The medication error protocol was followed.	7/30/22

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F 759	Continued From page 38 received the wrong medication. This deficient practice has the potential to affect all residents in the facility. Findings include: On 06/08/22 at 08:23 AM, during medication administration, observed Registered Nurse (RN)1 prepare and administer to Resident (R)48 one tablet of Senna Plus 50/8.6mg [milligrams]. Senna Plus is senna and docusate sodium, a laxative with stool softener compound. At 09:56 AM while reviewing R48's electronic health record (EHR), it was noted that the medication order was for senna 8.6mg (the laxative) alone. On 06/08/22 at 08:31 AM, during medication administration, observed RN1 prepare and administer to R41 one tablet of Calcium 600mg. At 10:00 AM while reviewing R41's EHR, it was noted that the medication order was for a Calcium Carbonate - Vitamin D Tablet 600-400 MG-UNIT.	F 759	Education was done with nurses regarding proper medication administration, including Medication Administration Rights, and the facility policy and procedure for medication-related errors. Identification of Others: Medication Administration Observations were conducted with a sample of nursing staff to identify potential errors and to provide education. If errors are identified, education will be provided to the nurse immediately and documented on the medication observation form. Systemic Changes: Medications are administered in accordance to physician orders. When administering medications, the dosing/label instructions are verified against the order. When giving medications, the following rights are followed: " Right Patient " Right Time " Right Drug " Right Dose " Right Dosage Form " Right Route " Right Documentation If a medication-related error is made, the facility policy and procedure is followed. Education will be done with nurses regarding proper medication administration, including Medication Administration Rights, and the facility policy and procedure for	

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F 759	Continued From page 39	F 759	medication-related errors upon hire and as needed. Monitoring: The SDC/designee will conduct medication pass observations with 2 nurses each week. This will be done weekly for four weeks, then monthly for two months and then re-evaluated. Based on the results of the observations, additional education will be done with the nurses as needed. The SDC/designee will report the results of the observations, along with any corrective action taken, to the QAPI committee for 90 days. The QAPI team will determine if compliance has been achieved and the frequency of ongoing monitoring.	
F 761 SS=D	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 personnel to have access to the keys.	F 761		7/30/22

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F 761	Continued From page 40 §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 observation and interview, the facility failed to ensure all medications used in the facility were securely stored in locked compartments, and that floor stock medications were not used past the manufacturer expiration dates. Proper storage and labeling of medications is necessary to promote safe administration practices, and to decrease the risk of medication errors and diversion of resident medications. This deficient practice has the potential to affect all residents in the facility. Findings include: On 06/07/22 at 09:10 AM, while walking through the unit, observed an unlocked and unmonitored medication cart outside a resident room, blocking the doorway. There was no staff in sight. The resident's room had no resident in Bed A, closest to the door, and Bed B, near the window, had its privacy curtain pulled closed. State Agency (SA) sat in hallway across from the resident's room and the unsecured medication cart to continue observations. Observed two residents and one staff member walk past the cart. At 09:14 AM, observed Licensed Practical Nurse	F 761	Corrective Action: The nurses were notified during survey and the carts were locked. The medications identified were removed from the cart when provided to the nurse during survey. Education was done with nurses regarding the facility policy on securing medications by locking medication carts when walking away and removing expired medications from carts to ensure they are not used. Identification of Others: Observations of medication carts were done to determine if they were locked. Based on the results of these observations, education was provided to nurses as needed. Each medication cart was checked for expired medications and if found, they were removed and discarded according to facility policy and procedure. Systemic Changes: Medication are securely stored in a locked	

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F 761	Continued From page 41 (LPN)4 come from behind the privacy curtain at 303, Bed B, return to the medication cart, place something on it, then turn and walk away from it without locking it. At 09:15 AM, LPN4 returned to the medication cart from the resident's privacy curtain once again. When asked if she usually locks the medication cart when she walks away from it, initially LPN4 answered "yes, I do." When asked why the medication cart was left unlocked this time, LPN4 responded by stating she doesn't lock the medication cart "if I can keep my eyes on it." On 06/08/22 at 08:18 AM, while walking through the unit, observed Registered Nurse (RN)1 walk away from a medication cart, leaving it unlocked as she entered a resident's room and walked to the bed closest to the window, which had its privacy curtain pulled closed. Neither the resident nor RN1 were visible from the medication cart. At 08:21 AM RN1 returned to the medication cart. When asked if she usually locks the medication cart when she walks away from it, RN1 responded "yes." When the surveyor pointed out that the medication was not locked, RN1 stated, "I didn't that one time for that short time, and it was within my view." On 06/09/22 at 08:28 AM, during an inspection of the medication cart on a nursing unit, observed two floor stock bottles of medication that had exceeded the manufacturer's expiration date. One bottle of Aspirin (a non-steriodal anti-inflammatory drug) 325 mg (miligram) had a manufacturer's expiration date of "02/2022." The Aspirin bottle also had a facility label on it that indicated it had been opened and used since 02/28/22. One bottle of Vitamin B-12 1000mcg	F 761	medication cart that is inaccessible by residents, visitors and other staff. It is the responsibility of the nurse to ensure the cart is locked when walking away. Expiration dates for floor stock medications are checked routinely. If medications have reached their expiration date, they are removed from the cart and sent for destruction. Education is done with nurses regarding the facility policy on securing medications by locking medication carts when walking away and removing expired medications from carts to ensure they are not used. This is done upon hire and as needed. Monitoring: The Staff Development Coordinator (SDC)/designee will conduct observations of medication carts to determine if they were locked. This will done 5 times per week for four weeks, then 1 time weekly for two months and then re-evaluated. The SDC/designee will check each medication cart for expired medications and if found, they will be removed and discarded according to facility policy and procedure. This will be done weekly for four weeks, then monthly for two months and then re-evaluated. Based on the results of these observations and cart checks, education will provided to nurses as needed. The SDC/designee will report the results of the observations and cart checks, along with any corrective action taken, to the QAPI committee for 90 days. The QAPI team will determine if compliance has been achieved and the frequency of	

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F 761	Continued From page 42 [micrograms] had a manufacturer's expiration date of "05/22." The Vitamin B-12 bottle also had a facility label on it that indicated it had been opened and used since 09/18/21. Both bottles were given to RN1 who agreed that they should have been pulled and discarded.	F 761	ongoing monitoring.	
F 812 SS=F	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: Based on observations, interviews with staff and review of the facility's dish machine log, the facility failed to ensure appropriate concentration of the sanitizing solution was maintained for the dish washing machine. This deficient practice has the potential to affect all resident in the facility.	F 812	Corrective Action: During the survey, the Ecolab representative adjusted the sanitizer dispenser to the low temp dish machine to increase concentration to ensure the PPMs met the manufacturer□s recommendations.	7/30/22

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F 812	Continued From page 43 Findings include: On 06/07/22 at 2:55 PM interviewed Dietary Aide (DA)1 regarding the dishwashing machine. DA1 reported dishes are sanitized with a chlorine solution. Requested DA1 test the solution. DA1 was observed to dip the test strip into the pool of water/solution mixture under the dish rack of the dishwasher. DA1 matched the color of the strip to the manufacturer's color chart. DA1 reported the solution was 50 ppm (parts per million). A request was made for the Food Service Director/Registered Dietitian (FSD/RD) to perform the testing. FSD/RD dipped the strip into the water/solution mixture and compared the strip to the color chart and stated it was at 50 ppm. Further observation found the test strips expired, 12/20/21. A review of the "Low Temperature Dish Machine Log" for June 2022 noted the chlorine solution at 100 ppm for breakfast, lunch, and dinner service. The entry for 06/07/22 at breakfast was 100 ppm. Further review of the log, notes "during the COVID-19 outbreak, along with [contractor name], we are requesting PPM's to be at 100 PPM..." FSD/RD agreed to contact their contractor. On 06/07/22 at 1:10 PM, observed the contractor test the solution. The test strips were not expired. The contractor dipped the strip into the solution in the dishwasher. The contractor tested the solution and read it as 75 ppm. Observed the color chart did not include a color match for 75 ppm and the color of the strip did not match the manufacturer's color chart. This was brought to the contractor's attention, he replied the color is between 50 and 100 ppm so it is 75 ppm. The	F 812	Identification of others: All residents who consume food are identified to be at risk Systemic changes: All dietary staff were educated on 7/5/2022 by the Foodservice Manager/RDN regarding dishwashing safety & how to respond if dish sanitizer falls below manufacture recommendations. Ongoing monitoring The dietary manager or designee will audit dish sanitizer levels to ensure at required level 3 x per week x 30 days. Audits will be brought to monthly QAPI meeting for review and audits will continue until QAPI committee determines sustained compliance.	

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F 812	Continued From page 44 contractor asked the surveyor if he should change the solution, he will do whatever the surveyor wanted. Redirected the contractor to ask the FSD/RD what should be done. FSD/RD informed the contractor that their corporation requires 100 ppm. Contractor was agreeable to make the adjustment.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		7/30/22

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F 880	Continued From page 45 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure appropriate	F 880	Corrective Action: The facility is not currently in a covid	

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F 880	Continued From page 46 protective and preventive measures for COVID-19 and other communicable diseases and infections. This is evidenced by the facility failing to ensure staff followed facility protocols for standard and transmission-based precautions (TBP) by wearing the proper personal protective equipment (PPE), wearing PPE appropriately, and failing to dispose of trash from an active COVID-19 room properly. In addition, the facility failed to provide care for residents with COVID-19 in alignment with the Centers for Disease Control and Prevention's (CDC) guidelines. These deficient practices have the potential to affect all residents in the facility, as well as all healthcare personnel, and visitors at the facility. Findings include: Cross-reference to F886 COVID-19 Testing. The facility failed to ensure staff conducting point-of-care (POC) COVID-19 outbreak testing on themselves conducted the testing in a manner consistent with current standards of practice for conducting COVID-19 tests. On 06/06/22 at 10:00 AM, upon entering the facility, the State Agency (SA) was informed that the facility was experiencing a COVID-19 outbreak. The facility stated that there were two residents on quarantine for COVID-19, one in room 404 and another in room 405. Both residents were "sheltering in place" with their roommates (who were previously positive). On 06/06/22 at 11:36 AM, while making observations outside the two COVID-19 rooms, the following was noted on the bright orange signs posted outside each room:	F 880	outbreak. Identification of Others: All residents have the potential to be affected. Systemic Measures: On 7/25/22 through 7/29/22 staff were re-educated on PPE protocol, disposal of trash from a covid positive room, utilizing disposable meal containers, cups and tableware to the extent possible, keeping door closed (if safe to do so, per CDC) or full closure of the barrier door, and the screen in process for visitors and contractors during times when a receptionist is not present. Clinical lab contractors were informed of proper screen-in process. During a covid outbreak, the facility will continue to follow CDC guidance and work with our county Infection Preventionist to determine a plan for the management of resources. CDC guidance, in pertinent part: " Determine the location of the covid-19 unit and create a staffing plan. " The location of the covid-19 care unit, should ideally, be physically separated from other rooms. " If possible, HCP should avoid working on both the covid-19 care unit and other units during the same shift. " To the extent possible, restrict access of ancillary personnel to the unit. " To the extent possible, environmental services staff should avoid working on both the covid-19 care units and other	

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F 880	Continued From page 47 " ...KEEP DOOR CLOSED ..." It was observed at this time, and throughout the length of the survey, that neither door was closed. The doors to both rooms remained open with thin plastic barriers unevenly secured around the inner door frames. The barriers went from the top of the door frames to approximately two inches above floor level. The center of each plastic barrier had a red zipper that extended the length of the barrier, to allow entry and exit into the room. At this time, and at several other points in the survey, the zippers on one or both of the plastic barriers were observed partially or fully open, with no staff in sight. The plastic barrier in the doorway of room 405 had an approximately 12-inch horizontal tear in it that had been repaired with clear 2-inch tape. On 06/06/22 at 11:51 AM, observed a bright yellow sign in the dining room and at the nurses' stations with the following information: "INFECTION PREVENTION ...LEVEL 2 ACTIVATION EFFECTIVE 5/21/22 ...EMPLOYEES (ALL) EYE PROTECTION REQUIRE IN RESIDENT AREAS ..." On 06/06/22 at 12:00 PM, while making observations outside room 404, observed Certified Nurse Aide (CNA)2 deliver lunch to both residents in the room. Resident (R)13's lunch was packed in disposable containers, while R5's lunch was on a plastic tray with reusable tableware. Both lunches were passed through the plastic barrier by Staff Member (SM)2 to CNA2. After CNA2 delivered the lunch to R5, she passed the plastic cover for the main dish back out to SM2, who placed it back on the meal cart.	F 880	units during the same shift. " To the extent possible, HCP dedicated to the covid-19 care unit will also be performing cleaning and disinfection of high-touch surfaces and shared equipment when in the room for resident care activities. " In general, it is recommended that the door to the room remain closed to reduce transmission of covid-19. This is especially important for residents with suspected or confirmed covid-19 infection being cared for outside of the covid-19 care unit. However, in some circumstances, keeping the door closed my pose resident safety risks and the door might need to remain open. Monitoring: The facility will complete the directed plan of correction (DPOC) and submit all training documents to the OHCA by 09/02/22 and provide education on infection control monthly for the next 90 days. When the facility has a resident who are placed on quarantine, staff will be monitored for correct infection control procedures 3x per week for the next 90 days. The QAPI team will determine if compliance has been achieved and the frequency of ongoing monitoring.	

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It was observed at this time that CNA2 was wearing her N95 respirator with both bands together at the back top of her head.

On 06/06/22 at 1:42 PM, an observation was done of Licensed Practical Nurse (LPN)3 exiting a resident's room with her eye protection sitting on the top of her head.

On 06/07/22 at 09:20 AM, during a review of the day-shift nurse staffing schedule for the week, it was noted that on 06/07/22 through 06/09/22, there was one CNA assigned to Rooms 306A-404A, and a second CNA assigned to Rooms 404B-412.

On 06/07/22 at 10:15 AM, while standing outside of Room 404, observed CNA1 exiting the plastic barrier with trash collected in the room in a double-bagged clear trash bag. CNA1 carried the trash from Room 404 through the hall to the dirty utility room where she placed it in a covered gray bin. Asked LPN2 if that was the proper handling of trash from a room with active COVID-19. LPN2 stated she would double-check.

On 06/07/22 at 10:20 AM, an interview was done with CNA3 outside room 404. Regarding meals, CNA3 stated all residents in rooms on isolation for COVID-19 should have disposable containers and utensils. Regarding staff assignments, CNA3 confirmed that staff who entered the COVID-19 isolation rooms were not dedicated to those rooms but assisted other residents in the unit as well.

On 06/07/22 at 10:27 AM, LPN2 stated she had confirmed that the protocol for trash taken from the isolated COVID-19 rooms was that they

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should be placed in yellow trash liners which are stocked in the bottom drawer of the PPE carts outside the rooms, then placed in the yellow bins in the dirty utility room. The yellow color of the trash liners and bins indicating that special handling was required.

On 06/08/22 at 09:38 AM, observed R36 sitting in his wheelchair outside of Room 405. R36 un-zipped the plastic barrier to his room and attempted to enter but his wheelchair got stuck on the plastic barrier. At 09:40 AM, Registered Nurse (RN)1 walked by and assisted R36 into the room. When asked about R36 being out of the isolation room when his roommate still had active COVID-19, RN1 stated "he is recovered from COVID, so he is allowed to be out ...[the Infection Preventionist] said he can be out even though his roommate has COVID as long as he wears a mask while he is out."

On 06/08/22 at 12:17 PM, an interview was done with the Infection Preventionist (IP) in an office next to the Reception area. The IP confirmed that the residents in isolation for COVID-19 were not in a dedicated space and did not have dedicated staff. The IP also confirmed that rather than cohorting the confirmed positive residents together, with their exposed roommates quarantined in a separate space, the decision had been made to leave them with their COVID-positive roommates. The IP stated that the facility had been advised by the State Disease Outbreak and Control Division (DOCD) that the residents could be "shelter[ed] in place," amongst other recommendations. The IP agreed that several of the infection control practices being followed in the facility, particularly in regard to the management of a COVID-19 outbreak, did not

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align with CDC recommendations, but stated that the decision had been made to follow DOCD recommendations instead. Documentation of recommendations made by DOCD and/or the evidence-based rationale for them was requested, but never produced by the facility.

During a review of the CDC's Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, updated 02/02/22, the following recommendations were noted:

"Identify Space in the Facility that Could be Dedicated to Monitor and Care for Residents with Confirmed SARS-CoV-2 Infection ... location of the COVID-19 care unit should ideally be physically separated from other rooms or units housing residents without confirmed SARS-CoV-2 infection ..."

"Identify HCP [healthcare personnel] who will be assigned to work only on the COVID-19 care unit when it is in use."

" ... it is recommended that the door to the room remain closed to reduce transmission of SARS-CoV-2. This is especially important for residents with suspected or confirmed SARS-CoV-2 infection being cared for outside of the COVID-19 care unit."

"Residents should only be placed in a COVID-19 care unit if they have confirmed SARS-CoV-2 infection."

2) On 06/09/22 at 07:10 AM observed a contractor enter the facility alongside a facility staff member. The contractor stopped at the

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F 880	Continued From page 51 nurse's station, reviewed a binder, and was observed walking down the hall and into a resident's room. The contractor was wearing a lab coat, procedural mask and eye protection. Observed the contractor did not take her temperature and complete the facility's screening questions for COVID-19. Reviewed the visitor log and found the contractor did not sign in. On 06/09/22 at 07:15 AM, interviewed the Infection Preventionist (IP). Queried whether contractors entering the facility are required to wear an N95 and sign-in. IP replied contractor's are required to wear an N95 and sign-in. After reviewing the facility's sign-in log, the IP confirmed the contractor did not sign-in. IP agreed to find the contractor and have her follow the facility's procedure for screening and wearing the appropriate personal protective equipment.	F 880		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility;	F 886		7/30/22

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(iii) The identification of any individual specified in this paragraph with symptoms
consistent with COVID-19 or with known or suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the
transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate
to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms
consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in

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F 886	Continued From page 53 emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staff conducting point-of-care (POC) COVID-19 outbreak testing on themselves conducted the testing in a manner consistent with current standards of practice for conducting COVID-19 tests. As a result of this deficient practice, the facility placed the residents and staff at an increased risk of COVID transmission. This deficient practice has the potential to affect all residents in the facility, as well as all healthcare personnel, and visitors at the facility. Findings include: On 06/08/22 at 12:21 PM, an interview was done with the Infection Preventionist (IP) in the conference room. The IP stated that the facility was currently in outbreak testing since 05/21/22. Residents were being tested for COVID-19 twice a week until 05/30/22, then decreased to once a week. Staff remained on twice a week testing. On 06/09/22 at 06:55 AM, arrived at the facility and observed Occupational Therapist (OT)2 and Staff Member (SM)1 standing outside the staff entrance after just swabbing themselves for COVID-19. Neither OT2 nor SM1 were wearing gloves or a gown at the time. SM1 was observed changing out her procedure mask for an N-95 respirator as she waited for the COVID-19 point-of-care (POC) test to result. Interviewed	F 886	Corrective Action: Education was done with all staff regarding facility process for COVID self-testing, including appropriate use of Personal Protective Equipment (PPE). Identification of Others Potentially Affected: All staff have the potential to be affected. Systemic Changes: Associates that are required to test for COVID, perform a self-test based on the frequency required by the facility. A designated space is set-up for this testing that promotes proper infection control practices. Instructions to associates include: " Testing alone only one associate to test in the testing area at a time " Hand hygiene is performed before and after conducting self-test " If obtaining a sample for testing for a resident or another associate, the associate will don an N95, eye protection, gown and gloves. " A minimum of a surgical mask is worn while in the testing area. Once the test sample is obtained, the surgical mask is immediately reapplied. " Disinfecting surfaces in testing area " While resulting, a minimum of a	

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F 886	Continued From page 54 OT2 about the process and was told that staff had been trained to swab themselves, then verify each other's results for the screening log. On 06/09/22 at 07:27 AM, during an interview with the Infection Preventionist (IP) in the conference room, The IP stated that staff had been trained to test themselves in January of 2022, prior to her employment at the facility. The IP continued on to say that she expected staff to at least be wearing gloves when swabbing themselves but did not expect full personal protective equipment (PPE) to be worn because staff were conducting the tests outside the facility. The IP was asked to locate the education and competency logs from the January 2022 training. Education logs were received, but competency logs were not. During a review of the Centers for Medicare & Medicaid Services (CMS) Memorandum QSO-20-38-NH, Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements, last revised on 03/10/22, the following was noted regarding COVID-19 testing: "During specimen collection, facilities must maintain proper infection control and use recommended personal protective equipment (PPE), which includes a NIOSH-approved N95 or equivalent or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown, when collecting specimens." During a review of the Centers for Disease Control and Prevention's (CDC) Interim	F 886	surgical mask is to be worn and associate(s) must maintain 6 ft distance for others in waiting area Education is done with associates regarding self-testing using antigen testing supplies, upon hire and as needed. This education includes the manufacturer□s recommendations for conducting the test along with use of appropriate infection control practices and PPE use. The Infection Preventionist (IP)/designee conducts observations of testing for infection control practices and determines if additional education or other corrective action needed. Monitoring: The IP/designee conducts observations of testing for infection control practices. This will be done weekly for four weeks, then monthly for two months, and then re-evaluated. If breaks in infection control practices are observed, the IP will conduct additional education. The IP will report the results of the observations, along with any corrective action taken, to the QAPI committee for 90 days. The QAPI team will determine if compliance has been achieved and the frequency of ongoing monitoring.	

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F 886	Continued From page 55 Guidelines for Collecting and Handling of Clinical Specimens for COVID-19 Testing, updated May 18, 2022, the following was noted: "For healthcare providers collecting specimens or working within 6 feet of patients suspected to be infected with SARS-CoV-2, maintain proper infection control and use recommended personal protective equipment (PPE), which includes an N95 or higher-level respirator (or face mask if a respirator is not available), eye protection, gloves, and a gown."	F 886		