STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE NANI REHABILITATION AND NURSING CENTER	1677 PENSACOLA STREET HONOLULU, HI 96822

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 07/14/23. The facility was found not to be in substantial compliance with §42 CFR 483, Subpart B. The OHCA survey team also investigated complaints and facility reported incidents (ACTS #10409, 10137, 10280, 10249, and 10109). There were deficient practices cited related to ACTS #10280, F609-Reporting of Alleged Violations, F689-Free of Accidents, and F657-Care Plan Revision). Survey Dates: 07/11/23 to 07/14/23 Survey Census: 266 Sample Size: 35	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.	F 550		8/18/23

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

Electronically Signed | 08/11/2023

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. 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 each resident was treated with respect and dignity to enhance the resident's quality of life and individuality for one resident (Resident (R)517) sampled. Findings include: During an interview with R517 on 07/11/23 at 11:55 AM, the resident reported some of the staff are not nice when they respond to her call light and stated, "it's like I'm bothering them, and they can't be bothered." R517 recalled that it made	F 550	Facility filed a grievance regarding R517□s concerns. R517 no longer resides in facility Residents residing in the facility are at risk. Administrator/designee have initiated education for staff on 7/27/23 regarding resident□s right to be treated with respect and dignity to enhance the resident□s quality of life and individuality.	

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F 550	Continued From page 2 her feel like she was not important and her needs did not matter to them. R517 stated, "It's not only what they say, it's how they say it. Like they are irritated when you call for them and they talk to you sharp. It doesn't feel good, but what can I do? I need help." At the time of the interview, a family member (FM3) of R517's roommate, interrupted the interview and collaborated staff's treatment of the resident. FM3 stated they have witnessed staff being more "short" when addressing R517 and some staff treat R517 noticeably different. On 07/12/23 at 02:15 PM, conducted a concurrent interview and record review of R517's electronic health record (EHR) with the Assistant Director of Nursing (ADON). This surveyor informed the ADON of R517's statement regarding staff treatment of the resident. ADON confirmed regardless of how busy staff are, the residents should always be treated in a respectful and dignified manner.	F 550	Administrator/designee will conduct interviews of 5 residents every week x4 weeks, then 4 residents monthly x 2 months to validate if the staff are providing residents their needs and are respectful. Findings will be reported to the QAPI committee x 3 months and if needs are identified in the audits, then will restart audits again.	
F 572 SS=E	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and	F 572		8/18/23

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F 572	Continued From page 3 regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is not met as evidenced by: Based on record review and interview with residents, the facility failed to ensure residents were verbally informed of their rights during their stay in the facility. Findings include: During a Resident Council interview on 07/13/23 at 10:04 AM, five of five Resident Council members (Residents (R)66, R194, R115, R33, and R98) concurred the facility does not discuss Resident Rights anymore. R66 stated the facility used to go over two resident rights at every Resident Council meeting but they have not done this in a long time. Review of the Resident Council minutes from April to June 2023 documented two rights were discussed each month at the meetings; however, Resident Council members concurred the rights were not discussed. Observed in front of the Resident Council members a booklet titled Resident Rights, members stated it was the first time seeing this booklet. R98 commented "...it is all for show." R66 referred to the booklet and stated "...see how it looks brand new."	F 572	Administrator/designee provided education to recreation director on requirements for discussing resident□s rights at resident council meetings on 8/8/23 Residents residing in the facility are at risk. Administrator/designee have initiated education for staff on 7/27/23 on requirements for resident□s rights. At least two resident rights will be read at resident council meetings. In addition, resident rights posters have been placed on each unit. Administrator/designee will attend monthly resident council meetings x3 months to validate that resident's rights are a part of the meeting. Findings will be reported to the QAPI committee x 3 months and if needs are identified in the audits, then will restart audits again.	
F 577 SS=E	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11)	F 577		8/18/23

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F 577	Continued From page 4 §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations and interview with residents and staff member, the facility failed to post in a place readily assessable to residents, family members, and residents' legal representatives, the results of the most recent survey of the facility and/or post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public for two of seven units. Findings include:	F 577	Survey results were placed in visible areas on Piikoi 1 and Piikoi 2 on 7/13/23. Residents residing in the facility are at risk. Administrator/designee has initiated education for staff regarding requirements for accessible survey results on 7/27/23. All units were also checked on 8/2/23 to validate that survey binders were visible to residents, visitors, and staff.	

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F 577	Continued From page 5 During a Resident Council interview on 07/13/23 at 10:04 AM, Resident (R)155 expressed he did know where the facility posted the results of the most recent survey on his unit (Piikoi 1). On 07/13/23 at 10:56 AM at Piikoi 1 and 11:04 AM at Piikoi 2, observations in the hallways of both units (bulletin boards and walls), the posting of the most recent survey results and/or posted notice of the availability of the results were not found. On 07/13/23 at 11:12 AM interview with Staff Development Coordinator (SDC) was done at Piikoi 2. Inquired where the results of the most recent survey was located, SDC found results in the bookshelf behind the nurses station. SDC confirmed the survey results were not accessible to residents and only staff members are allowed in the nurses' station. SDC stated she will move the results to a space in front of the nurses' station wall.	F 577	Administrator/designee will complete an audit on all units to validate that survey results are visible on the unit weekly x4 weeks then monthly x2 months. The administrator/designee will present findings. Findings will be reported to the QAPI committee x 3 months and if needs are identified in the audits, then will restart audits again.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the	F 584		8/18/23

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F 584	Continued From page 6 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 observations and interviews, the facility failed to maintain a clean, homelike environment for one of the sampled residents (Resident (R)187). The standing fan had a heavy buildup of dust on the front screen and fan blades. Findings include: On 07/12/23 at 07:78 AM, observed R187 lying in bed with an empty tube feeding bag hanging on a pole and a fan at her bedside. The fan was on,	F 584	R187□s fan was cleaned on 7/12/23. Residents residing in the facility are at risk. Facility conducted an audit on fans and found no further issues. Administrator/designee has initiated education for staff regarding the requirement to maintain a clean, homelike environment for residents on 7/27/23.	

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F 584	Continued From page 7 facing the resident, and there was a heavy buildup of dust on the front screen. At 02:30 PM, concurrent observation and interview conducted with Licensed Practical Nurse (LPN)1 at R187's bedside. LPN1 confirmed that there was a heavy buildup of dust on the front screen of the fan. Asked LPN1 if she knows how often the fans are cleaned, she advised to check with maintenance or housekeeping since they are responsible for cleaning the fans in the facility. On 07/13/23 at 07:48 AM, observed the front screen of the fan still had a heavy buildup of dust. At 02:04 PM, met the Housekeeping Supervisor (HS) by the nurses' station. Asked HS how often are the fans in the facility cleaned. HS responded they are cleaned monthly and as needed. Showed HS the fan at R187's bedside and asked when was the last time the fan was cleaned. HS responded that if the fan was the personal property of the resident, they are not allowed to perform any type of service on it unless they have a consent from the resident or the resident's family. HS said they will need to remove screws on the screen in order to clean it along with the fan blades which also had a buildup of dust. HS also added that the nursing staff are supposed to notify the resident or their family as well to get consent from them if their personal equipment needed to be serviced by the housekeeping or maintenance staff. Unit Manager (UM)2 entered the room while HS was explaining the process. UM2 confirmed that the fan was dirty and that the staff are supposed to let the nurse on duty know so they can get consent from R187's family. UM2 said she will call the family for consent.	F 584	Administrator/designee will complete an audit for 4 random residents to validate that fan and/or personal items are properly cleaned weekly x4 weeks then monthly x2 months. Findings will be reported to the QAPI committee x 3 months and if needs are identified in the audits, then will restart audits again.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F 609		8/18/23

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F 609	Continued From page 8 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff member, the facility failed to ensure an allegation of sexual abuse was reported immediately, but not later than two hours after the allegation was made to the State Survey Agency. The facility also failed to report the allegation of abuse to adult protective services (APS).	F 609	APS was notified of event report on 7/20/23. Residents residing in the facility are at risk. Administrator and DON have been reeducated on APS notification reporting	

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F 609	Continued From page 9 Findings include: Review of Resident (R)143's Event Report (ACTS #10280) submitted by the facility on 05/10/23 regarding an incident which occurred on 05/09/23, a staff member observed R148 kiss R143 on the cheek. On 07/13/23 at 01:02 PM interview with Administrator was done. Administrator confirmed allegations of abuse are to be reported to the State Survey Agency within two hours after the allegation was made. Administrator further confirmed the incident occurred on 05/09/23 and the facility reported the incident on 05/10/23 which was not within the required timeframe. Inquired if the facility reports allegations of abuse to APS, Administrator stated the facility usually does but does not recall reporting this incident to APS. Review of the facility's policy and procedure number 606 "FREEDOM FROM ABUSE, NEGLECT, and EXPLOITATION Abuse Policies" documents under reporting/response "1. Staff will immediately report allegations or suspicions of abuse to the Administrator, stage agency, adult protective services and other required agencies...within specified timeframes...3. Allegations reported to the Administrator or DON [Director of Nursing], will be reported to required agencies within required timeframes." The facility's policy and procedure did not define the required timeframes.	F 609	requirements for allegations of abuse. An audit was conducted on 8/4/23 to validate that all applicable event reports in the last 90 days were reported to APS. Facility found no further untimely APS notifications on event reporting. Administrator/designee will also complete an audit for all event reports x3 months to validate that appropriate agencies were contacted per reporting requirements. Findings will be reported to the QAPI committee x 3 months and if needs are identified in the audits, then will restart audits again.	
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer.	F 623		8/22/23

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F 623	Continued From page 10	F 623		

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, 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.

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§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 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

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F 623	Continued From page 12 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 interviews and record reviews, the facility failed to provide proper notification of discharge/transfer to 3 of 4 residents in the sample. Residents (R)65, 154, and 153, were transferred and/or discharged to an acute care hospital without receiving written notification of their discharge, their right to appeal the discharge, or contact information for the Office of the State LTC [long-term care] Ombudsman (LTCO). This deficient practice has the potential to affect all residents at the facility when they are discharged or transferred. Findings include: 1) Review of R153's electronic health record (EHR) on 07/11/23 at 03:03 PM noted he was admitted to the facility on 05/30/23 and transferred to the emergency room on 06/13/23. On 07/14/23 at 07:54 AM, further review of R153's EHR noted no documentation of written notification was issued to either R153 or his	F 623	The ombudsman was notified of R65, R153, and R154's discharge from facility. Residents residing in the facility are at risk. Administrator/designee has initiated education for staff regarding timely notification of transfer/discharge, the right to appeal, or contact the LTCO on 7/27/23. An audit was conducted for residents discharged to acute within the last 30 days to validate that ombudsman was notified of acute transfer. No others were found. Administrator/designee will complete an audit for 4 discharging residents at random to validate that resident/RP/ombudsman notifications have been completed weekly x4 weeks then monthly x2 months. Findings will be reported to the QAPI committee x 3	

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F 623	Continued From page 13 representative. On 07/14/23 at 10:41 AM, an interview was done with the Assistant Director of Nursing (ADON) in the nursing office. After review of the EHR, the ADON confirmed that no written notification of transfer had been documented. 2) R65 was readmitted to the facility on 03/15/23. A review of the progress notes found documentation on 03/12/23 at 02:01 PM, R65 was transferred to an acute hospital via ambulance for an acute fracture of left hip. R65 was admitted to the acute hospital at 06:25 PM. On 03/15/23 at 03:22 PM, R65 was readmitted to the facility. Requested to review the written notification to the resident or resident's representative and the Ombudsman of the transfer. On 07/13/23 at 02:27 PM, the Administrator reported the facility did not provide written notification to the Ombudsman. The facility did not provide documentation that the resident or resident's representative received written notice containing the required information as soon as practicable of the transfer. 3) R154 was transferred to an acute hospital and admitted on 05/03/23. Review of R154's EHR did not contain documentation regarding a written notification of the resident's discharge, right to appeal, or contact information for the LTCO. On 07/12/23 at 2:05 PM, conducted a concurrent interview and record review with the Assistant Director of Nursing (ADON) regarding the written	F 623	months and if needs are identified in the audits, then will restart audits again.	

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F 623	Continued From page 14 notifications for R154 prior to transfer/discharge to the acute hospital. ADON reviewed R154's EHR and could not provide documentation that the notices were given to the resident/resident representative. The ADON advised to check with the business office staff. At 03:15 PM, went into the business office and requested the above-mentioned documents for R154. A form titled "Discharge/Transfer Notice" was received; however, the document does not provide adequate information or proof such as the resident/resident representatives' signature, date or time stamp, or any information proving the written documents were provided to the resident. Requested with the Regional Nurse (RRN) and the Administrator for documentation that the required documents were provided in writing to the resident/resident representative upon R154's transfer and admission to the acute hospital. RRN reported the staff that would have provided the written notification no longer worked at the facility and was doubtful they would be able to provide the necessary documentation.	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 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	F 625		8/18/23

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F 625	Continued From page 15 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 provide proper notification of bed-hold policy and return for one of 4 residents in the sample. Resident (R)154, was transferred and/or discharged to an acute care hospital without receiving written notification of a bed-hold policy prior to transfer. This deficient practice has the potential to affect all residents at the facility who are discharged or transferred. Findings include: Cross Reference to F623. R154 was not provided with a written notification of transfer/discharge with the required information. R154 was transferred to an acute hospital and admitted on 05/03/23. Review of R154's electronic health record (EHR) did not contain documentation regarding a written notification of	F 625	R154 has been discharged from the facility. Residents residing in the facility are at risk. Administrator/designee has initiated education for staff regarding requirement for bed hold notice upon transfer on 7/27/23. Facility□s bed hold notice will be placed in discharge packets. An audit was conducted for resident□s discharged to acute within the last 30 days to validate that the resident, representative and ombudsman were notified of the bed hold policy/discharge. No others were found. Administrator/designee will conduct an audit to validate that timely notification of transfer/ bed hold policy was given out to	

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F 625	Continued From page 16 the bed-hold policy. On 07/12/23 at 03:15 PM, went to the business office and requested documentation of the written notification for transfer/discharge and bed-hold policy. Requested with the Regional Nurse (RRN) and the Administrator for documentation that the required documents were provided in writing to the resident/resident representative upon R154's transfer and admission to the acute hospital. RRN reported the staff that would have provided the written notification no longer worked at the facility and was doubtful they would be able to provide the necessary documentation. On 07/13/23 at 08:00 AM, the facility provided a typed document titled R154 Bed Hold Documentation 5.17.23. The document was signed by the Admission Director (AD). The note documented the AD called the resident's spouse to inquire whether they would like a bed-hold. The spouse was informed of an out-of-pocket cost. The spouse declined bed-hold. The facility documented the resident/resident representative was given verbal notification. There was no documentation the resident/resident's representative was provided with written notification.	F 625	4 residents at random x4 weeks then monthly x2 months to validate that policy is being given to residents who discharge from the facility.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656		8/18/23

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medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:

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F 656	Continued From page 18 Based on observations, record reviews, and interviews the facility failed to develop and implement comprehensive person-centered care plans for 3 of 35 residents sampled (Residents 153, 120, and 40). This deficient practice resulted in failure to address the needs of each resident to assure they attain or maintain their highest practicable physical, mental, and psychosocial well-being. Findings include: 1) On 07/11/23 at 12:44 PM observed a dark thumb size bruise on R120's left forearm. Inquired with R120 where he got the bruise and he stated he did not remember and had not noticed it earlier. On 07/13/23 at 08:20 AM observed the same bruise on R120's left forearm had gotten bigger from the initial observation. On 07/14/23 at 08:32 AM interview and concurrent observation with Certified Nurse Aide (CNA)3 was done. Observed the bruise to left forearm larger than initial and second observation, at approximately 2 inches long. Inquired with CNA3 where he got the bruise from and if it was reported, CNA3 stated she saw the bruise yesterday when she started and did not report it because it was there prior to her shift. On 07/14/23 at 08:39 AM interview, concurrent observation, and record review was done with Registered Nurse (RN)4. RN4 was not aware of the bruise and stated R120 has frail skin and bruises easily. RN4 confirmed R120 receives an anticoagulant and should be monitored for bleeding and bruising. RN4 further stated	F 656	R153 discharged on 7/17/23. Care plans for R120 and R40 were updated to reflect current needs. Residents residing in the facility are at risk. DON/designee has initiated education for staff regarding implementing comprehensive person-centered care plans on 7/27/23. DON/designee will also complete an audit for 4 residents at random to validate that care plans reflect current psychosocial needs x4 weeks then monthly x2 months. Findings will be reported to the QAPI committee x 3 months and if needs are identified in the audits, then will restart audits again.	

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residents receive weekly skin assessments or as needed. Inquired when would a resident be assessed as needed, RN4 stated when staff member notices an unusual occurrence on the skin, such as new bruising. Concurrent review of R120's Electronic Health Record (EHR), RN4 confirmed the bruise was not documented in R120's skin assessments and in the progress notes. RN4 confirmed the bruise should have been reported and monitored.

On 07/14/23 at 11:31 AM interview and concurrent review of R120's EHR was done with Director of Nursing (DON). DON confirmed R120 is on an anticoagulant, Xarelto, and should be monitored for bruising and bleeding. DON further confirmed the bruising to left forearm was not assessed, documented, and monitored. Concurrent review of R120's CP, DON confirmed the CP includes to inform the nurse if there is any new bruising.

2) During initial observation on 07/11/23 at 08:47 AM, R40 stated his bed was uncomfortable and that his butt was sore. R40 further reported he is supposed to be positioned in bed on his left and right side and the device that helps with that is not working properly. R40 was observed lying at an approximately 45 degree angle in supine (on back), flat on his back, and with no positioning devices to offload his left or right side.

Review of R40's EHR documented R40 has a Stage 1 pressure ulcer to sacrum since 10/26/22. Review of R40's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 06/23/23 documented in Section M. Skin Conditions, R40 has an unhealed Stage 1 pressure ulcer and is at risk of developing

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pressure ulcers. Further review of R40's MDS documented under Section G. Functional Status in Activities of Daily Living (ADL), R40 required extensive assistance with two person physical assistance for bed mobility (how resident moves to and from lying position, turns side to side, and positioning body while in bed).

On 07/13/23 observations were made at 08:26 AM, 09:30 AM, and 11:25 AM of R40 lying in the same position in bed at an approximate 45 degree angle in supine position with a rolled up sheet in the same spot, along his left side under arm to lower back. At 12:37 PM observed the rolled up sheet in the same spot, along the left side under arm to lower back with R40 sitting in a 90 degree angle for lunch. Inquired with R40 if staff members moved or removed the rolled up sheet from the left side during observations, R40 stated no. Only at 01:47 PM observed R40 repositioned differently, lying flat in supine position without any rolled up sheets on either side of him.

Review of R40's CP documented under ADL "BED MOBILITY PROGRAM: Assist resident to turn and reposition per established schedule and prn [as needed]" and under potential skin "Encourage/assist to turn and reposition in bed per established schedule." The CP did not define or specify how often R40 was to be turned and repositioned.

On 07/14/23 at 08:53 AM interview and concurrent observation of R40 with CNA4 was done. CNA4 reported R40 is to be repositioned every two hours and that he does not have a repositioning pillow so a rolled up sheet is used. Observed a rolled up sheet on R40's right side

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from under his arm to lower back.

On 07/14/23 at 11:01 AM interview and concurrent review of R40's EHR with DON was done. DON reported staff are to reposition residents who need assistance every two hours, or as needed, and if a resident needs to be repositioned more often it will specify in the care plan. DON reported R40 has a sacrum pillow behind his back and is turned every two hours. DON described turning in no specific order as to the left, then to the right, then on his back and if R40 refused it would be documented. DON confirmed there is no documentation of R40 refusing to be repositioned on 07/13/23.

On 07/14/23 at 12:39 AM interview and concurrent review of R40's EHR with Director of Wounds (DOW) was done. DOW reported R40 was assessed to have a Stage 1 pressure ulcer since 10/26/22. DOW stated the way to prevent pressure ulcers from developing or getting worse is turning and positioning for residents who are not able to turn or position themselves. DOW reported even with special mattresses, pillows, or devices the resident still needs to be turned and repositioned at least every two hours to prevent pressure ulcers. DOW further reported the goal to turn, and position every two hours and timing is adjusted based on the needs of the resident. Inquired what it means for a resident to be turned and positioned based on established schedule as written, on R40's CP, DOW stated he did not know what that meant and why it was written like that.

Review of the facility's policy and procedure number 656 "COMPREHENSIVE CARE PLANS" documented "The care plan will be

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F 656	Continued From page 22 person-specific with measurable objectives, interventions and timeframes..." 3) Cross reference to F676 - Activities of Daily Living (ADLs)/Maintain Abilities. Despite identifying a language barrier upon admission, the facility failed to appropriately care plan to meet Resident (R)153's communication needs. Cross reference to F684 - Quality of Care. The facility failed to ensure R153's indwelling catheter care plan was implemented, placing him at increased risk of complications and infection.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		8/18/23

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F 657	Continued From page 23 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility did not ensure a care plan was revised for one of 35 residents in the sample. Findings include: Cross Reference to F689-Accidents. Resident (R)148 had an incident on 05/09/23 (ACTS #10280) where he was on another unit and was observed kissing R143 on the cheek. There was a subsequent incident on 06/30/23 when R148 wandered into another room on his unit. This room is next door to his room and occupied by female residents. A review of the resident's care plan found the facility failed to assess the efficacy of the interventions that were in place following the incidents on 05/09/23 and 06/30/23 and did not revise interventions to prevent further incidents from occurring.	F 657	Care plan for R148 was reviewed and updated on 7/14/23 Residents residing in the facility are at risk. DON/designee has initiated education regarding care plan revision and efficacy of interventions following event reports on 7/27/23. DON/designee will complete an audit of all event reports to validate that care plan revisions are completed x3 months. Findings will be reported to the QAPI committee x 3 months and if needs are identified in the audits, then will restart audits again.	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate	F 676		8/18/23

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F 676	Continued From page 24 that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review, the facility failed to provide the necessary care and services for one (Resident 153) of two residents in the sample to communicate his needs, express his choices, and fully participate in activities of interest. As a result of this deficient practice, Resident (R)153 was hindered from attaining his highest practicable well-being and	F 676	A communication booklet in resident□s primary language was provided to R153. Residents residing in the facility are at risk. Administrator/designee has initiated education regarding the importance of	

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F 676	Continued From page 25 placed him at risk for a decreased quality of life. This deficient practice has the potential to affect all residents at the facility who do not speak English. Findings include: R153 is a 91-year-old male admitted to the facility on 05/30/23 for short-term rehabilitation. During a review of his admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 06/05/23, it was noted that R153 was identified as having a preferred language of Korean, and in "need or want" of interpreter services. On 07/11/23 at 11:36 AM, observation was done of R153 sitting in the dayroom at the far end of the hall. A staff member was present in the room, but not interacting with R153 in any way. The TV in the dayroom was on a Japanese language channel with the volume low and a golf tournament playing. The remote control for the TV was not observed. R153 did not appear interested in watching TV, nodded his head when greeted, then returned to staring off into space. At 11:45 AM, R153 was observed pointing at something outside the window and saying something in Korean. Neither Registered Nurse (RN)8, who was the Charge Nurse for the unit, nor the Surveyor, could make sense of what R153 was repeatedly attempting to communicate. RN8 confirmed that R153 spoke primarily Korean with very limited English. Asked RN8 how staff communicate with R153 when his primary language is Korean. RN8 responded there was usually a communication book kept in the resident's room right at the entrance. Inquired if it is really kept at the room entrance when R153	F 676	residents to communicate and express their choices in their primary language and translation services on 7/27/23. Administrator/designee will interview 4 residents at random to validate that facility is providing personalized activities in their chosen language x4 weeks then monthly x2 months. Administrator/designee will report findings to the QAPI committee x 3 months and if needs are identified in the audits, then will restart audits again.	

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occupied the bed furthest from the entrance. RN8 confirmed that placement is usually at the room entrance no matter which bed the involved resident occupies. When RN8 and the Surveyor went to R153's room, a communication book was nowhere to be found. RN8 then went to the Nurses' Station and pulled a large communication binder out that included common phrases in multiple languages, and stated that it should be in R153's room. Inquired whether there would be a smaller book that was resident-specific, and RN8 re-confirmed that it should be the entire book with multiple languages. RN8 then stated that the facility also utilizes a "translator" service, but could not provide the name of the program, or describe the process of accessing interpreter services.

On 07/11/23 at 03:02 PM, during a review of R153's electronic health record (EHR), the following was noted in his Comprehensive Care Plan (CP) under Cognitive/Communication: " ...language barrier ...speaks Korean which is his primary language." Under Interventions for Communication: "Resident prefers to communicate in Korean ... Provide a Korean speaking translator [sic] to validate his needs as needed." Notably absent from the interventions was a communication book or board with common phrases for quick reference. A review of his Activities of Daily Living (ADL) and Activity/Recreation Care Plans also noted no interventions for his communication needs/language barrier.

On 07/11/23 at 03:32 PM, an interview was done with the Director of Nursing (DON) at the Nurses' Station. From there, R153 could be seen still sitting alone in the Dayroom with the TV on a

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F 676	Continued From page 27 Japanese channel. While discussing R153's language/communication barrier, the DON agreed that there should be a resident-specific communication book kept at the bedside for quick reference in addition to utilizing the interpreter services available as necessary. On 07/12/23 at 08:14 AM, observed R153 sitting alone in the Dayroom at the far end of the hall with the TV on, but muted, and National Geographic playing in English language. The remote control for the TV was not observed. R153 did not appear interested in watching TV. When asked if he spoke Japanese or Korean, R153 replied, "Huh? Oh, the TV, Korean OK." Surveyor went to find a staff member to change the channel. Certified Nurse Aide (CNA)7 was asked to adjust the TV. With difficulty, CNA7 located the remote control for the TV on a bookcase far out of reach for R153 and began to adjust the TV. CNA7 was unfamiliar with what channel(s) would be Korean speaking, so she went to the guide channel and scrolled through them for several minutes trying to find a channel R153 liked. A review of the facility policy, Resident Rights, Right to Information and Communication, noted the following: "The facility will have written translations... and make services of interpreter available as needed."	F 676		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on	F 679		8/18/23

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F 679	Continued From page 28 the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure to support a resident's choice of activity to meet the interest and support the mental and psychosocial well-being of one of four residents (Resident (R)222) in the sample. Findings include: During an interview with R222 on 07/11/23 at 10:16 AM, the resident expressed he wished the facility offered spiritual services as an activity. R222 reported he used to be a catholic priest and spirituality and spiritual worship was very important to him. R222 reported that since he was admitted to the facility, he had not been offered any type of spiritual activity and was not aware if the facility had any type of church service for any denomination. Conducted a review of R222's Electronic Health Record (EHR). R222 was admitted to the facility on 05/08/23. Review of the resident's admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 05/15/23, Section C. Cognitive Patterns, Brief interview for Mental Status (BIMS) R222 had a score of 15, indicating R222's cognition is intact. Section F. Preferences for Customary Routine and Activities	F 679	R222□s activity preferences were reviewed and updated on 7/14/23. Personalized religious services for R222 were offered to resident on 7/21/23. Residents residing in the facility are at risk. Administrator/designee has initiated education regarding providing individualized activities to meet the interests of and support the physical, mental, and psychosocial wellbeing of each resident on 7/27/23. Administrator/designee will interview 4 residents at random to validate that facility is providing personalized religious preferences x4 weeks then monthly x2. Findings will be reported to the QAPI committee x 3 months and if needs are identified in the audits, then will restart audits again.	

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F. 0500 Interview for Activity Preferences. E. how important is it to you to do things with groups of people and H. how important is it to you to participate in religious services or practices were documented as "Very important".

On 07/12/23 at 02:52 PM, conducted a concurrent interview and record review of R222's EHR with the Assistant Director of Nursing (ADON). Reviewed R222's activity care plan which documented the resident is a Catholic priest and enjoys praying. Review of R222's EHR to include but not limited to progress notes, activity records, attached documents did not provide documentation supporting R222 was offered, participated in, or refused to participate in church services when the activity was available.

On 07/14/23 at 08:45 AM, conducted a concurrent record review and interview with Recreation Staff (RS)2 regarding R222's participation in church services. RS2 stated spiritual and church services are offered twice a month with two different community groups. RS2 reviewed R222's EHR and could not provide documentation that R222 was offered participation in church services, participated in services, or refused participation in church services.

On 07/14/23 at 09:03 AM, concurrent record review and interview with the Recreation Director (RD) was conducted. RD stated R222 has not been wanting to participate or be involved in church services. RD was informed of R222's interview during which the resident reported no church services had been offered and focused how important it was for the resident to participate in church services. Review of the activity

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F 679	Continued From page 30 calendar documented church services were offered on 05/10/23, 06/07/23, and 06/14/23. Review of R222's activity record documented the resident did not attend the church services and only participated in activities independently (reading, watching TV) or talked with staff. RD reviewed R222's EHR and could not provide documentation that the activity was offered to the resident and confirmed staff did not document in R222's EHR any refusal of church services. On 07/14/23 at 11:30 AM, requested the following documents from the Regional Nurse (RRN), documentation of the dates church service was available to R222 in the facility, a copy of R222's activity log, and any documentation of R222 refusing church services or spiritual activities. RRN confirmed services were offered on 05/10/23, 06/07/23, and 06/14/23 and there were no documentation that R222 refused church services or that it was offered. At 02:25 PM, reviewed a document titled Follow Up Question Report provided by RRN which documented R222's activity participation in 1:1 for 05/01/23 to 05/31/23 and 06/01/23 to 06/30/23. Review of the documents provided noted on 05/10/23 at 11:06 AM the resident's response to invitation was marked as not applicable. After the document was printed from R222's EHR, staff hand wrote "Refused" next to "Not Applicable". No documents were provided of R222 refusing the activity at the time it was offered.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		8/25/23

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F 684	Continued From page 31 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure nursing care was provided to meet the needs of 2 of 35 residents (R) in the sample (R153 and R162), and were in alignment with standards of good clinical practice. As a result of this deficient practice, these residents were placed at risk of avoidable injury and/or complications, and were hindered from attaining their highest practicable well-being. Findings include: 1) Resident (R)153 is a 91-year-old male admitted to the facility on 05/30/23 for short-term rehabilitation. His admitting diagnoses include but are not limited to, Sepsis (severe infection), hydrocephalous (a condition where one or both kidneys become stretched and swollen as the result of a build-up of urine inside them), and pyelonephritis (inflammation of the kidney due to a bacterial infection). In addition, R153 was admitted with an indwelling urinary catheter (foley) that he removed himself, and was sent to the Emergency Room to be re-inserted on 06/13/23, where he was also diagnosed with a urinary tract infection (UTI). On 07/11/23 at 11:39 AM, observation of R153 and an interview with Registered Nurse (RN)8,	F 684	R153's foley was irrigated per MD order on 7/12/23. R162 received chest Xray on 7/14/23. Residents residing in the facility with a foley and X-ray orders are at risk. DON/designee reeducated LNs regarding notification of MD for additional intervention and following physician's orders on 7/27/23. Facility has also reeducated licensed nurses on updated foley process that includes increased monitoring for residents with catheters on facility's electronic medical record system. Monitoring will include urine color, output, hydration status, provider notification and that privacy bag is in place and not touching ground. An audit was conducted for residents with foley catheters, and x-ray orders to validate that orders were carried out on 7/12/23 and 7/13/23. An additional audit was conducted on 8/22/23 to validate that monitors are in place for residents with catheters. DON/designee will conduct an audit on 4 random residents with foley catheters and X-ray orders to validate that MD orders and interventions were carried out in a	

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F 684	Continued From page 32 who was the Charge Nurse on the unit, were done concurrently in the Dayroom at the end of the hall. Observed dark brown, blood-tinged urine in R153's foley collection tube. Asked RN8 about R153's hydration. Without checking his urine output in the foley collection tube, RN8 responded that R153's hydration was "good." RN8 further reported that R153 had no signs of a UTI. Asked RN8 to look at his urine output and describe it. RN8 donned (put on) gloves and pulled R153's foley collection bag out of the privacy bag that covered it. Observed approximately 100 mls (milliliters) of dark brown urine in the collection bag. RN8 described it at as "tea-colored, a little concentrated, maybe blood-tinged because he pulls on the tube." RN8 stated that the collection bag had last been emptied at 07:00 AM. When asked if the amount of urine that had collected and the color of the urine were indicators of good hydration, RN8 answered that the Certified Nurse Aide (CNA) had informed her at the start of the shift that R153's urine "was concentrated" so they had been pushing fluids since. "We offer hydration every time," meaning every couple of hours, and that is what she meant by describing R153's hydration as good. On 07/11/23 at 03:14 PM, an interview was done with Nurse Supervisor (NS)1 at the Nurses' Station. NS1 reported that R153 had 175 mls (milliliters) documented for the past 8 hours. When asked what his normal urine output was for an 8-hour period, NS1 responded "500 to 800 mls." After observing the dark brown color of R153's urine, NS1 agreed that the color and amount of output was a concern. NS1 confirmed that there was no documentation that the doctor had been informed, or additional interventions	F 684	timely manner x4 weeks, then x2 months. DON/designee will report findings to the QAPI committee x 3 months and if needs are identified in the audits, then will restart audits again.	

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applied.

On 07/11/23 at 03:32 PM, an interview was done with the Director of Nursing (DON) at the Nurses' Station. The DON agreed that for urine as dark as R153's was, especially if identified at the start of the shift, she would have expected the doctor to be called, and additional interventions to be applied. The DON stated she would follow-up on it.

On 07/12/23 at 02:06 PM, observed R153 wheeling himself into the Dayroom, observed clear yellow urine in his foley collection tube. A review of R153's electronic health record (EHR)noted the following:

Nurse Progress Note from 07/11/23 at 04:13 PM, "Noted resident with tea-colored urine, and low output=175 ml this shift. Offered fluids in between and during meal times. Foley catheter checked and intact. Updated ... [provider] at the end of shift, with order to irrigate foley catheter with 100 ml of NS [normal saline] ... carried out."

Standing provider order since 06/30/23, with no end date, "Irrigate Foley Catheter with 100 ml NS as needed daily."

Foley Catheter Care Plan with the intervention, "Monitor/record/report to MD [medical doctor] for s/sx [signs or symptoms] UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color ..."

On 07/12/23 at 03:00 PM, an interview was done with the DON in her office. The DON agreed that further intervention was warranted besides pushing fluids and the expectation is that the

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provider be notified. Also agreed that since there was an as needed foley irrigation order on file already, irrigation could and should have been done when the problem was identified, not at the end of the shift.

2) R162 is a 78-year-old male admitted to the facility on 04/04/23. His past medical history include but not limited to acute respiratory failure with hypoxia (oxygen deficiency), congestive heart failure, chronic obstructive pulmonary disease, ischemic cardiomyopathy (decreased ability of the heart to pump blood adequately), diabetes mellitus type two, and constipation. R162 BIMS (Brief Interview for Mental Status) at 15 indicating the resident is cognitively intact.

Record review was conducted of R162's EHR. On 07/12/23 at 12:48 PM, R162's physician ordered a "Stat chest X-Ray CHF [Congestive Heart Failure].

Concurrent observation and interview were conducted on 07/12/23 at 02:20 PM with RN2. R162 was observed in his room with an X-ray technician. X-ray technician was attempting to complete R162's chest X-ray but R162 was refusing at that time because he was having abdominal pain and was in the process of having a bowel movement. X-ray technician exited R162's room and waited for 15 minutes. When R162 was asked if he was ready for his X-ray he replied, "No, I'm trying to go right now." X-ray technician was overheard telling RN2 that he is going to go to another appointment and that they can call the X-ray company when R162 was ready. X-ray technician also added that there is another technician available from 05:00 PM to

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09:00 PM who they can call as well.

Observation and interview were conducted on 07/13/23 at 02:00 PM with Certified Nurse Aide (CNA)1. R162 was lying in bed with intravenous fluids infusing. R162 was complaining to CNA1 of abdominal pain and trouble breathing. CNA1 relayed the message to RN1. This surveyor asked R162 if he had completed his chest X-ray the day prior. He answered, "No one came back." At the nurse's station RN1 was heard on the phone with the X-ray company.

The stat order by R162's physician was made on 07/12/23 at 12:48 PM. A review of R162's chest X-ray results noted the radiologist electronically signed the report on 07/13/23 at 05:13 PM.

Observation was conducted on 07/14/23 at 07:45 AM. R162 was lying in bed. R162's respiratory rate was in the mid 20's and he was using his accessory muscles to breath.

Concurrent observation and interview with R162's Medical Doctor (MD) was conducted on 07/14/23 at 08:52 AM. R162 was lying in bed and staff were preparing him to go to the emergency room. MD stated that R162's chest X-ray result indicated pleural effusion (a buildup of fluid between the tissues that line the lungs and the chest). MD also added that R162 will probably need a thoracentesis (procedure performed to remove fluids from the lungs) and a chest tube in the hospital.

Interview was conducted on 07/14/23 at 10:32 AM in the nursing office with Assistant Director of Nursing (ADON). ADON was informed of R162's stat chest X-ray order placed on 07/12/23 at

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 36 12:48 PM. ADON stated that a stat order is usually completed 1-2 hours after order is placed. If that is not possible, then it should at least be done during the same shift that it was ordered.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to assist Resident (R)126 in making an audiologist appointment to obtain hearing assistive devices. Findings include: During an interview with R126 on 07/1/23 at 09:53 AM, R126 expressed he has difficulty hearing and stated, "the CNAs (Certified Nurse Aides) and I don't know how to cope with that." R126 reported he told nursing staff that he cannot hear, and they need to speak closer to his ear, but they continue to talk to him from far away. R126 stated he wants hearing aids and requested for an audiologist appointment but no one at the	F 685	Audiology Appointment was scheduled for R126. Residents residing in the facility are at risk. DON/designee-initiated education for LNs on ensuring residents receive proper treatment and assistive devices to maintain hearing and vision abilities on 7/27/23. An audit was conducted for residents with orders for hearing appointments to validate that appointments were carried out. No issues were found.	8/18/23

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F 685	Continued From page 37 facility helped him try to make an appointment. Review of R126 nursing note documented " ...Resident is requesting a referral to audiologist/specialist. He is indicating he needs new hearing aids and does not want to go back to his otolaryngologist. Request was placed in MD's binder..." On 07/14/23 at 10:39 AM interview and concurrent record review with Director of Nursing (DON) was done. DON confirmed R126 currently does not have hearing aides and there was no documentation that the facility attempted to make an audiologist appointment, or the primary physician spoke to R126 regarding scheduling an audiology appointment and hearing aids. Review of the facility's policy and procedure number 685 "QUALITY OF CARE Hearing and Vision" documented "The facility will assist residents to receive treatment and assistive devices to maintain vision and hearing abilities. The facility will assist in making appointments and arranging for transportation to and from appointments."	F 685	DON/designee will interview 4 residents to validate that facility is scheduling ancillary appointments in a timely manner for x4 weeks, then x2 months. DON/designee will report findings to the QAPI committee x 3 months and if needs are identified in the audits, then will restart audits again.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		8/18/23

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F 689	Continued From page 38	F 689		

by:
Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 6 residents sampled were free from accident hazards as evidenced by the application of an instant hot pack directly to Resident (R)208's skin, failure to implement and revise care plans for wandering and falls for R148, and potential accident hazard related to a cracked power strip for R108. As a result of this deficient practice, these residents were placed at risk of an avoidable accident and/or injury.

Findings include:

1) Resident (R)208 is a 98-year-old female admitted to the facility on 06/27/23 for skilled therapy following hospitalization for a loss of consciousness and collapse at home. Her admitting diagnoses include but are not limited to chronic kidney disease (CKD), diabetes, communication deficits, and need for assistance with personal care. Her age coupled with her existing medical conditions place R208 at high risk for sensory impairment (a condition where one or more of our senses is no longer normal), such as a decreased feeling and awareness of the sensations of hot or cold, increasing her risk of burn injuries.

On 07/13/23 at 08:11 AM, observation was done of Registered Nurse (RN)8 preparing medications for R208. One of the medications due was a medicated pain patch. Before RN8 could apply the patch, she needed to remove a disposable "Instant Hot Pack" that had been applied directly to the skin of R208's right neck. After applying the medicated pain patch to R208's right shoulder, RN8 asked her if she would like the hot

Staff removed unauthorized power strip from resident's bedroom on 7/14/23. RN8 was reeducated on proper hot pack application on R148□s care plan was updated to include appropriate interventions on 7/14/23.

Residents residing in the facility are at risk.

Administrator/designee reeducated staff on ensuring residents environment remains free of accident hazards and each resident receives supervision and assistance to prevent accidents and hot pack application procedures on 7/27/23. An audit was conducted on all resident rooms to validate that there were no unauthorized power strips residing in resident rooms on 7/11/23.

Administrator/designee will audit 4 random resident rooms x4 weeks then monthly x2 months to validate that power strips are in working condition. Administrator/designee will present findings to the QAPI committee x 3 months and if needs are identified in the audits, then will restart audits again.

DON/designee will audit all units for residents with hot pack treatment orders x4 weeks, then x2 months to validate hot packs are being applied per manufacturer□s instructions.

DON/designee will audit 4 residents with behaviors x4 weeks, then monthly x2

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F 689	Continued From page 39 pack re-applied, stating "it's still warm." R208 responded "yes", and RN8 re-applied the instant hot pack directly to the skin of the resident's right neck. At no time was RN8 observed assessing the skin on R208's right neck. At 08:15 AM, an interview was done with RN8 outside of R208's room. When asked if the instant hot pack was safe to be applied directly to the skin of R208 given her risk of sensory impairment, RN8 replied, "I think so." RN8 reported that the instant hot packs were locked in the medication room on the unit and could only be accessed by a nurse. At 08:55 AM, observed an unused hot pack with RN8 outside of room 5. The hot pack had a visible and prominently placed information on the front of the packaging, "WARNING: Do not apply against unprotected skin. Wrap in soft cloth and apply..." RN8 acknowledged that she was not aware of the warning and did not look at the hot pack for warnings before she re-applied it. On 07/14/23 at 10:56 AM, an interview was done with the Assistant Director of Nursing (ADON) in the Nursing Office. When asked about the training nurses receive regarding care of the elderly's skin, the use of instant hot packs, and the risk for injury, the ADON stated that nurses should have received in-services and/or training on all of those topics. In addition, the ADON verbalized his expectation is that all staff would read warnings on anything they give to a resident. Documentation of the in-services done regarding the use of instant hot packs was requested.	F 689	months to validate that residents with behaviors have appropriate interventions in place and are followed. DON/designee will present findings to the QAPI committee x 3 months and if needs are identified in the audits, then will restart audits again.	

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On 07/14/23 at 12:05 PM, an interview was done with the Staff Development Coordinator (SDC) in the Conference Room. The SDC provided the State Agency (SA) with documentation of an in-service beginning 07/13/23 titled, Hot/Cold Pack Application. When asked what prompted the in-service, the SDC stated "I was informed yesterday that an in-service was needed." The SDC continued to report that she began the in-service yesterday afternoon, and repeated it this morning, but that the training was ongoing so that she could catch everyone. Documentation of any in-service done prior to yesterday was requested at this time, but was not provided by the facility before completion of the survey.

2) Cross Reference to F657-Care Plan Revision.

R148 was admitted to the facility on 11/17/20. Diagnoses include but not limited to unspecified dementia, unspecified severity, without behavioral disturbance, mood disturbance and anxiety; unspecified dementia, unspecified severity, with other behavioral disturbance; history of falling; and unsteadiness on feet.

The facility submitted an event report (ACTS #10280), documenting on 05/09/23 at 06:00 AM, a staff member witnessed R148 kiss a female resident (R143) on the cheek. Brief review noted R143 resides on another unit (Pensacola).

On 07/11/23 at 12:03 PM, 01:45 PM, and 02:11 PM observed R148 lying in bed asleep. The resident's walker was placed next to his bed. On 07/13/23 at 08:09 AM observed R148 was not in bed. Certified Nurse Aide (CNA)18 reported, R148 was out walking on the unit. At 08:17 AM

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observed R148 walking with the use of a walker in the breezeway from the Pensacola to Piikoi unit. The Administrator In Training (AIT)2 approached R148 and attempted to redirect him to his unit. Inquired whether R148 is supposed to stay on his unit. AIT2 responded R148 has a wanderguard then went on to ask a staff member, the location of R148's aide.

Record review on 07/12/23 found no progress note documenting the incident of 05/09/23. There was alert charting; however, there was no indication of why R148 was on alert charting. Further review found an entry dated 06/30/23 documenting R148 was found in room 106 (this room is located next to R148's room at the end of the hall and is occupied by female residents).

A review of the quarterly Minimum Data Set with an assessment reference date of 04/21/23 notes R148 yielded a score of 11 (moderately impaired cognition) upon administration of the Brief Interview for Mental Status. R148 was also coded to require supervision (oversight, encouragement or cueing) with one personal physical assist for walking in his room and in the corridor. R148 was also coded to be not steady, but able to stabilize without human assistance for walking with an assistive device.

Further review noted a care plan for wander risk (resident wanders aimlessly within the units and staff have to redirect resident back to his assigned unit). Interventions include the use of an elopement prevention device which is placed on the resident's walker. There were no revisions to the care plan to address R148 wandering into another resident's room.

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R148 also has a plan to address mood/behavior, inappropriate touching, stripping clothes off and walking naked, hitting and spitting on staff, and rummaging through trash. Interventions included administer medications as ordered, if reasonable discuss the residents behavior and explain why behavior is inappropriate and/or unacceptable, provide a program of activities that is of interest and accommodates residents status, and put his urinal in front of his walker when up and about. There were no revisions to the care plan to address the incident of 05/09/23.

On 07/13/23 at 01:40 PM concurrent observation with RN42 found R148 ambulating with his walker in the hall on his unit alone. RN42 stated R148 needs to be on 1:1 supervision when ambulating. RN42 instructed the CNA to supervise R148.

On 07/14/23 at 10:11 AM, interviewed CNA21. Inquired whether R148 requires supervision when ambulating on the unit. CNA21 reported sometimes the staff will follow the resident as he tends to fall in the breezeway. CNA reported R148 becomes agitated when he is followed. CNA21 was not aware of R148 entering other residents' room.

On 07/14/23 at 10:19 AM an interview was conducted with the Unit Manager (UM)5 at the nurses' station. UM5 was asked about R148's wandering. UM5 reported, R148 has not left the facility but will ambulate on his unit (Lewalani) and Pensacola. UM5 reported it is preferable for someone to accompany R148 while he is ambulating as he is at risk for falls. Inquired whether UM5 was aware of the incident on 05/09/23, UM5 responded she heard about it. UM5 further reported when staff see R148

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ambulating alone, they will accompany him (walking behind him) or redirect him. UM5 stated, R148 becomes agitated and is hard of hearing, making it difficult to re-direct him. Further queried whether R148's care plan was revised to prevent reoccurrence of behavior. UM5 reported she is not sure as she is covering for the UM on leave.

On 07/14/23 at 10:33 AM an interview and record review was conducted with RN48 at the nurses' station. Inquired whether RN48 was aware of the incident on 05/09/23. RN48 responded if it is a reportable then management will investigate and update the care plan. Further queried whether R148's care plan was revised following the incident. RN48 responded the doors are closed to keep R148 out of the area. RN48 also stated the care plan includes staff to provide supervision. Noted the intervention date was 12/09/22, RN48 agreed intervention was in place prior to the date of the event. RN48 reported R148 is provided 1:1 as needed; however, requires 1:1 especially when walking or going to another unit. Further requested assistance from RN48 regarding documentation of the incident of 05/09/23. RN48 confirmed there was no documentation of the event. Also, RN48 was not aware of R148 entering another resident's room.

On 07/14/23 at 11:37 AM an interview and concurrent record review was conducted with the Assistant Director of Nursing (ADON) in the nursing office. The ADON was asked what was the facility's response following the incident of R148 kissing R143's cheek on 05/09/23. ADON responded, R148 was placed on alert charting. ADON clarified alert charting includes documenting every shift for the next three days.

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ADON clarified the resident was being monitored for behavior/acute issue. ADON was unable to find an entry which documented the incident on 05/09/23. Inquired if there is no documentation of the event, how does the staff know what specific behavior to monitor. ADON confirmed the reason for alert charting was not specific but generally it would be for wandering, agitation, and sexual expression.

R148's care plan was reviewed with the ADON. Inquired if the facility revised interventions to address R148's behavior related to the incident. ADON responded the team reviewed the behavior care plan interventions and determined interventions continued to be appropriate. ADON was asked if the interventions were already in place and implemented, how did the team determine these interventions were still appropriate when R148 was able to wander into another unit and witnessed to have kissed R143's cheek? ADON reported the facility already had an intervention to follow the resident when he goes to other units, which he confirmed was initiated in December 2022. This intervention was in place when the event occurred on 05/09/23 and when the resident wandered into female residents' room on 06/30/23. Further queried what interventions did the facility add/revise to ensure R143 and other residents are protected?

Informed ADON that R148 was also noted to enter a room occupied by female residents on 06/30/23. ADON responded R148 was escorted out of the room. ADON reported staff followed the current interventions - knowing R148's whereabouts, providing redirection, frequent visual checks, and during rounds pass by his

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F 689	Continued From page 45 room and check on him. ADON was asked what should have taken place. ADON replied, based on the resident's presentation, the facility needed to add more interventions. ADON added R148 is on medication and it looks like the pharmacological intervention is not effective, therefore, consultation with the physician and pharmacist will be done to change the resident's regimen. 3) Observation on 07/11/23 at 11:00 AM of R108's room showed a cracked electrical power strip supplying power to two outlets. The cracked electrical power strip also had a hole the size of a dime exposing the internal circuit. Staff interview on 07/12/23 at 02:40 PM, Maintenance Director (Maint) acknowledged that the electrical power strip was damaged and there was a risk for accident hazards. Maint said that they would immediately replace the damaged electrical power strip.	F 689		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 690		8/18/23

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F 690	Continued From page 46 (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility did not ensure that 4 (Residents 516, 153, 187, and 141) of 5 residents sampled for indwelling catheters received the appropriate treatment and services to prevent urinary tract infections. This deficient practice exposed residents to contaminants that may cause preventable urinary tract infections. Findings include: 1) On 07/12/23 at 01:23 PM, observed R187 lying in bed with eyes closed. Urinary catheter drain bag and tubing was placed on the right side of the bed frame. Both drain bag and tubing were	F 690	Foley bags and tubing for R153, R141, R87, and R516 were repositioned appropriately. Residents residing in the facility with foleys are at risk. DON/designee reeducated LNs regarding appropriate placement of catheters. An audit of residents with catheters was conducted on 7/14/23 to validate that placement was appropriate. No further findings. DON/designee will conduct an audit on 4	

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F 690	Continued From page 47 touching the floor. At 02:30 PM, concurrent observation and interview conducted with Licensed Practical Nurse (LPN)1 at R187's bedside. Asked LPN1 if the catheter bag and tubing are supposed to be touching the floor. LPN1 said, "No because it gets contaminated." 2) On 07/12/23 at 02:49 PM, observed R141 in bed with head elevated and watching television. Urinary catheter drain bag was placed on the left side of the bed frame and was touching the floor. Concurrent observation and interview conducted with Registered Nurse (RN) 3 outside R141's room at 02:50 PM. Asked RN3 if catheter bag was supposed to be touching the floor. RN3 said, "The catheter bag should be off the floor for infection control." On 07/14/23 at 01:28 PM during an interview with both the Director of Nursing (DON) and the Infection Preventionist (IP), both confirmed that the catheter drain bags and lines should be off the floor at all times. 3) While conducting an interview with R516's roommate on 07/11/23 at 11:43 AM, an observation was made of Certified Nurse Aide (CNA)56 assisting R516 to the restroom. CNA56 utilized a wheelchair to assist the resident to the bathroom. R516 was transferred to the toilet and CNA56 placed the resident's catheter bag and excess tubing on the bathroom floor next to the left side of the toilet. On 07/12/23 at 02:39 PM, conducted an interview with the Assistant Director of Nursing (ADON) regarding observation of R516's catheter bag and tubing on the floor next to the toilet. ADON stated	F 690	residents with foley bags to validate that foley bags are not touching the floor for x4 weeks, then x2 months. DON/designee will report findings to the QAPI committee x 3 months and if needs are identified in the audits, then will restart audits again.	

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F 690	Continued From page 48	F 690		

if the resident was transferred to the bathroom with a wheelchair, then the catheter bag should remain on the wheelchair, staff should ensure the tubing does not touch the ground, and the catheter bag should be below the resident. This surveyor informed the ADON of the observation and the ADON confirmed the catheter bag and tubing should not have been placed on the ground next to the toilet.

On 07/14/23 at 11:39 AM, the IP was informed of the observation of R516's catheter and tubing on the bathroom floor next to the toilet and confirmed the catheter bag and/or tubing should not have been placed on the ground.

4) R153 is a 91-year-old male admitted to the facility on 05/30/23 for short-term rehabilitation. His admitting diagnoses include but are not limited to, Sepsis (severe infection), hydronephrosis (a condition where one or both kidneys become stretched and swollen as the result of a build-up of urine inside them), and pyelonephritis (inflammation of the kidney due to a bacterial infection). In addition, R153 was admitted with an indwelling urinary catheter (foley) that he removed himself, and was re-inserted in the Emergency Room on 06/13/23, where he was also diagnosed with a urinary tract infection (UTI).

On 07/11/23 at 11:36 AM, observation was done of R153 sitting in a wheelchair in the Dayroom at the far end of the hall. His foley collection bag was observed within a thin, permeable privacy bag, and was attached to crossbars underneath his wheelchair in such a way that the privacy bag was touching the ground. If the wheelchair

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F 690	Continued From page 49 moved, the privacy bag and the foley collection bag within it would drag on the ground. On 07/11/23 at 11:39 AM, an interview was done with Registered Nurse (RN)8, who was the Charge Nurse for the shift, in the Dayroom. When asked about the placement of the foley collection bag, RN8 agreed that it (and the privacy bag) should not be touching the ground. With difficulty, RN8 re-positioned the bag under the wheelchair. When asked, RN8 stated that the foley collection bag should always be positioned above the ground to reduce the risk of infection.	F 690		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		8/18/23

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F 755	Continued From page 50 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that drug records are in order and that an account of all controlled drugs are maintained and reconciled. Findings include: 1) On 07/12/23 at 01:55 PM, conducted an inspection of medication cart #2 on the third floor. Review of the Narcotic Count Sheet documented the controlled medications were not reconciled with the night shift nurse on 07/11/23 and the on-coming day nurse on 07/12/23. Registered Nurse (RN)23 stated the Narcotic Count Sheet is signed off with two nurses present (on-coming and off-going nurses) to ensure the accurate reconciliation and to avoid the opportunity for diversion, RN23 confirmed the Narcotic Count Sheet was not signed and should have been. On 07/12/23 at 01:55 PM, conducted an interview with the Assistant Director of Nursing (ADON) regarding the unsigned Narcotic Count Sheet. ADON confirmed the Narcotic Count Sheet should have been signed at the time the count was completed with both nurses present and was not.	F 755	LNs were reeducated on signing medication logs in a timely manner to ensure accurate reconciliation and to prevent diversion of controlled medications on 7/27/23. Residents residing in the facility are at risk. DON/designee initiated reeducation on 7/27/23 for LNs to validate that drug records are in order and that an account of all controlled drugs are maintained and reconciled. An audit was conducted to validate that all narcotic logs are accurate and up to date on 8/10/23. Facility found no further missing signatures in narcotic logs. DON/designee will audit all unit narcotic logs for timely completion x4 weeks, then x2 months to validate that drug records are in order and that an account of all controlled drugs are maintained and reconciled. DON/designee will present findings to the QAPI committee x 3 months and if needs are identified in the audits, then will restart audits again.	

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F 755	Continued From page 51 Review of the facility's policy and procedure "Controlled Medication Storage" documented "6. At each shift change or when keys are surrendered, a physical inventory of all Scheduled II, including refrigerated items, is conducted by two licensed nurses or per state regulation and is documented on the controlled substances accountability record or verification of controlled substances count report. 2) On 07/12/23 at 02:05 PM, conducted a review and reconciliation of narcotic medication (Oxycodone 5 mg) for R250 with the ADON. A review of the pharmacy administration sheet documented R250 should have had 52 pills of Oxycodone 5 mg. A count of the actual Oxycodone 5 mg tablets in the blister pack with the ADON documented there were only 49 tablets. The ADON confirmed there was a discrepancy between the documented number of tablets and the actual amount of Oxycodone 5 mg tablets remaining in the blister pack. Review of R250's Electronic Medication Administration Record (EMAR) documented RN23 had administered the medication earlier to the resident but did not update the pharmacy's administration sheet. ADON confirmed RN23 should have signed the pharmacy sheet immediately following the actual administration of the medication.	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		8/18/23

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F 757	Continued From page 52 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff member the facility failed to ensure each resident's drug regimen was free from unnecessary drugs for one of five residents sampled (Resident (R) 40). The facility failed to adequately monitor R40 for side effects and behaviors related to use of an antipsychotic medication. Findings include: During review of R40's Electronic Health Record (EHR) on 07/12/23 at 08:16 AM, R40's physician's orders include Quetiapine Fumarate (Seroquel) Oral Tablet 25 milligrams (MG). Order included, give 0.5 tablet by mouth at bedtime related to generalized anxiety disorder and depressive disorder effective 10/22/22 and monitor behaviors and side effects related to use of antipsychotic medication were documented as	F 757	Behavioral monitoring for R40 was updated on 7/14/23. Residents on Psychotropic medications residing in the facility are at risk. DON/designee reeducated LNs to adequately monitor residents for side effects and behaviors related to the use of antipsychotic medications on 7/27/23. Re-admitted residents with orders for psychotropic medications will be reviewed during the next clinical meeting to verify monitoring of targeted behaviors has been implemented and is consistent between physician's orders, care plan, and behavior monitors. An audit was conducted for residents requiring behavior monitoring to verify that monitored behaviors were consistent with the Care	

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F 757	Continued From page 53 effective 07/11/23. Further review of R40's EHR found no documentation of the facility's monitoring R40's behaviors and side effects related to antipsychotic use after the antipsychotic was prescribed (effective date) and prior to 07/11/23. On 07/14/23 at 11:11 AM interview and concurrent record review with Director of Nursing (DON) was done. DON confirmed R40's behavior and side effect monitoring related to antipsychotic use ended on 10/15/22 and started back on 07/11/23. DON confirmed R40's physician's order for Seroquel effective date was 10/22/22 and documentation of monitoring for behavior and side effects was not done until 07/11/23. Review of the facility's policy and procedure "Medication Monitoring Medication Management" dates 11/17 documented "Each resident's drug regimen is reviewed to ensure it is free from unnecessary drugs. This includes any drug...without adequate monitoring..."	F 757	Plan and monitors were reflective of physician's orders on 7/14/23 DON/designee will audit 4 re admitted residents with new or updated orders for psychotropic medications to validate monitors have been initiated x4 weeks, then 4 residents/week x 2 months. DON/designee will present findings at the facility□s QAPI committee x 3 months and if needs are identified in the audits, then will restart audits again.	
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	F 761		8/25/23

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F 761	Continued From page 54 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all medications used in the facility were securely stored in locked compartments, and were labeled in accordance with professional standards, including expiration dates. Proper storage and labeling of medications are necessary to promote safe administration practices, and to decrease the risk of medication errors and diversion of resident medications. This deficient practice has the potential to affect all residents in the facility. Findings include: 1) On 07/13/23 at 08:11 AM, observations were done of Registered Nurse (RN)8 preparing medications for Resident (R)208. As RN8 entered the room to administer the medications, she left the medication cart wedged in the doorway, but neglected to lock it before walking away. R208 was situated in the bed furthest from the room entrance, requiring RN8 to have her back to the medication cart as she administered her medications. After administering the	F 761	Identified unlocked medication cart was locked. Expired/unlabeled medications were removed from circulation. R35's care plan was updated to reflect resident's medication preferences. Residents residing in the facility are at risk. DON/designee initiated education regarding unlocked carts, labeling insulin/inhalers, expiration dates on OTC, and appropriate storage of medications. An audit of medication carts was conducted on 7/14/23. No further carts were found unlocked. An audit on 8/22/23 was completed to validate that medications were not left at bedside for R35's unit. No further medications were found. A self-administration evaluation was completed for R35 to validate that he can self administer medications safely. DON/designee will conduct medication	

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F 761	Continued From page 55 medications, RN8 entered R208's bathroom, leaving the medication cart out of her sight completely. At 08:15 AM, interviewed RN8 outside the room. RN8 acknowledged that she should have locked the medication cart before walking away from it. RN8 also confirmed that the facility policy is to secure the medication cart at all times. 2) On 07/11/23 at 09:29 AM observed a small disposable pill cup containing a large oval green pill, a small round yellow pill, and a small round white pill and in a separate small disposable cup observed blue unidentified liquid on top of R35's bedside table. Inquired with R35 what the pills and liquid were on his bedside table, R35 reported the green pill is a vitamin, the other two small pills are baclofen and aspirin, and the liquid is a mouth wash. R35 further reported he asked the nurse to leave his medication on his bedside table and he would take them after breakfast but forgot to take them. R35 stated he already finished breakfast. Review of R35's medication administrative record (MAR) for July documented at 09:00 AM, R35 was administered Aspirin EC Tablet Delayed 81 milligrams (mg), MiraLax Powder, Baclofen Tablet 10 mg, and Chlorhexidine Gluconate Solution on 07/11/23. On 07/13/23 at 12:45 PM interview with Registered Nurse (RN)4 was done. Inquired if there were any residents on her unit, the unit R35 resides on, that self-administered medication, RN4 confirmed there were none. Inquired if a resident can ask to leave their medication on the	F 761	storage and labeling audit of medication carts to validate that staff are locking medication carts, labeling of insulin/inhalers, expiration dates of OTCs, and appropriate medication storage weekly x4 weeks, then monthly x 2 months. DON/designee will conduct an audit to validate that medications are not left at bedside for 4 residents weekly X4 weeks, then monthly X2 months. DON/designee will present findings at the facility's QAPI committee x 3 months and if needs are identified in the audits, then will restart audits again.	

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F 761	Continued From page 56	F 761		

bedside table and they will take it later, RN4 stated the nurse administering the medication should take the medication with them and go back later. RN4 reported they should not leave medication with a resident without ensuring the resident took and ingested the medication.

On 07/13/23 at 02:58 PM inquired with Administrator if there were any residents on R35's unit that can self-administer medication. Administer confirmed there was none.

On 07/14/23 at 10:37 AM interview with Director of Nursing (DON) was done. DON reported the nurse assigned to administer medication must watch the resident take their medication before documenting it on the MAR to ensure the resident swallows their medication.

3) On 07/13/23 at 01:55 PM observation of the medication cart was done with Registered Nurse (RN)42. Observation found an insulin Lantus Solostar pen for Resident (R)41. There was a sticker affixed to the pen which documented an open date of 07/13/23, the discard date was not documented. There was a vial of insulin (Humulin N) for R15 labeled with an open date of 07/13/23 with no documentation of the discard date. RN42 confirmed there was no documentation of discard date. RN42 reported insulin is discarded 28 days from the open date and the discard date is usually documented upon first usage.

Further observation found an inhaler (Spiriva) for R200. The inhaler was labeled with an open date of 07/04/23. The discard date was not documented. RN42 confirmed there was no

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F 761	Continued From page 57 documentation of discard date. RN42 reported inhalers are to be discarded 90 days from the open date. Observation of the house stock medications found an opened bottle of aspirin (81 mg) with a handwritten label affixed to the bottle with the date of 02/16/23. Inquired when would the aspirin be discarded. RN42 responded the aspirin will be discarded according to the manufacturer's expiration date. RN42 was unable to locate the manufacturer's expiration date on the bottle. Observed a box containing nasal spray (fluticasone propionate) for R24 which was labeled with an open date of 04/19/23 and no documentation of discard date. Observed a label wrapped around the plastic dispenser, the label affixed to the dispenser was illegible, smeared, resulting in no identification of resident's name, dosage, and prescribing physician.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		8/18/23

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F 812	Continued From page 58 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to store food items under sanitary conditions. This failed practice could place all facility residents at risk for food-borne illness. Findings include: 1) Concurrent observation and interview were conducted on 07/11/23 at 08:29 AM with the Food Service Manager (FSM). Observed in the facility's walk-in fridge of the kitchen a plastic container filled with 21 cartons of milk were observed with an expiration date 07/10/23. Food Service Manager (FSM) confirmed that the expired milk cartons should not have been in the fridge and should have been discarded by one of the kitchen staff. 2) Concurrent observation and interview were conducted on 07/11/23 at 08:50 AM in the kitchen. A scooper was observed left in a container filled with thickening powder. FSM was questioned on the location of the scooper. FSM confirmed that the scooper should not have been left in the container and one of the kitchen staff had forgotten to remove it. 3) Concurrent observation and interview were conducted on 07/13/23 at 08:54 AM on the Lewalani 2 unit, outside room 202. A white powder in a blue bowl with a plastic cover was	F 812	Expired milk removed from the kitchen on 7/11/23. Scooper removed from thickener on 7/11/23. Undated thickener removed from circulation on 7/11/23. Residents residing in the facility are at risk. Staff have been reeducated on storing food items under sanitary conditions on 7/11/23. All fridges in the kitchen were checked to validate milk and liquids were not expired. Kitchen areas were checked to validate that scoopers were not left inside containers. Medication carts were checked to ensure that it did not contain undated thickener. No further findings. Administrator/designee will audit the kitchen weekly x4 weeks then monthly x2 months to validate that foods/liquids are not expired. Audit will also validate that scoopers are not left in containers. Administrator/designee will present findings at the facility□s QAPI committee x 3 months and if needs are identified in the audits, then will restart audits again.	

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F 812	Continued From page 59 observed on the bottom drawer of the Lewalani 2 medication cart. The powder was labeled "thickener." The container filled with white powder did not have an open date or expiration date on the label. Registered Nurse (RN) 1 verbalized that everything in the medication cart should be labeled with an expiration date. RN1 also added that the white powder did not have an expiration date because it was provided to the unit from the facility kitchen. Interview was conducted with the Director of Nursing (DON) on 07/14/23 at 11:30 AM in the hallway outside the conference room. DON stated that the facility has a policy in place that when the kitchen distributes the thickening powder to the units, it needs to be labeled with a date of when it was opened. A review was completed on a facility document titled, "DIETARY SERVICES: Receiving Food Deliveries," dated 01/2023. Document indicated, "Perishable foods will be properly covered, labeled, and dated ...will not be left on the floor for an extended period of time." In addition, a review of the facility document titled, "DIETARY SERVICES: Shelf-life of Common Foods," dated 01/2023 was conducted. The document indicated, "The maximum amount of time any food may be stored will be based on recommended storage timeframes and will not exceed manufacturer's use by date ...Thickener 1 year."	F 812		
F 851 SS=D	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing	F 851		8/18/23

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HALE NANI REHABILITATION AND NURSING CENTER	1677 PENSACOLA STREET HONOLULU, HI 96822

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F 851	Continued From page 60	F 851		

information based on payroll data in a uniform format.
Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.

§483.70(q)(1) Direct Care Staff.
Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).

§483.70(q)(2) Submission requirements.
The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:
(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);
(ii) Resident census data; and
(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

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F 851	Continued From page 61 §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow the regulation for mandatory submission of staffing information based on payroll data to the Centers for Medicare and Medicaid Services (CMS). The facility did not report hours worked by staff for the month of March 2023 in a timely manner resulting in inaccurate data and multiple metrics triggered in the PBJ (Payroll-Based Journal) Staffing Data Report for Fiscal Year 2023 Quarter 2. Findings include: Review of the PBJ report for January 1 to March 31, 2023, revealed the following metrics were triggered: One Star Staffing Rating, Excessively Low Weekend Staffing, No RN Hours, and Failed to have Licensed Nursing Coverage 24 Hours/Day (hours per day). The PBJ report also	F 851	PBJ submission was completed No residents are at risk from this practice. Education was provided to Administrator on the requirements for timely submission of PBJ on 8/4/23 An audit to validate PBJ submission is completed timely will be conducted x3 months.	

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F 851	Continued From page 62 showed that there were no RNs or licensed nursing coverage for the month of March 2023. Review of facility assessment under "Staffing Plan" documented the following daily staffing needs based on the facility's average daily census of 266: day shift, 16 licensed nurses (mix of Registered Nurses and Licensed Practical Nurses), three unit managers (Registered Nurses) and 38 nurse aides (Certified Nursing Assistant); and evening shift, 11 licensed staff, one nursing supervisor and 28 nurse aides; night shift, nine licensed staff, one nursing supervisor and 23 nurse aides. On 07/14/23 at 07:30 AM, requested a copy of the payroll data submitted to CMS for March 2023 and the staff schedule for March and July 2023 from the Administrator. At 08:02 AM, Administrator provided a copy of the requested report and schedule. He also stated that the company changed payroll systems back in March 2023 which may have caused some inaccuracies in the data submitted. Administrator gave the contact information of their assigned payroll staff (PS) who is responsible for transmitting the payroll data to CMS. Review of schedule and payroll report revealed that the facility had licensed staff working for the month of March 2023. At 10:25 AM, phone interview was conducted with PS located in Ohio. PS stated that the data for March 2023 was transmitted late to CMS. Submission deadline was at 09:00 PM eastern standard time and the data was transmitted at 09:00 PM Hawaii standard time, six hours after the deadline. PS stated that the timing for the transmission of data was adjusted for April 2023.	F 851		
F 880 SS=E	Infection Prevention & Control	F 880		8/18/23

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F 880	Continued From page 63 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 64 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure hand hygiene procedures were followed by staff between glove change, prior to donning gloves, and when moving from one resident to another. The facility's system for enhanced barrier precautions was not followed or clear to staff members. This deficient practice encourages the development and transmission of communicable diseases and infections which may affect the health and safety of residents,	F 880	Education was provided to nursing staff related to EBP and hand hygiene on 7/27/23. Residents residing in the facility are at risk. DON/designee initiated education to RNs and CNAs on 7/27/23 regarding EBP practices and hand hygiene. An infection	

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F 880	Continued From page 65 staff, and visitors. Findings include: 1) On 07/11/23 at 02:42 PM, observed Registered Nurse (RN)3 change the dressing for Resident (R)57's left hip wound. R57 was lying in bed, supine position. RN3 told R57 that she will change the dressing to her left hip wound and asked R57 to turn to her right side. RN3 performed hand hygiene, donned a pair of gloves and removed R57's incontinence brief and the dressing to left hip wound. After removing the old foam dressing, RN3 removed her gloves and donned a new pair without performing hand hygiene. RN3 then wet a piece of gauze with normal saline, wiped the wound, dried it with another piece of gauze, applied an ointment and a new foam dressing to the wound. After replacing R57's incontinence brief, RN3 changed gloves again without performing hand hygiene. RN3 assisted R57 with her blanket, repositioned her pillows, removed gloves and washed hands in the bathroom sink. 2) On 07/14/23 at 08:26 AM, observed Certified Nursing Assistant (CNA)2 come out of room 210. Resident in room 210 is on Enhanced Barrier Precautions (EBP) so gown, gloves and mask are required when entering the room. CNA2 removed her gown and gloves outside the room and placed them in the receptacles by the doorway. CNA2 did not perform hand hygiene after removing her gloves and gown. CNA2 continued to walk down the hall, greeted another resident that was in a wheelchair and touched her on the shoulder. CNA2 then entered room 205 without performing hand hygiene and came out with a meal tray. After placing the meal tray in the cart	F 880	control binder was added to all units to inform staff of isolation rationale. Facility will participate in infection control training in collaboration with the Hawaii Department of Health on 8/16/2023. DON/designee will conduct interviews for 5 staff members to validate if the staff are competent on EBP and hand hygiene practices x4 weeks then monthly x2 months. DON/designee will present findings at the facility□s QAPI committee x 3 months and if needs are identified in the audits, then will restart audits again.	

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F 880	Continued From page 66	F 880		

that was in the hallway, CNA2 performed hand hygiene using the alcohol based hand rub (ABHR) mounted on the wall by room 209. All the rooms have an ABHR dispenser mounted just outside the doors in the hallway.

On 07/14/23 ant 10:37 AM during an interview, the Director of Nursing (DON) confirmed that all the staff were trained to perform hand hygiene between glove changes and after removing personal protective equipment (PPE).

3) On the morning of 07/13/23 observed RN49 don a gown outside of R2's room. There were no gloves in the cart. RN49 asked another staff member to pass him some gloves from another cart. The staff member did not sanitize her hands and grabbed a bunch of gloves out of the box. RN49 communicated to the staff member that he would get his own gloves. RN49 hand sanitized and proceeded to remove gloves from another box.

Interview with the Infection Preventionist (IP) confirmed staff members should perform hand hygiene prior to donning (putting on) gloves.

4) On 07/11/23 at 09:20 AM observed CNA18 assisting R19 with her breakfast. Observed signage posted outside of R19's room, "Enhanced Barrier Precautions." The instructions included everyone must clean their hands before entering and when leaving the room. The instructions for providers and staff also included: wear gloves and a gown for the following high-contact resident care activities - dressing, bathing/showering, transferring, changing linens,

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F 880	Continued From page 67	F 880		

providing hygiene, changing briefs or assisting with toileting, device care use (central line, urinary catheter, feeding tube, tracheostomy), and wound care (any skin opening requiring a dressing).

Interviewed Unit Manager (UM)3 to inquire whether staff is required to don gloves and gown when assisting a resident with their meal. UM3 responded staff should don gloves and gown as they are touching the resident during the meal. UM3 observed CNA18 assisting R19 with her meal. UM3 reported he would check on the status for the need for enhanced barrier precautions for this room.

On 07/11/23 at 12:07 PM observed the signage for enhanced barrier precaution was removed for room 106. Observed CNA18 continued to wear gloves and a gown while in the room. On 07/11/23 at 12:22 PM, a follow-up interview was conducted with UM3. UM3 reported the IP was consulted and the signage was removed as the resident's wound had healed and enhanced barrier precautions are no longer indicated.

5) On 07/11/23 at 02:58 PM observed R221 sitting outside of his room in his wheelchair and a tray table in front of him. On his tray table was a used thickened water cup that he received assistance in drinking. As Certified Nurse Aide (CNA)4 walked past R221 she touched and moved R221's water cup toward the center of his tray table and walked in his room. On her way out of R221's room she grabbed a sandwich from the snack bin in the hallway and walked into another resident's room to deliver the snack without hand sanitizing. During the observation, Staff Development Coordinator (SDC) was

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F 880	Continued From page 68 concurrently in the hallway and began walking away when she suddenly turned back around and walked toward CNA4 loudly saying "gel in, gel out," indicating to CNA4 to hand sanitize her hands when she enters and exits a room.	F 880		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of equipment service manual, the facility failed to ensure routine maintenance cleaning of the cabinet filter, based on the manufacturer's recommendation. This deficient practice put Resident (R)56 at risk for the development and transmission of communicable diseases and infections. Findings include: Resident observation, on 07/11/23 at 09:15 AM, R56 was receiving oxygen via a Perfecto2 V Oxygen Concentrator. The cabinet filter of that oxygen concentrator appeared to have hair, dust and lint on the cabinet filter. Review of Electronic Health Record showed that R56 was admitted with diagnosis including Chronic Obstructive Pulmonary Disease, Dementia, Abdominal Aneurysm, Spinal Stenosis, Diabetes, Polyneuropathy, Hypertension. R56 had a doctor's order to give oxygen for oxygen saturation less than 89%.	F 908	Education was provided to nursing staff related to EBP and hand hygiene on 7/27/23. Residents residing in the facility are at risk. DON/designee initiated education to RNs and CNAs on 7/27/23 regarding EBP practices and hand hygiene. An infection control binder was added to all units to inform staff of isolation rationale. Facility will participate in infection control training in collaboration with the Hawaii Department of Health on 8/16/2023. DON/designee will conduct interviews for 5 staff members to validate if the staff are competent on EBP and hand hygiene practices x4 weeks then monthly x2 months. DON/designee will present findings at the facility□s QAPI committee x 3 months and if needs are identified in the audits, then will restart audits again.	8/18/23

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F 908	Continued From page 69 During staff query on 07/12/23 at 03:10 PM, Central Supply Staff (CS1) acknowledged that the cabinet filter was dirty and required maintenance cleaning based on manufacturer's recommendation. CS1 said they would immediately clean or change the filter. Review of the Service manual for the Perfecto2 V Oxygen Concentrator, Section 6 - Preventive Maintenance revealed the following: Cleaning the cabinet filter. There is one cabinet filter located on the back of the cabinet. 1. Remove the filter and clean at least once a week depending on environmental conditions. Note: Environmental conditions that may require more frequent cleaning of the filters include but are not limited to; high dust, air pollutants, etc. 2. Clean the cabinet filter with a vacuum cleaner or wash in warm soapy water and rinse thoroughly. 3. Dry the filter thoroughly before reinstallation.	F 908		