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	125019	A. BUILDING _____ B. WING _____	10/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARE CENTER OF HONOLULU	1900 BACHELOT STREET HONOLULU, HI 96817

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F 000	INITIAL COMMENTS The State Agency (SA) conducted a focused infection control and special focus facility survey from 09/28/21 to 10/04/21. The SA also investigated a complaint and two facility reported incidents from the Aspen Complaints/Incidents Tracking System (ACTS) #8809, #9055, and #9097. The complaint and facility reported incidents were not substantiated. The facility was not in compliance with regulatory requirements at 42 CFR §483 Subpart B. Census: 126 Sample Size: 30	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		11/26/21

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

Electronically Signed | 11/08/2021

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure Resident (R) 94's right to a dignified existence in a manner that promotes his/her quality of life. R94, who's left arm was amputated and requires staff assistance for dressing, asked a staff for help with putting on a pair of shorts over the resident's incontinent brief and staff told the resident to wait. Staff did not return to assist the resident. R94 stated it embarrassing to have to be around other residents (in the room) with just an incontinent brief on and to need staff's help and be forgotten not have the resident's personal dignity maintained. R94 also stated there were times when staff has been providing direct care to the resident and staff were speaking to each other in Filipino. The resident reported feeling	F 550	1) Resident (R) 94 was visited by the Director of Nursing (DON) on 11/5/21 with no concerns regarding dignity and is happy with care provided. 2) Residents residing in the facility have the potential to be affected. Audit was done with current residents and any newly identified issues were addressed. 3) Staff Development Coordinator (SDC)/Designee re-educated staff on 10/14/21, and on an ongoing basis, regarding resident rights' dignity, including speaking to residents during care and in resident care areas.	

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F 550	Continued From page 2 self-conscious that staff could be speaking about him/her, making the resident feel uncomfortable. The resident asked staff to speak English and they ignored the resident's request. Findings include: R94 was admitted to the facility on 05/12/20. R94's diagnoses includes a left arm amputation and requires assistance with activities of daily living. On 09/29/21 at 10:30 AM, conducted an interview with R94. The resident stated that, at times, staff do not treat the residents like they are human beings with respect instead of another task to do. R94 went on to say that he has asked staff for assistance with putting on and pulling up the resident's shorts, staff told the resident he was going to have to wait and left the room. R94 reported staff did not come back and was lying in bed with a diaper. R94 stated, "It made me feel bad, you know. I already feel bad because I need their (staff) help because I only have one arm. Then I ask for help and they (staff) don't come back and I just gotta sit there. It doesn't make me feel like a man, it doesn't make me feel like a human being. We should be treated like human beings." The resident also reported when staff are providing care for the resident or if staff is in the room providing care for the resident's roommate, staff will speak to each other in Filipino. R94 stated, "I don't know what they're talking about. They could be talking about me, making fun of me, it makes me feel self-conscious." During record review on 10/01/21 at 01:06 AM, R94's quarterly Minimum Data Set (MDS) with an	F 550	4) Dignity focused rounds will be conducted by the DON/Designee to verify compliance of the maintenance of residents' dignity and respect as individuals. Rounds to include 3 residents per unit per week x 4 weeks, and then 4 residents per week x 2 months. DON/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	

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F 550	Continued From page 3 Assessment Reference Date of 08/24/21 documented the resident's Brief Mental Status (BIMS) was 15. A score of 15 indicated that the resident was cognitively intact. Section G. Functional Status, of how the resident performs Activities of Daily Living (ADL) and assistance the resident needs to put on and remove clothes, documented the resident needs extensive assistance with one person to physically assist the resident.	F 550		
F 558 SS=E	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 observation, interview, and record review (RR), the facility failed to accommodate the needs of three residents by not ensuring that their call lights were always placed within their reach or provided a call light the resident could operate. As a result of this deficient practice, Residents (R)65, R37, and R81 were placed at risk of not having their emergent needs met in a timely manner and were prevented from achieving independent functioning with regards to calling for help. Findings include: 1) R65 is a 56-year-old male admitted to the facility on 11/20/2018 for long-term care services. R65's diagnoses include left-sided hemiplegia	F 558	1) R81 was given a touch pad call light as per care plan. R65 and R37 had EZ sensor call lights placed in the correct spot for access. 2) Residents residing in the facility have the potential to be affected. Call lights audit was done to validate those residents have the proper device in place and any newly identified issues will be addressed. 3) SDC/Designee re-educated staff on 10/14/21, and on an ongoing basis, to check for correct call light, placement, and availability before leaving the room. 4) DON/Designee will audit 3 residents	11/26/21

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F 558	Continued From page 4	F 558		

(paralysis on one side of the body) and hemiparesis (muscle weakness affecting one side of the body) following a cerebral infarction (stroke), a dense contracture (a shortening and hardening of muscles, tendons, or other tissue, leading to deformity and rigidity of joints) of the left elbow, and decreased range of motion of both hands and fingers. As a result of these conditions, R65 can no longer grasp anything, cannot activate a button-type call light, has great difficulty activating a pad-type call light, and is fully dependent on staff for all activities of daily living.

On 09/28/21 at 03:22 PM, an observation and concurrent interview were done of R65 in his room on the second floor. R65 was lying in bed with his "E-Z touch call light" (a wide-based touchpad call light designed for individuals with limited movement) positioned six inches below his left elbow. When asked if he could reach it, R65 stated "where is it?" and tried to move his head to see the call light but could not lift his head from the pillow. After this surveyor pointed to where the call light was located, R65 reported he could neither see nor reach the call light.

On 10/01/21 at 12:54 PM, an observation was done of R65 in his room on the second floor. R65 was lying in bed with his E-Z touch call light clipped to his pillowcase above his left shoulder, with the side that gets pressed to activate the call light facing away from him. Again, R65 stated he could neither see nor reach the call light when asked.

2) R37 is a 79-year-old female admitted to the facility on 01/19/21 for long-term care services with diagnoses that include quadriplegia

per unit per week x 4 weeks, then 4 residents per week x 2 months, for call light placement, accessibility, and correct device. DON/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.

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F 558	Continued From page 5	F 558		

(paralysis of all four limbs) and right hand and left elbow contractures. As a result of these conditions, R37 is fully dependent on staff for all activities of daily living.

On 09/28/21 at 03:32 PM, an observation was done of R37 in her room on the second floor. R37 was asleep in bed and her call light was not visible anywhere on her bed, or on her person.

On 09/29/21 at 01:54 PM, a review of R37's Comprehensive Care Plan was done, and the following was noted: "Place the E-Z touch call light on her stomach when she is in bed ..."

On 10/01/21 at 12:56 PM, an observation was done of R37 in her room on the second floor. R37 was asleep in bed with her E-Z touch call light positioned at her left shoulder with the side that gets pressed to activate the call light facing away from her. A certified nurse aide (CNA)196 was passing by the bed, so this surveyor asked her if R37 could reach the call light where it was placed (with the part to press facing out), and CNA196 answered "no", then repositioned the call light onto R37's stomach.

3) R81 was admitted to the facility on 07/28/21 and receiving hospice services with diagnoses including cerebrovascular disease, history of transient ischemic attack (TIA) and cerebral infarction, dementia without behavioral disturbances. and Alzheimer's.

On 09/29/21 at 11:35 AM and 10/01/21 at 09:40 AM, observed R81 had a push button call light. The call light was pinned to the resident's pillow and hanging over the top of the bed towards the ground, out of the resident's reach. This surveyor

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F 558	Continued From page 6 asked the resident if he/she was able to reach the call light. R81 was unable to verbally respond and did not attempt to reach for the call light. On 10/01/21 at 3:35 PM, conducted a review of R81's Electronic Health Record (EHR). R81's Comprehensive Care Plan was completed and documented "The resident needs a touch pad call light due to: Limited mobility, generalized weakness r/t (related to) disease process, on hospice." Interventions included, "Place the touch pad at the LEFT hand") which was initiated on 08/02/21. On 10/01/21 at 09:40 AM, conducted an interview with RN89 regarding R81's call light. RN89 confirmed R81's call light was not in reach and the resident could not operate the push button call light provided. RN89 stated R81 should have a touch pad call light.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make	F 561		11/26/21

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F 561	Continued From page 7	F 561		

choices about aspects of his or her life in the facility that are significant to the resident.

§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.

§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and interview with residents and staff members, the facility failed to assure and/or promote Resident (R) 124 and R386's right to make choices about their lives. R124 had requested, for the past year, to have his bed repositioned to face the window so that he could see his family when they came to visit. His request was not granted. R386 stated no one had ever asked her about her food allergies or preferences, never been given a menu to choose from, and was not told about alternate menus.

Findings include:

1) Cross Reference F921. During initial observation and interview with R124 on 09/29/21 at 11:06 AM, his hospital bed was facing forward toward the wall and was not able to be moved or repositioned toward the window. R124 stated that he had requested, for the past year, that his bed have the ability to be moved or repositioned to face the window so that he could see his family when they come to visit. R124 said that the

1) R124 bed was replaced and repositioned per resident's choice. Nursing Manager confirmed on 11/6/21 that R124 continues to be satisfied with his bed and its position. DON visited R386 with no further dietary concerns and care plan was updated.

2) Residents residing in the facility have the potential to be affected. Audit was done with current residents and any newly identified concerns were addressed.

3) Nursing staff re-educated by SDC/Designee on 10/14/21, and on an ongoing basis, regarding resident choices and to bring them to a nursing supervisor's attention as warranted. Staff will report resident choices to ADON/designee as warranted for follow up. Dietary staff re-educated by Registered Dietitian (RD)/Designee on 10/5/21 regarding obtaining resident food preferences in a timely manner. In

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F 561	Continued From page 8 facility was aware of the request, but was told that parts/wheels were on order and that the shipment was delayed because of COVID. On 09/30/21 at 01:10 PM, Maintenance Staff (MS)1 was queried about R124's request. MS1 said that they were not aware of any request and/or any order for parts/wheels with shipment delays. On 09/30/21 at 01:39 PM, Certified Nursing Aide (CNA)7 acknowledged that R124's bed was not able to be moved/repositioned to face the window. CNA7 mentioned that the wheels seemed to be stuck in the steer position. On 09/30/21 at 02:30 PM, the facility replaced R124's hospital bed with another hospital bed that was able to be moved or repositioned toward the window as requested by R124. 2) R386 is a 62-year-old female admitted to the facility on 09/03/21 for short-term rehabilitation and surgical wound care services following a severe infection in her left foot. Additional admitting diagnoses include insulin-dependent diabetes and a stage 3 pressure ulcer (bed sore) to her left buttock. On 09/29/21 at 11:33 AM, an interview was done with R386 in her room on the second floor. When asked, R386 stated that no one had ever asked her about her food allergies or preferences, that she had never been given a menu to choose from, that she was not told about alternate menus, and that she had no idea she could ask for anything else other than what was brought on her meal trays. R386 also stated she could not recall being seen by anyone from dietary.	F 561	addition, Monthly Menu and Alternate Menu to be included in Admission Packet, and at admission interview for food preferences, dietary staff to verify knowledge of allergies and confirm that they have received the menus. 4) DON/Designee will conduct audits with 5 residents per week x 4 weeks, then 3 residents per week x 2 months to validate that residents' choice and preferences are met. In addition, this have been included in the Facility's Leadership Rounds to verify ongoing compliance. RD/Designee will audit new admission charts for presence of dietary preferences and follow up as warranted x 2 weeks, then 5 new admissions per week x 2 weeks. DON and RD will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	

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F 561	Continued From page 9 On 10/01/21 at 09:14 AM, an observation was done of R386 in her room on the second floor as the registered nurse (RN)31 administered her 09:00 AM medications. R386's breakfast tray was sitting on her bedside table with less than 25% of her breakfast eaten. When RN31 asked, R386 stated she did not want to eat anything else from the tray. On 10/04/21 at 09:35 AM, an observation was done of R386 in her room on the second floor. R386's breakfast tray was sitting on her bedside table with less than 25% of her breakfast eaten. When asked, R386 stated she "ate the cereal only, the rest just doesn't appeal to me." R386 also confirmed that no one had come by yet to ask her about her food preferences. On 10/04/21 at 03:14 PM, a review of R386's electronic health record (EHR) noted the initial Dietary Note documented on 09/30/21 did not include any mention of R386's food preferences or allergies, nor were they documented in her comprehensive care plan, or found anywhere else in her EHR.	F 561		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to	F 584		11/26/21

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F 584	Continued From page 10 use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to exercise reasonable care for the protection of at least two residents' property from loss, as evidenced by the presence of Resident (R)11's pictures and personal items on display above R37's headboard, and the inability to immediately identify where R37's personal effects	F 584	1) R11 and R37 personal properties were moved to their respective rooms. 2) Belongings of current residents residing in the facility have been audited and no other residents have been identified.	

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F 584	Continued From page 11 were located. This deficient practice has the potential to result in not providing residents with a homelike environment and loss of resident's personal property. Findings include: On 09/29/21 at 12:45 PM, a phone interview was done with R37's Resident Representative (RR). RR shared concerns that because R37 had been moved "so many times lately [due to a COVID outbreak]", she didn't know if R37 still had all her personal effects, such as vases, eyeglasses, and pictures. RR stated she had noticed pictures of people she did not recognize on the wall above R37's headboard during the last two FaceTime calls. On 09/30/21 at 02:20 PM, an observation and concurrent interview was done in R37's room on the second floor. When asked, Registered Nurse (RN)70 identified the pictures and personal effects on the board above R37's headboard as belonging to R11. None of R37's property was observed near or around her. RN70 stated that resident property was left in their old rooms because the residents move so much. When questioned further, RN70 admitted that she did not really know what happened to residents' property when they changed rooms during the outbreak and directed this surveyor to "ask the manager." On 09/30/21 at 02:25 PM, an interview was done with Assistant Director of Nursing (ADON)1 at R37's bedside. ADON1 acknowledged that the personal property currently with R37 was not her own and belonged to R11. ADON1 stated that staff had been trained that personal property	F 584	3) SDC/Designee re-educated housekeeping, nursing, and maintenance staff on 10/14/21, and on an ongoing basis, regarding moving residents' personal property, including items on the walls and in the closet when changing rooms. 4) Social Services Director (SSD)/ Designee will audit 5 room moves per week x 4 weeks to validate property is moved as they occur. In addition, this have been included in the Facility's Leadership Rounds to verify ongoing compliance. SSD will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	

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F 584	Continued From page 12 should always be moved with the resident and inventoried after each movement.	F 584		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge,	F 623		11/26/21

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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 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

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F 623	Continued From page 14 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, interview with staff members, and review of the facility's policy and procedures, the facility did not assure residents or residents' representatives were provided with a written notice of transfer/discharge which included the required contents for 2 (Residents 113 and 20) of 4 residents sampled for hospitalization and one add-on (Resident 136). The deficient practice has the potential to cause a lack of communication between the facility and the resident and/or resident representative. Also, the deficient practice has the potential to deny residents' right to appeal the decision for a discharge or transfer. Findings include:	F 623	1) R113, R20 and R136 have returned from the hospital. Family and/or representatives are aware. The Ombudsman was notified of R136 hospital transfer, notice has been uploaded into resident's electronic health records (EHR). 2) Current residents transferring out to acute care have the potential to be affected. 3) SDC/Designee educated Licensed Nurses (LNs), Social Services, and Medical Records Staff on 11/4/21, and on an ongoing basis, regarding the process for notification with discharge.	

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F 623	Continued From page 15 1) Resident (R)20 was transferred to the hospital on 07/21/21 and readmitted to the facility. R20 was transferred to the hospital on 08/19/21 and later readmitted to the facility. Record review could not find documentation that written notification was provided to the resident or the resident's representative. 2) Resident (R)136 is a 74-year-old male originally admitted to the facility on 02/09/16. During a review of his electronic health records (EHR) on 10/04/21 at 10:47 AM, it was noted that R136 was sent and admitted to an acute care hospital on 09/12/21 with respiratory distress in the presence of COPD (Chronic Obstructive Pulmonary Disease) and COVID. There was no discharge notification or Long Term Care Ombudsman notification found in the EHR for this discharge. 3) R113 was admitted to the facility on 09/18/18. The resident's diagnoses including chronic respiratory failure, sepsis, ventilator Pneumonia, tracheostomy, gastrostomy, and supraventricular tachycardia, hyperkalemia, and major depressive disorder. Conducted a review of R113's Electronic Health Record (EHR) on 09/29/21 at 02:46 PM. A progress note written on 07/30/21 at 08:00 AM by Nurse Practitioner (NP)1 documented R113 was transferred to an acute hospital on 02/02/21 to 02/11/21 due to septic shock. A copy of a Discharge/Transfer Notice for admission to the acute hospital was not found in the resident's EMR. 4) On 10/04/21 at 12:00 PM, reviewed the "Discharge/Transfer Notice" provided by the	F 623	4) Medical Records Director (MRD)/Designee will audit residents discharged weekly x 4 weeks to verify that appropriate notification was provided. MRD will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	

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F 623	Continued From page 16 facility. Review of the notice documented the form was for the Ombudsman's and not the Resident Representative. On 10/04/21 at 12:05 PM, during an interview with the Administrator inquired if residents and resident representatives are notified in writing, when a resident is transferred or discharged. The Administrator confirmed the facility only provides a written notification to the Ombudsman. Resident representatives are called prior to the resident's transfer or discharge and are not provided with any written notification. On 10/04/21 at 12:08 PM, conducted an interview with R113's representative. The resident representative did not receive a written notice of transfer or discharge for R113's transfer to an acute hospital on 02/2/21 to 02/11/21. 5) On 10/04/21 at 02:43 PM, an interview was done with the Administrator, the Director of Nursing (DON), and the Medical Records Manager (MRM) in the Administrator's Office. The DON and the Administrator confirmed that written discharge notification should be given to the resident and/or their representative and sent to the LTCO for all discharges and transfers. The MRM confirmed that no written notification was created or issued for R136's discharge on 09/12/21.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or	F 625		11/26/21

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F 625	Continued From page 17 the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure written notification of the facility's bed hold policy was provided to Resident (R)136 or his surrogate upon discharge to an acute care hospital. This deficient practice has the potential to affect all residents at the facility who are discharged to an acute care hospital. Findings include: Resident (R)136 is a 74-year-old male originally admitted to the facility on 02/09/16. During a review of his electronic health records (EHR) on	F 625	1) R136 was readmitted to the facility. 2) Current residents transferring out to acute care have the potential to be affected. 3) SDC/Designee educated Social Services, Admissions, and Medical Records staff on 10/27/21 on the process for notification of Bed Hold Policy with discharge. Bed Hold Policy will be included in the transfer packet for residents transferred to a hospital and	

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F 625	Continued From page 18 10/04/21 at 10:47 AM, it was noted that R136 was sent and admitted to an acute care hospital on 09/12/21 with respiratory distress in the presence of COPD (Chronic Obstructive Pulmonary Disease) and COVID. There was no documentation found in the EHR that written notification of the facility's bed hold policy was issued for this discharge. On 10/04/21 at 02:43 PM, an interview was done with the Administrator, the Director of Nursing (DON), and the Medical Records Manager (MRM) in the Administrator's Office. The DON and the Administrator confirmed that written notification of the facility's bed hold policy should be given to the resident and/or their representative for all discharges to an acute care hospital. The MRM confirmed that no written notification was created or issued for R136's discharge on 09/12/21.	F 625	provided to those going on therapeutic leave. 4) MRD/Designee will audit residents transferred to hospital or goes on therapeutic leave weekly x 4 weeks to verify that notification of bed hold policy was provided and documented. MRD will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656		11/26/21

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F 656	Continued From page 19 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview with staff members, the facility failed to implement the plan of care to ensure: call lights were correctly placed for residents requiring modified call lights; splints were applied for resident with limited range of motion/contracture; interventions (i.e. repositioning, floating heels) for the prevention of pressure ulcers; and correct application of an abdominal binder for a resident with history of pulling out his feeding tube. The failure to implement residents' person-centered comprehensive care plans could potentially result in unmet residents' needs or adverse outcomes	F 656	1) R133, R9, R65, R386, R37, R81, and R113 care plans have been updated and are receiving care as indicated. 2) Residents residing in the facility have the potential to be affected. Residents with skin integrity issues will be audited to verify that MD orders are in place and care planned. 3) SDC/Designee re-educated nursing staff and IDT Team on 10/27/21, and on an ongoing basis, regarding the care plan	

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F 656	Continued From page 20 (development of pressure injuries, re-hospitalization to reinsert gastrostomy tube). Findings include: 1) Resident (R)133 was readmitted to the facility on 05/25/21 following admission to the hospital on 05/24/21 for replacement of gastrostomy tube (a feeding tube that goes directly into the stomach to provide liquid food and fluids) that had been pulled out. On 09/28/21 during the initial tour, R133 was observed lying in bed. Subsequent observation on 09/28/21 at 10:03 AM, R133 was laying in bed with gastrostomy tube (GT) feeding. He was wearing a white abdominal binder . At 10:30 AM, R133's feeding was completed, he was observed with white abdominal binder applied. The Assistant Director of Nursing (ADON)2 did not release the binder while discontinuing the resident's feeding. Observation on 09/29/21 at 02:26 PM found the abdominal binder was applied. On 09/30/21 at 02:50 PM, interviewed Certified Nurse Aide (CNA)197 regarding the use of the abdominal binder. CNA197 reported the binder is released every two hours and is used as R133 had pulled out his tubing. Further queried whether the resident is able to remove the binder, CNA197 demonstrated the binder is affixed with velcro which is placed to the resident's side. During this demonstration, R133's tubing was observed to be hanging below the abdominal binder. CNA197 released and reapplied the binder. R133's tubing was again observed to be hanging below the abdominal binder providing opportunity for the resident to pull the tubing again. CNA197 did not	F 656	process and implementation of residents' plan of care. 4) DON/Designee will conduct audits on 5 residents per week x 4 weeks, then 2 residents per week x 2 months to validate those residents are receiving services according to their preference and plan of care. DON/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	

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secure the feeding tube to prevent resident from pulling it out before she left the room.

Review of the care plan found interventions to apply abdominal binder properly/correctly (make sure binder is snug but not too tight) and apply abdominal binder to prevent him from pulling out his GT (remove and check surrounding skin for redness/irritation, may remove binder every two hours during care).

A review of the progress note (08/31/21) notes R133 has history of pulling out GT, foam mitts were initially applied; however, resident was able to independently remove foam mitts.

2) Cross Reference to F558 - Reasonable Accommodations Needs/Preferences. R9 is a 68-year-old female admitted to the facility on 12/25/18 for long-term care services. Her admitting diagnoses include chronic pain, generalized muscle weakness, and contractures (a shortening and hardening of muscles, tendons, or other tissue, leading to deformity and rigidity of joints) to both knees. R9 cannot get out of bed herself and is mostly dependent on staff for her activities of daily living.

On 09/28/21 at 03:42 PM, an interview was done with R9 in her room on the second floor. R9 reported that "They [staff] don't clean me very well", when asked if she meant when being changed or being bathed, resident stated "both." R9 continued explaining that when she gets changed, staff do not wipe her completely and she always feels dirty. She cannot remember her last bed bath, but describes them as "quick", and stated staff "never" help her wash or clean her hands before meals. When asked, R9 stated she

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does not get up to shower, and she stays in bed every day. R9 also stated that no one ever asks her if she would like to get up to her wheelchair.

On 10/04/21 at 01:41 PM, a review of R9's CP revealed the following: "Resident to be up out of bed everyday (sit) for approximately 2 hours (after lunch around 1300) as preferred."

3) R65 is a 56-year-old male admitted to the facility on 11/20/2018 for long-term care services. R65's diagnoses include left-sided hemiplegia (paralysis on one side of the body) and hemiparesis (muscle weakness affecting one side of the body) following a cerebral infarction (stroke), a dense contracture (a shortening and hardening of muscles, tendons, or other tissue, leading to deformity and rigidity of joints) of the left elbow, and decreased range of motion of both hands and fingers. As a result of these conditions, R65 can no longer grasp anything, cannot activate a button-type call light, has great difficulty activating a pad-type call light, and is fully dependent on staff for all activities of daily living.

On 09/28/21 at 03:22 PM, an observation and concurrent interview were done of R65 in his room on Unit 3. R65 was lying in bed with his "E-Z touch call light" (a wide-based touchpad call light designed for individuals with limited movement) positioned six inches below his left elbow. When asked if he could reach it, R65 stated "where is it?" and tried to move his head to see the call light but could not lift his head from the pillow. After this surveyor pointed to where the call light was located, R65 reported he could neither see nor reach the call light. Despite visible contractures, no splints, bedrolls, or other

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contracture support(s) were observed either on or near his person.

On 09/30/21 at 02:32 PM, an interview was done with restorative nurse aide (RNA)121 at the Unit 3 nurse's station. RNA121 stated she had just returned to Unit 3 the previous day, after being moved to Unit 2 during the COVID outbreak. When asked about her general observations of the residents on Unit 3 after not seeing them for weeks, RNA121 stated she had noticed overall a decline in range of motion and hygiene for the residents. RNA121 also confirmed that since she came back up to Unit 3, she had not observed any of the residents wearing their splints or seen any splints at the bedside.

On 09/30/21 at 03:30 PM, a review of R65's CP revealed the following: "Keep call light and frequently used items within reach at all times.", and "The soft elbow splint left elbow will be worn to prevent further contractures ...the left resting hand splint will be worn per wearing scheduled ...the right hand resting splint will be worn 5 hours after am [morning] care removed after 5 hours and put back on after dinner for 5 hours."

4) R386 is a 62-year-old female admitted to the facility on 09/03/21 for short-term rehabilitation and surgical wound care services following a severe infection in her left foot. Additional admitting diagnoses include insulin-dependent diabetes and a stage 3 pressure ulcer (bed sore) to her left buttock.

On 09/28/21 at 03:26 PM, an observation and concurrent interview were done with R386 in her room on the second floor. R386 was observed sitting at the edge of her bed with the bed in its

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lowest position, her left foot and ankle were bandaged, and she was noted to be sitting on a regular mattress on her bed. R386 stated that she was seen by the wound care team once a week for her left foot wound, a right thigh wound (where skin had been grafted from), and the pressure ulcer on her left buttock. When asked, R386 stated that the wound care team keep telling her she should be on a pressure-relieving mattress to promote wound healing of her pressure ulcer, but the facility still had not issued her one.

On 09/29/21 at 11:33 AM, an interview was done with R386 in her room on the second floor. When asked, R386 stated that no one had ever asked her about her food allergies or preferences, that she had never been given a menu to choose from, that she was not told about alternate menus, and that she had no idea she could ask for anything else other than what was brought on her meal trays. R386 also stated she could not recall being seen by anyone from dietary. During the same interview, R386 stated she had been confined to her room since admission due to a COVID outbreak in the facility and throughout that time, had not been offered activities in her room, had not been offered zoom visits with family, and stated that no one had come in to ask her questions about her normal activities or preferences. R386 stated she could not wait for visits to start because she missed her family.

On 09/30/21 at 03:15 PM, a review of R386's comprehensive care plan revealed the following intervention was initiated on 09/09/21: "Pressure relieving mattress to bed." It was also noted that the CP did not have an activities care plan.

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On 10/04/21 at 03:14 PM, a review of R386's electronic health record (EHR) noted the initial Dietary Note documented on 09/30/21 did not include any mention of R386's food preferences or allergies, nor were they documented in her comprehensive care plan, or found anywhere else in her EHR.

5) Cross Reference to F558 - Reasonable Accommodations Needs/Preferences. R37 is a 79-year-old female admitted to the facility on 01/19/21 for long-term care services with diagnoses that include quadriplegia (paralysis of all four limbs) and right hand and left elbow contractures. As a result of these conditions, R37 is fully dependent on staff for all activities of daily living.

On 09/28/21 at 03:32 PM, an observation was done of R37 in her room on Unit 3. R37 was asleep in bed and her call light was not visible anywhere on her bed, or on her person. Also, despite visible contractures, no splints, braces, bedrolls, or other contracture support(s) were observed either on or near her person.

On 09/29/21 at 01:54 PM, a review of R37's CP revealed the following: "Place the E-Z touch call light on her stomach when she is in bed ...", and "Apply AFO [a brace usually made of plastic that provides correction, support, and/or protection] to both feet, R [right] hand and L [left] elbow splints ..."

6) On 09/29/21 at 11:35 AM and 10/01/21 at 09:40 AM, observed R81 in bed resting, with a pillow placed under both resident's calves, and both heels were in direct contact with the bed.

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On 10/01/21 at 09:41 AM, RN89 and this surveyor observed R81's heels in direct contact with the bed and the placement of a pillow under the resident's calves. RN89 confirmed the resident's heels were in direct contact with the bed and a pillow was placed under the resident's calves to elevate the resident's heels off the surface of the bed for pressure ulcer prevention. However, the pillow was not placed properly, allowing the resident's heels to be in direct contact with the bed, putting the resident at risk of developing pressure ulcer(s) to one or both heels. RN89 also confirmed, the R81 is unable to reposition himself/herself in bed and requires 2-person assistance in bed.

On 10/01/21 at 3:35 PM, conducted a review of R81's Electronic Health Record (EHR). Review of R81's care plan documented the resident has the potential/actual impairment to skin integrity related to decreased mobility and weakness with an intervention to float heels when in bed as he/she allows. Review of the R81's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/04/21 documented in Section G. Functional Status, A0110. Activities of Daily Living (ADL) Assistance A. Bed Mobility- how a resident moves to and from lying position, turns side to side, and positions body while in bed or alternative sleep furniture, R81 requires extensive assistance with two or more persons for physical assist.

7) On 09/29/21 at 10:58 AM and 1:00 PM and 10/01/21 at 09:35 AM and 11:45 AM, observed R113 lying supine (on the resident's back) in bed.

On 10/01/21 at 3:36 PM, conducted a review of R113's EHR. Review of R113's care plan for skin

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F 656	Continued From page 27 integrity, the resident should be encouraged to turn every two hours and as needed. Review of the resident's annual MDS with an ARD of 08/25/21 documented R113 in Section G. Functional Status, A0110. Activities of Daily Living (ADL) Assistance A. Bed Mobility- how a resident moves to and from lying position, turns side to side, and positions body while in bed or alternative sleep furniture, R81 requires extensive assistance with two or more persons for physical assist. On 10/01/21 at 11:45 AM, conducted an interview with RN89 while making an observation of R113. Informed RN89 of observations made by this surveyor, during which the resident was not turned or repositioned every 2 hours or as needed. RN89 confirmed R113 should have been turned but was not.	F 656		
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	F 657		11/26/21

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F 657	Continued From page 28 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 observations, record review and interview with staff members, the facility failed to ensure a care plan (CP)was revised to include interventions for the prevention of pressure injuries. Findings include: R386 is a 62-year-old female admitted to the facility on 09/03/21 for short-term rehabilitation and wound care services following a severe infection in her left lower leg and foot. Additional admitting diagnoses include insulin-dependent diabetes and a stage 3 pressure ulcer (bed sore) to her left buttock. As a result of her multiple wounds upon admission, R386 was referred to the wound care team consultants for weekly wound assessments and treatment. On 10/04/21 at 03:03 PM, during a review of R386's electronic health record (EHR), a Wound Care SNF [skilled nursing facility] Consult Service Progress Note (PN), dated 09/22/21, was found. Documented by a Physician Assistant (PA)1 consultant on the wound care team, a review of the progress note revealed the following: " ...heel	F 657	1) R386 skin care plan has been revised. 2) Residents with skin integrity issues will be audited to verify that MD orders are in place and care planned. Revisions will be made as indicated. 3) SDC/Designee re-educated nursing managers, MDS nurses, and IDT team on 10/27/21, and on an ongoing basis, regarding care plan revision process. 4) DON/Designee will audit 5 resident care plans with skin integrity issues weekly x 4 weeks to verify that revisions have been completed if needed. DON/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	

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F 657	Continued From page 29 lifts ordered 09/08/21, pending as of 09/22/21 ...RN to escalate 09/22/21 ..." and "Recommend daily dressing changes. Order placed 09/22/21 ..." Further review of R386's EHR noted her CP did not reflect these orders/recommendations.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interview with resident representative and staff members, the facility failed to ensure activities of daily living were provided to 2 (Residents 132 and 9) of 3 residents who are dependent on staff for activities of daily living. As a result of this deficient practice, both residents were hindered from attaining their highest practicable well-being and placed residents at risk for a decreased quality of life. Resident (R)132 is dependent on staff for oral hygiene was observed with built up white substance between the teeth, this deficient practice has the potential for residents developing gum disease of loss of teeth. R9 observed with lack of personal hygiene and decreased range of motion. Findings include: 1) On the morning of 09/29/21 observed Resident (R)132 in her room laying in bed awake. Surveyor greeted R132, she smiled in response and mouthed "hi". Observed white substance between her upper front teeth. Inquired whether	F 677	1) R132 had their teeth brushed, but white substance is not removable with routine oral care. Dental consult is scheduled for 11/9/21. R132 has had the white substance build up prior to admission. R9 was bathed, hair brushed, nails cleaned, provided a clean gown and sheets, and care plan was updated. R58 had hand hygiene provided and care plan was updated. 2) Residents residing in the facility have the potential to be affected. 3) SDC/Designee re-educated nursing staff on 10/14/21, and on an ongoing basis, regarding providing oral care and hand hygiene for residents. 4) DON/Designee will observe/interview 5 residents per week x 4 weeks, then 2 residents per week x 2 months to verify that oral care, bathing, and hand hygiene were provided. DON/Designee will report	11/26/21

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F 677	Continued From page 30 staff members brush her teeth, she nodded yes. Interview with the Resident Representative (RR) was done on 09/29/21 at 02:00 PM. RR reported that when visiting, it was noted that there is substance between R132's teeth. RR stated it looks like built up tartar. Review of R132's quarterly Minimum Data Set with assessment reference date of 09/07/21 notes the resident has modified independence (some difficulty in new situations) for cognitive skills of daily decision making. R132 also noted to require extensive assistance with two+ persons physical assist for personal hygiene which includes teeth brushing. Section L., Oral/Dental Status notes no dental concerns. R132 also receives nutrients via feeding tube. Concurrent observation of R132 in her room was done with Unit Manager (UM)4 on the morning of 10/04/21. Upon opening of her mouth, UM4 commented R132 probably needs a dental consult for teeth cleaning. 2) R9 is a 68-year-old female admitted to the facility on 12/25/18 for long-term care services. Her admitting diagnoses include chronic pain, generalized muscle weakness, and contractures (a shortening and hardening of muscles, tendons, or other tissue, leading to deformity and rigidity of joints) to both knees. R9 cannot get out of bed herself and is mostly dependent on staff for her activities of daily living. On 09/28/21 at 03:42 PM, an observation and concurrent interview were done with R9 in her room on Unit 3. R9 was sitting up in bed wearing a dirty gown, hair matted and tangled, black bits of debris noted on the sheet on her right side, and	F 677	findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	

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F 677	Continued From page 31 a thick layer of black dirt was observed caked under each fingernail. R9 stated "they don't clean me very well," when asked if she meant when being changed or being bathed, R9 answered "both." R9 continued explaining that when she gets changed, staff do not wipe her completely and she always feels dirty. She cannot remember her last bed bath, but describes them as "quick", and stated staff "never" help her wash or clean her hands before meals. R9 also stated that staff will only cut her nails for her when they are "really long, but they never clean them." On 09/30/21 at 02:32 PM, an interview was done with restorative nurse aide (RNA)121 at the Unit 3 nurse's station. RNA121 stated she had just returned to Unit 3 the previous day, after being moved to Unit 2 during the COVID outbreak. When asked about her general observations of the residents on Unit 3 after not seeing them for weeks, RNA121 stated she had noticed overall a decline in range of motion and hygiene for the residents. RNA121 explained that she had gone into R58's room to do her RNA program and when she went to stretch the fingers on R58's right hand, she noticed a "smelly" foul odor, and had to clean caked up dirt from the resident's hand.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		11/26/21

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F 689	Continued From page 32 accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview with staff members, the facility failed to ensure a resident who independently self-propels inside and outside of the facility receives supervision of his whereabouts, specifically when he is outside of the facility. Also, the facility did not assure there is a safety plan in place should resident require assistance. This deficient practice has the potential to result in a fall or place resident in a hazardous situation. Findings include: On 09/28/21 during the initial tour of the facility, Resident (R)48 was not in his room. Asked Certified Nurse Aide (CNA)197 where is R48. CNA197 stated if he is not in bed he may be in the lobby area (by the television), informed CNA that there are no residents in the lobby area, she then stated he may be on the lanai outside of the dining room. Concurrent observation was done with the CNA, R48 was not on the lanai. CNA197 was agreeable to look for R48. R197 returned and stated that R48 was downstairs in the parking lot by the elevator. Inquired whether he was waiting to go for hemodialysis, she replied he goes to HD on Mondays, Wednesdays and Fridays. Observation on 09/29/21 at 01:40 PM found R48 sitting in the lobby area in front of the television. R48 observed with a cellular phone hanging around his neck. Asked the resident if he is able to use the cellular phone, he responded yes. Further queried whether he informs the staff when he goes outside of the facility, he shook his	F 689	1) R48 can self-propel with wheelchair and likes to go outside in front of the facility or to the garage. Resident understands and can ring doorbell at the gate for re-entrance. MD has determined that resident is safe to go outside on his own without supervision and care plan has been updated. 2) Residents residing in the facility who can independently self-propel themselves outside of the facility has the potential to be affected. Audit of residents that are independently seeking time outdoors or in the garage will be done and those identified will have a care plan developed by the IDT with interventions as needed. 3) SDC/Designee re-educated staff on 10/14/21, and on an ongoing basis, regarding residents' safety and assuring that staff is aware of the whereabouts of their residents and where to find individualized interventions for residents found to be at risk for harm from wandering. 4) Activities Director/Designee will observe residents who are able to self-propel outside 4x/week x 8 weeks to verify compliance with resident's care plan. Activities Director will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	

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head no. Also asked what is he going to do if he falls out of his wheelchair and he is outside, R48 responded, by shaking his head "no" and waving his hands at the surveyor. Then asked whether he is able to use the phone, he nodded yes, removed the phone from the holder to show the surveyor his phone.

Record review notes R48 was readmitted on 07/09/21. Diagnoses include, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dyspahgia following cerebral infarction, and end stage renal disease. Further review of quarterly "Wandering Risk Scale" from 10/23/20 to 09/24/21 assesses R48 at low risk. R48 is up in wheelchair and is able to propel wheelchair without assistance and does not exhibit exit seeking behaviors.

A review of the quarterly Minimum Data Set (MDS) with assessment reference date (ARD) of 07/21/21 documents R48 did not exhibit wandering behavior. Previous quarterly assessments of 04/12/21 and annual assessment of 10/18/20 codes R48 as not exhibiting wandering behavior. The facility developed a care plan for wandering, initiated 08/10/21 which includes intervention for staff to redirect resident with activities when wandering and/or exit seeking behaviors are exhibited. The care plan did not include interventions to monitor the resident's whereabouts or process for resident signing out of the facility and a safety/crisis plan to get help if needed.

An incident note dated 09/24/21 documents at approximately 12:15 PM a CNA observed R48 attempt to transfer from the bed to the wheelchair. Assistance was offered but resident

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F 689	Continued From page 34 "strongly refused". At approximately 12:20 PM resident was seen lying on the floor, he stated he slipped and fell when he was transferring himself from bed to wheelchair.	F 689		
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. §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, interview, and record review, the facility failed to ensure all medications used in the facility were labeled in accordance with professional standards, including current	F 761	1) R31's insulin pen is properly labeled with a sticker indicating "Directions changed refer to chart".	11/26/21

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F 761	Continued From page 35 dosages to be administered. Proper labeling of medications is necessary to promote safe administration practices and decrease the risk for medication errors. Findings include: On 10/01/21 at 09:26 AM, medication pass observations were conducted with Registered Nurse (RN)31 in Unit 3 on the second floor. As RN31 prepared the insulin administration for Resident (R)38, surveyor asked RN31 what dosage she was preparing to give, to which RN31 answered "6 units." A review of the insulin pharmacy label at the time read: "Novolog Flexpen 100 units/mL Inject SQ [subcutaneously] 5 units in the morning with breakfast ..." When asked about the discrepancy in dosage, RN31 stated that the physician had increased the morning dose to 6 units on 09/20/21. This change in dosage was confirmed by a review of the order by this surveyor. When asked if it was normal practice to continue to use an insulin pen labeled with outdated dosage instructions, RN31 stated facility practice did allow continued usage, however the outdated instructions on the pharmacy label should have been covered with a red pharmacy alert sticker that read: "DIRECTIONS CHANGED REFER TO CHART."	F 761	2) Residents residing in the facility with current insulin orders have the potential to be affected. Audit of insulin orders were completed to verify label matches current dosage with no additional residents identified. 3) SDC/Designee re-educated LNs on 10/14/21, and on an ongoing basis, regarding procedure to update insulin pens by placing a sticker when a dose is changed. 4) DON/ Designee will audit insulin order changes weekly x 4 weeks to verify that MD order matches dose on insulin pen or a sticker is in place indicating a change in the order. DON/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	
F 807 SS=D	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident	F 807		11/26/21

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F 807	Continued From page 36 hydration. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to implement a hydration program that recognizes, evaluates, and addresses the hydration needs of every resident. This is evidenced by a failure to offer fresh water daily to one resident (R)9 in the sample. Individuals who do not receive adequate fluids are more susceptible to urinary tract infections, pneumonia, pressure injuries, skin infections, confusion, and disorientation. Findings include: R9 is a 68-year-old female admitted to the facility on 12/25/18 for long-term care services. Her admitting diagnoses include chronic pain, generalized muscle weakness, and contractures (a shortening and hardening of muscles, tendons, or other tissue, leading to deformity and rigidity of joints) to both knees. R9 cannot get out of bed herself and is mostly dependent on staff for her activities of daily living. On 09/28/21 at 03:42 PM, an observation and concurrent interview were done with R9 in her room on the second floor. A water jug was observed on R9's bedside table less than half-full. When asked, R9 stated the water jug will stay there until empty and she asks for more water, staff do not check the status of her water, or offer/bring her fresh water routinely. On 09/30/21 at 08:38 AM, an observation was done of R9 in her room on the second floor. R9's water jug was observed on her bedside table less than a quarter-full. When asked, R9 confirmed	F 807	1) R9 was provided with a new water jug and care plan was updated. Visit done by DON on 11/6/21 confirmed that resident had newly refilled water and is happy with current plan of care. 2) Residents residing in the facility have the potential to be affected. 3) SDC/Designee re-educated nursing staff on 10/28/21, and ongoing basis, regarding the process for passing water to residents and the hydration cart. 4) DON/Designee will audit 5 residents per week x 4 weeks, then 2 residents per week x 2 months to validate that water pass and hydration cart process is being followed. DON/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	

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F 807	Continued From page 37 that it was the same water from the two days prior. R9 stated that she usually only drinks the fluids on her meal tray because she knows those are fresh and cold. On 09/30/21 at 02:28 PM, an observation and concurrent interview were done with certified nurse aide (CNA)179 as she conducted "nourishment" rounds on the second floor. CNA179 stated she did nourishment rounds at 10:00 AM and 2:00 PM daily, offering fluids to all the residents and distributing snacks to those residents who received snacks. The cart she pushed around was observed to contain two carafes of juice, packaged crackers labeled with specific resident's names, no water, and no ice. CNA179 was observed offering R9 juice, which R9 refused. No alternatives for hydration were offered before CNA179 continued on to the next room.	F 807		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		11/26/21

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F 880	Continued From page 38	F 880		

reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(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

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F 880	Continued From page 39 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement the following infection prevention and control measures, and failed to implement the following protective measures to prevent the spread of COVID-19: 1) Staff member did not sanitize pulse oximeter and blood pressure cuff between residents while taking vitals for Residents (R) 133 and 114. 2) Staff failed to change the enteral feeding administration set every twenty-four hours as recommended by the manufacturer for R113. 3) Maintenance Staff failed to properly transport soiled laundry by throwing soiled laundry bags off the second-floor landing onto the ground below. 4) Staff did not ensure urinals for R71 and R136 were not placed on the residents' bedside tables which were used for eating their meals. The deficient practice placed R71, R113, R114, R133, R136 and all other residents at risk for potential spread of infection and/or spread of communicable diseases. Findings include: 1) On 10/01/21 at 09:20 AM observed Certified Nurse Aide (CNA)93 taking vitals for Resident	F 880	1) R114 did not develop an infection. R113 had their enteral feeding and supplies replaced. R136 and R71 had their bed side tables disinfected. Maintenance staff were re-educated on proper handling of soiled linen. 2) Residents residing in the facility have the potential to be affected. 3) SDC/Designee re-educated staff on 10/14/21, and on an ongoing basis, on the importance of maintaining Infection Control Policy and Procedures. 4) DON/Designee will audit infection control practices using the Infection Control Surveillance Tool 5x per week x 8 weeks. DON/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	

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(R)133. CNA93 removed the pulse oximeter from the resident's finger and placed it in the basket of the mobile stand. No sanitizing of the pulse oximeter was observed before CNA93 placed it back in the basket of the mobile stand. CNA93 exited the room, no hand sanitizing or sanitizing of blood pressure cuff and pulse oximeter were observed. CNA93 spoke to CNA197 then entered Room 122 (no hand sanitizing was performed upon entering the room) to take vitals for R114. CNA93 affixed the blood pressure cuff on the resident's arm, took the blood pressure, removed the cuff and rolled it up and placed it in the basket of the mobile stand. CNA93 then placed the pulse oximeter on R114's finger. The pulse oximeter was also placed in the basket. CNA93 did not sanitize the equipment before placing it back in the basket.

On 10/01/21 at 09:30 AM, interviewed CNA197. Inquired after taking vitals, was it required to sanitize the equipment. CNA responded, "yes" and further elaborated the mobile stand had a carton of sanitizing wipes which required a one minute dwell time (amount of time a disinfectant must remain visibly we on surfaces to effectively kill a specific germ/virus/bacteria).

Interviewed CNA93 and asked what she does after taking the residents' vitals. CNA93 responded that she wipes down the equipment. Informed her she was not observed to wipe down the equipment between residents and now the mobile stand was parked in the hall. CNA93 spoke to CNA197 and returned to the mobile stand, removed cloths from the container, wiped down the equipment, but did not don gloves prior to sanitizing the equipment.

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2) On 10/01/21 at 09:00 AM, a review of R113's Electronic Health Record (EHR) documented a physician's order for enteral feed every shift Novasource Renal, continuous feed at 35 milliliters per hour for 20 hours (on 06:00 hours-off 02:00 hours), every 4 hours hydration Flush 200 ML of water via feeding tube.

On 10/01/21 at 09:35 AM, observed a bag of Novasource Renal enteral formula infusing, via closed-system pump, for R113. The Novasource Renal formula bag infusing for R113 was labeled "09/30/21 at 06:00 AM."

On 10/01/21 at 02:50 PM, a review of the facility Policy & Procedure Enteral Feeding Safety Protocol, dated 06/15/21, noted the following: "Administration set changes...Change administration sets for closed-system enteral feedings according to manufacturer's instructions." Review of the equipment (Coviden Epump ENPlus Spike Set) was labeled with a clear printed manufacturer's instruction, "Do not use for greater than 24 hours."

On 10/01/21 at 03:10 PM, conducted a concurrent observation and interview with RN89. An observation was made with RN89 of the same Novasource Renal enteral formula administration set (dated 09/30/21 at 06:00 AM) for R113. Inquired with RN89 how long is enteral formula administration set was considered safe to administer once the bag has been prepared (punctured and primed). RN89 stated the date and time on the formula bag indicates when the formula bag was prepared and the enteral formula is good to be administered for 24 hours from that date and time. RN89 looked at the date and time written on R113's Novasource Renal

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F 880	Continued From page 42	F 880		

enteral formula bag, then stated, "it's labeled 09/30/21 at 06:00 AM and expired on 10/01/21 at 06:00 AM." RN89 acknowledged that the R113's enteral formula administration set had expired on 10/01/21 at 06:00 AM.

3) On 09/28/21 at 10:41 AM, observed Maintenance Staff (MS)10, without gloves, throw approximately 6 bags of soiled laundry off the second-floor stairway landing onto the ground below. The tops of the laundry bags were not fully sealed. After MS10 threw the laundry bags from the second floor, MS10 left the area and returned to the ground floor with a large rolling laundry bin. MS10 then picked up the thrown soiled laundry bags from the ground and placed them into the laundry bin. During an interview with M10 at 10:45 AM, M10 confirmed the contents of the laundry bags was soiled laundry from the "Red Zone" unit, which consisted of residents with active COVID-19 infection.

4) On 09/28/21 at 02:15 PM, an observation and concurrent interview was done with R136 in his room on the second floor. An empty urinal was observed on R136's bedside table. When questioned about it, R136 stated that after the certified nurse aide (CNA) emptied it, "she put it back" on the bedside table. This surveyor asked if the bedside table is ever wiped down before meals, R136 answered "no." The empty urinal was also observed on R136's bedside table on 09/30/21 at 08:33 AM.

On 10/01/21 at 09:24 AM, while observing RN31 administer morning medications to R71 in his room on the second floor, a half-filled urinal was observed sitting in the middle of his bedside table. After administering his oral medications,

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F 880	Continued From page 43 RN31 turned to leave the room. When this surveyor called RN31 back to the bedside and asked her about the urinal, RN31 stated "yeah, it shouldn't be there." RN31 proceeded to don a pair of gloves, emptied and rinsed the urinal, then placed it on R71's left upper bedrail, explaining to R71 that the bedside table is "for food."	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility	F 883		11/26/21

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F 883	Continued From page 44 must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that 5 (Residents 80, 98, 109, 386 and 122) or immunization review either had their influenza immunization refusals documented or had their influenza and pneumococcal immunization status assessed and documented. Coupled with advanced age and chronic conditions, this deficient practice placed these residents at a potential risk of developing influenza and/or pneumococcal infections and related complications such as pneumonia. Findings include:	F 883	1) R98, R109, R386, and R122 continued to refuse immunization and their EHR have been updated per their current vaccination preferences. R80 representative consented and will be receiving their flu shot. 2) Resident currently residing in the facility has the potential to be affected. MRD/Designee will audit consents for compliance for current residents and those identified without documented pneumococcal vaccine will be offered the	

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F 883	Continued From page 45 1) On 10/03/21 at 09:31 PM, an influenza and pneumococcal immunization review was done for the following five residents: Resident (R)80, R98, R109, R386, and R122. The residents' Electronic Health Records (EHRs) were reviewed for documentation that the residents were offered, and either received or refused immunizations they were eligible for, and/or had their immunization status assessed and documented. R80 is a 70-year-old female admitted to the facility on 10/15/11. Review of R80's EHR revealed no documentation that R80, either directly or through her representative, had been offered, received, or refused an influenza immunization in the past year. 2) R98 is a 45-year-old male originally admitted to the facility on 10/02/18. Review of R98's EHR revealed documentation that R98 had refused the offer of an influenza immunization in the past year, however his signed declination could not be found. 3) R109 is a 77-year-old male admitted to the facility on 08/20/21. Review of R109's EHR revealed no documentation that his influenza immunization status or eligibility had been assessed or discussed. 4) R386 is a 62-year-old female admitted to the facility on 09/03/21. Review of R386's EHR revealed no documentation that her influenza or pneumococcal immunization status or eligibility had been assessed or discussed. 5) R122 is an 86-year-old male admitted to the facility on 05/26/21. Review of R122's EHR	F 883	vaccine and place documentation in chart. Currently, the influenza vaccine is being offered to residents and documentation of response will be placed in residents' EHR. 3) SDC/Designee re-educated nursing staff on 11/4/21, and on an ongoing basis, regarding documentation of vaccines, including paper consent form. 4) MRD/Designee will audit new admissions weekly x 4 weeks to verify that influenza and pneumococcal immunization refusals are documented or had their influenza and pneumococcal immunization status assessed and documented. MRD will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	

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F 883	Continued From page 46 revealed no documentation that his influenza or pneumococcal immunization status or eligibility, either directly or through his representative, had been assessed or discussed. The missing documentation listed above was requested from the Medical Records Manager (MRM) on 10/04/21 at 08:49 AM. On 10/04/21 at 11:14 AM, a brief interview was done with the Director of Nursing (DON) and the MRM in the conference room. Both verbally confirmed that the documentation requested above could not be located.	F 883		
F 885 SS=D	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a	F 885		11/26/21

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F 885	Continued From page 47 confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to inform two residents (Residents 101 and 111) in the sample by 5 PM the next calendar day following the occurrence of confirmed COVID-19 infection of more than three residents and staff and cumulative updates thereafter. 62 residents and 31 staff were confirmed with COVID-19 infection. The residents were not provided notification in writing from the facility during the COVID-19 outbreak. Findings include: Surveyor reviewed a copy of the letter sent to the resident, families, friends, and staff on 09/10/21. "Despite our best efforts to prevent COVID-19 from being introduced into our facility, it has been confirmed through PCR testing conducted yesterday, that 26 residents and six (6) additional staff members tested positive for COVID-19 since the last update. In total, 26 residents and seven (7) staff members have tested positive since the beginning of the outbreak on September 3rd. All residents currently remain at the facility and are being monitored closely. The COVID-19 unit has been activated with dedicated staffing. Based upon our initial contact tracing, it is believed that COVID-19 entered the building through a staff member who contracted the virus in the community." Surveyor reviewed a copy of the letter sent to residents, families, friends, and staff sent on	F 885	1) R101 is aware of facility's current COVID Status and visit with DON on 11/6/21 confirmed that they have been provided with written updates. R111 was discharged to home. 2) Residents currently residing in the facility do not have the potential to be affected due to no active COVID status. 3) SDC/Designee educated NHA and Social Services Staff on 10/27/21, and Nursing Staff on 10 11/4/21, and on an ongoing basis, regarding the procedure to notify residents and responsible party when a COVID outbreak occurs. 4) If an outbreak occurs indicating the need of a notification, SSD/Designee will audit notifications daily x 4 weeks to verify that they were provided timely. SSD/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	

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	125019	A. BUILDING _____ B. WING _____	10/04/2021

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F 885	Continued From page 48	F 885		

09/28/21. "Total of 62 residents and 31 staff members have tested positive for COVID-19. Eight residents were transferred to the hospital due to COVID symptoms requiring acute care...three residents have since returned from the hospital, one discharged home and one is recovering in the COVID unit. All other residents but two remain at the facility and have completed their quarantine.

The facility experienced COVID outbreaks in November, April, and August of this year totaling two (2) residents, eight (8) employees, and one (1) contractor who tested positive."

On 10/01/21 at 10:16 AM surveyor interviewed Resident (R)101 in her room. Surveyor asked R101 if she or her family received a letter from the facility to inform her when staff or resident's tested positive for COVID-19. R101 stated that she wasn't told about anyone with COVID-19 and that one day the staff came in, shut their doors, gave her and her roommate masks, and there was a lot of commotion. We never received anything in writing that we had anyone in the facility with active COVID. My family who lives on the mainland saw it on the news that there was an outbreak here and they called me to ask if I was okay.

On 10/01/21 at 11:00 AM, surveyor interviewed R111 in his room. Surveyor asked R111 if he received a written letter from the facility to inform him when the first staff and residents tested positive for COVID-19. R111 replied that he did not receive a letter and that he learned of the outbreak from the staff when they shut the doors and gave them a mask to wear. R111 stated that he didn't know if his son received notification

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F 885	Continued From page 49 about the outbreak. On 10/02/21 at 01:06 PM surveyor interviewed the DON/IP and Administrator in the physical therapy conference room. Surveyor asked how the facility notified the residents and family/ representatives of the outbreak by 05:00 PM the following day after the first staff and residents tested positive with COVID-19. The Administrator responded that after the first staff tested positive, a letter was drafted and passed out to alert residents, copies of the letter were placed on the infection control board and families were sent a copy of the letter by e-mail. Surveyor discussed the resident interviews with two alert residents who stated they did not receive any notice from the facility about the COVID outbreak and weren't aware that their emergency contacts were notified.	F 885		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and	F 887		11/26/21

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F 887	Continued From page 50 risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).	F 887		

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F 887	Continued From page 51 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that 3 of 5 residents selected for vaccination review either had their COVID-19 vaccination refusals documented or had their vaccination status assessed and documented. Coupled with advanced age and chronic conditions, this deficient practice placed these residents at an increased risk of developing a COVID-19 infection. This deficient practice has the potential to affect all residents at the facility. Findings include: 1) On 10/03/21 at 09:31 PM, a COVID-19 vaccination review was done for the following three residents: resident (R)98, R109, and R122. The residents' electronic health records (EHRs) were reviewed for documentation that the residents were offered, and either received or refused a COVID-19 vaccination, and/or had their vaccination status assessed and documented. R98 is a 45-year-old male originally admitted to the facility on 10/02/18. Review of R98's EHR revealed documentation that R98 had refused the offer of a COVID-19 vaccination, however his signed declination could not be found. 2) R109 is a 77-year-old male admitted to the facility on 08/20/21. Review of R109's EHR revealed no documentation that his COVID-19 vaccination status or eligibility had been assessed or discussed. 3) R122 is an 86-year-old male admitted to the facility on 05/26/21. Review of R122's EHR revealed no documentation that his COVID-19	F 887	1) R98, R109, and R122 vaccination records have been updated to reflect current COVID vaccination status. 2) Residents currently residing in the facility without documented COVID vaccinations have the potential to be affected. MRD/Designee will audit consents for compliance for current residents. 3) SDC/Designee re-educated the nursing staff on 11/4/21, and on an ongoing basis, regarding documentation of vaccines including paper consent form. 4) MRD/Designee will audit new admits weekly x 4 weeks for accurate COVID vaccination documentation. MRD/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	

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F 887	Continued From page 52 vaccination status or eligibility, either directly or through his representative, had been assessed or discussed. The missing documentation listed above was requested from the Medical Records Manager (MRM) on 10/04/21 at 08:49 AM. On 10/04/21 at 11:14 AM, a brief interview was done with the Director of Nursing (DON) and the MRM in the conference room. Both verbally confirmed that the documentation requested above could not be located.	F 887		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe, functional, and comfortable environment for residents and staff as evidenced by the following: 1) Room 128 missing a louver and having a torn screen. 2) the bed for R124 not being able to be repositioned. Findings include: 1) On 09/28/21 at 10:38 AM, observed from the exterior, room 128 was missing a louver and the screen was torn directly above the air conditioning unit; and room 134 had between 4 louvers missing and screen was torn right below the air conditioning unit. The missing louver(s) and torn screen in both rooms, were large	F 921	1) R124 bed was replaced, and Nursing Manager confirmed on 11/6/21 that R124 continues to be satisfied with his bed. Rooms 128 and 134 louvers and screens have been repaired. 2) Residents residing in the facility has the potential to be affected. Maintenance audited current beds and will address issues as warranted. Maintenance also performed a room-to-room audit for missing louvers/torn screens and will repair those identified. 3) SDC/Designee re-educated staff on 10/14/21, and on an ongoing basis,	11/26/21

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F 921	Continued From page 53 enough to allow a rodent or other pest to freely enter the rooms. Vulnerable residents who require staff assistance for mobility, repositioning, and/or was totally dependent on staff, and/or unable to functionally operate a call light to alert the staff of their need for assistance would not be able to alert staff if a rodent entered the room. 2) Cross Reference to F561. R124 requested his bed be repositioned toward the window when his family visits so that he can see his family. Further investigation found the bed was unable to move as it was stuck in the steer position. The maintenance department reportedly was not aware of any request and/or orders for parts/wheels with shipment delays.	F 921	regarding identification of needed repairs and the procedure to notify maintenance. 4) Facilities Manager/Designee will observe 5 rooms per week x 4 weeks, then 3 rooms per week x 2 months, to verify that the residents have a safe, functional, and comfortable environment. In addition, this have been included in the Facility's Leadership Rounds to verify ongoing compliance. Facilities Manager/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	