STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING _____ B. WING _____	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 09/11/23 - 09/14/23. The facility was not in compliance with 42 CFR 483 Subpart B. Facility Reported Incidents (ACTS #10019, 10418, 10434) were also investigated. There was non-compliance in ACTS 10434. Survey Census: 104 Sample Size: 29	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584		

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

Electronically Signed

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F 584	Continued From page 1 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to assure a safe, clean, and comfortable homelike environment for two of five sampled residents (Resident (R)37, and R43). Findings include: On initial tour of facility 09/11/23 at 09:56 AM, at the bedside of R43's, equipment was observed. Surveyor noted that the tube feeding pole and parts of the bed were splattered with spilled/spots of questionable formula which smelled like milk. Also noted were areas of the bed with black stain and/or questionable dirt. An observation on 09/11/23 at 12:18 PM, tube feeding was in progress for R 37. Noted fresh formula and a dried crusty substance was spilled on the pole where the formula bag hangs. On 09/12/23 at 08:44 AM, surveyor observed	F 584		

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F 584	Continued From page 2 R43's bedside table, feeding machine, pole, and bed were splattered with a milky and crusty substance. Noted an odor that smelled like formula. On 09/13/23 at 09:44 AM, an interview with nursing supervisor (NS)1 was done. Surveyor and NS1concurrently observed the soiled equipment and the smell of milk. NS1 agreed that cleaning is needed for rooms of R37 and R43.	F 584		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve 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	F 609		

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F 609	Continued From page 3 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 interviews and record reviews, the facility failed to ensure alleged verbal abuse and an injury of unknown source resulting in serious bodily harm, were reported immediately, but not later than 2 hours after the allegation was made to the administrator of the facility and other officials, including to the State Survey Agency (SA) and Adult Protective Services (APS) for two residents (Resident (R)82 and R31) sampled. As a result of this deficient practice, all residents are at a risk of harm, including psychosocial harm. Findings include: The facility's Policy, Prevention of Resident Abuse, Neglect, Involuntary Seclusion and Misappropriation of Property, effective date: 11/03/21 was reviewed. "Residents, et al. shall not be humiliated, harassed...", it is the facility's policy to report alleged complaints and/or violations involving abuse, neglect, involuntary seclusion, injury of unknown origin and misappropriation of property immediately to the Administrator and the DON of the facility and shall be reported to the State agencies within specified timelines. (Cross Reference to F610: Investigate/Prevent/Correct Alleged Violations) 1) Review of the State Agency's (SA) Aspen Complaints/Incidents Tracking System (ACTS) documented the Director of Nursing (DON)	F 609		

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F 609	Continued From page 4 emailed an Event Report of an allegation of abuse injury of unknown origin to the SA on 07/16/23 at 03:32 AM. The initial Event Report documented on 07/15/23 at 03:05 PM, a Certified Nurse Aide (CNA)1 reported to Licensed Nurse (LN)56 that R82 was displaying symptoms of pain to the lower left abdominal area. Upon assessment, NS56 documented R82 was lying in bed guarding the left side. LN56 called and included an interpreter language service via telephone to communicate with the resident. The nurse instructed the interpreter to ask the resident where does it sore? The resident initially answered, "The lady with pain went away". The resident was asked a second time, where does it sore? R82 answered, "Someone kicked her". The resident refused to go to the hospital, LN56's head to toe physical assessment documented no redness, no swelling, and no ecchymosis (discoloration of the skin resulting in bleeding under the skin, typically caused by bruising). The physician was notified and ordered an x-ray of the left lower rib cage. On 09/13/23 at 2:58 PM, conducted a concurrent record review of R82's electronic health record (EHR) to include the facility's completed investigation of the allegation of abuse and interview with the Director of Nursing (DON). Review of R82's x-ray results documented R82 sustained acute lateral 7th and 8th rib fractures, the physician interpreting the x-ray findings signed the results on 07/15/23 at 08:34 PM and staff wrote " Noted 07/15/23" which was initialed by staff acknowledging receipt of the x-ray results. During the interview, the DON stated she was not notified by Nursing Supervisor (NS)29 of the incident within 2 hours of the incident but could not recall or provide documentation of the	F 609		

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exact time. The DON also confirmed there was no documentation of the time the Administrator was notified of the incident. Inquired why was there a delay in NS29 informing the Administrator and the DON. DON stated, NS29 did not identify the incident as an allegation of abuse because staff know the resident has cognitive deficits and did not believe that someone kicked the resident. The DON confirmed NS29, and the DON made an initial determination that R82's allegation was not credible prior to reporting the allegation and of have been treated as an allegation of abuse and/or injury of unknown origin. Thus, the event was not reported to SA with in the 2-hour period and confirmed the facility did not report the incident to APS as required by federal and state regulation.

On 09/13/23 at 04:38 PM, conducted an interview with the Administrator. Inquired when did the Administrator first become aware of R82's allegation of abuse. The Administrator reviewed the investigation and phone records and confirmed she was not immediately notified of the incident, but once she became aware, she informed nursing staff and the DON that R82's incident is a reportable event, and the SA and APS should be notified, and a complete investigation should be conducted. The Administrator confirmed NS29 did not immediately notify the DON and Administrator as soon as the resident verbalized the allegation of physical abuse but did not.

On 09/14/23 at 02:50 PM, conducted an interview with NS29 regarding R82's allegation of abuse. NS29 confirmed the resident has cognitive deficits and her assessment of the resident and what the resident was saying to the interpreter, in

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her opinion, did not constitute as a credible report of abuse. NS29 could not recall or provide documentation of when she notified the DON and the Administrator of the event.

2) On 09/11/23 at 08:58 AM, conducted an interview with R31 at the resident's bedside. R31 stated, "Last week a male CNA (CNA23) was really mean to him and his roommates." and CNA23 called the resident a "motherfucker" and "treated me like a dummy." R31 also reported that he was upset because CNA23 handled his roommate, who is totally dependent on staff, roughly and he did not like that. Inquired if R31 had reported the incident to staff. R31 confirmed the facility knows about the incident and that CNA23 continued to work on the same floor as the resident. R31 reported feeling extremely upset at just the sight of CNA23 and in addition to speaking to the resident.

On 09/14/23 at 10:52 AM, conducted a concurrent record review of R31's EHR and interview with Nurse Manager (NM)5. Inquired about the incident R31 reported to this surveyor. NM confirmed she became aware of the situation on Monday, 09/11/23. LN56 documented the incident as R31 having a behavior of swearing at CNA23. NM5 stated R31 reported that CNA23 called him the name of an actor that does not have teeth or hair, which upset R31. R31 felt like CNA23 was teasing him. NM5 stated LN56 called NS29 to address the situation.

On 09/14/23 at 10:14 AM, conducted a concurrent record review and interview with the DON regarding R31's allegation of abuse. The DON reviewed the facility's documentation and stated she was first informed of the incident on

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F 609	Continued From page 7 09/12/23 when an event report was created and confirmed NS29 did not identify R31's reports of abuse by CNA23 as an allegation of abuse. The DON confirmed NS29 made an initial determination whether the allegation is credible before reporting the allegation. As a result of NS29 initial determination that the allegation of abuse was not credible, the DON and Administrator was not immediately made aware of the situation, CNA23 should have been sent home to protect the resident and/or other resident from the potential of abuse, and the SA and APS should have been notified within the 2-hour timeframe but was not. On 09/14/23 at 12:33 PM, conducted a concurrent record review and interview with Social Worker (SW)1 regarding R31's reported incident. SW1 stated on 09/08/23, SW1 heard a commotion in the hallway involving R31. SW1 took R31 into the solarium to calm the resident down and find out what was going on. SW1 recalled that she had not seen R31 this mad before and R31 informed SW1 that CNA23 told the resident "Okininam, which means fuck you in Ilocano." While in the solarium with R31, SW1 reported CNA23 came into the room and began arguing with R31 about what happened, then CNA23 stormed off. SW1 stated she was concerned about CNA23's behavior and interaction with the resident. SW1 stated that she informed LN56 and NS29 that the incident between CNA23 and R31 was possibly abuse, that CNA23 should not be working on the floor until an investigation is completed, and the DON and the Administrator should be notified immediately. SW1 reported that CNA23 informed NS29 that he wanted to go home and did not want to work due the allegations of abuse, but	F 609		

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F 609	Continued From page 8 NS29 informed CNA23 that if he went home, he would be fired for resident abandonment. CNA23 was reassigned to another part on the same floor and worked the rest of the shift. On 09/14/23 at 2:23 PM, conducted an interview with NS29 regarding R31's allegation of verbal abuse by CNA23. Inquired if NS29 identified the incident as an allegation of verbal abuse. NS29 stated she did not identify the incident involving R31 and CNA 23 an allegation of abuse because the resident is well known will harass staff. NS29 denied that SW1 had informed her that the incident could potentially be abuse and needed to be handled according to the the facility's policy and procedure for abuse. NS29 stated she handled it as a grievance, informed CNA23 he could not leave, and did not inform the Administrator or the DON of the incident. NS29 confirmed the incident should have been handled as an allegation of abuse but did not.	F 609		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 610		

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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 observations and interviews, in response to an allegation of abuse the facility failed to ensure allegations of abuse were thoroughly investigated, prevent further abuse while the investigation was in progress. As a result of this deficient practice, residents are at risk of abuse and experiencing harm.

Findings include:

(Cross Reference to F609: Reporting of Alleged Violations)

On 09/13/23 at 02:58 PM, conducted a concurrent record review of R82's electronic health record (EHR) of the facility's completed investigation of the allegation of abuse with the Director of Nursing (DON). Inquired with the DON about the details of the investigation related to R82's report that someone kicked her in response to Licensed Nursing Staff (LN)56 assessing the resident's lower left abdomen for pain. The DON confirmed as a result of Nursing Supervisor (NS)29's determination that R82's allegation of being kicked in response to questioning regarding lower left abdomen pain as not being a credible allegation, the incident was not thoroughly investigated, but should have been. DON stated R82's physician determined that the resident's fractured ribs was a result of Osteopenia and not from being kicked. Inquired if R82 had a known diagnosis of Osteopenia at the time the allegation was made. The DON

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F 610	Continued From page 10 confirmed R82 did not have a diagnosis of Osteopenia or sign/symptoms prior to the allegation of abuse. DON stated Certified Nurse Aide (CNA)1 identified R82's symptoms of pain in the lower left abdomen when the resident was lying in bed (the resident has three mattresses side by side which are placed on the floor for the resident's safety) and when LN56 assessed the resident there was no observable trauma. Inquired about the resident's cognition and the DON confirmed that although the resident does have cognitive deficits the resident is able to make needs known at the resident may have been able to discern if a person was the cause of the injury. Reviewed staff 's written statements and inquired about CNA34's statement that the resident had signs and symptoms of pain while assisting CNA1 with transferring the resident from the shower, prior to returning the resident to her bed. The DON confirmed she was not aware that CNA34's statement and did not investigate the resident's activities prior to LN56 assessing R82 in the bed. Inquired if the DON confirmed she had not interviewed the staff involved and used the completed witness statements and progress notes as the source of information for the investigation. After reassessing the details of the investigation, the DON confirmed a thorough investigation had not been conducted and it is possible that R82 could have sustained the fractured ribs during transfer or other means which were not investigated due to staff discrediting the resident's allegation before conducting a thorough investigation. Reviewed the facility's policy and procedure for investigating an allegation of abuse and the DON confirmed the procedure for investigating allegations was not implemented and should have been.	F 610		

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F 610	Continued From page 11 On 09/14/23 at 02:50 PM, conducted an interview with NS29 regarding R82's allegation of abuse. NS29 confirmed the resident has cognitive deficits and her assessment of the resident and what the resident was saying to the interpreter, in her opinion, did not constitute as a credible report of abuse.	F 610		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;	F 623		

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F 623	Continued From page 12 (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State 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	F 623		

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F 623	Continued From page 13 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and review of policy, the facility failed to provide written notice of discharge for two Residents (R)R32 & R90) out of two residents sampled. As a result of this deficiency, there was a potential for miscommunication and/or misunderstanding of discharge. Findings include: 1) Review of the Electronic Health Record (EHR) indicated that R32 was admitted to the hospital	F 623		

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F 623	Continued From page 14 on 06/27/23 with diagnosis including Stroke, Diabetes, High Blood Pressure and discharged from the hospital on 07/03/23. Further review did not show any written notice of discharge to the resident and/or representative. During staff interview on 09/13/23 at 01:50 PM, Social Worker (SW1) acknowledged that the facility did not provide written notification of discharge to R32 and/or representative. The Discharge/Transfer Notice form for R32 showed the family, representative was verbally notified by phone of discharge but there was no written notification given. 2) On 09/12/23 at 10:19 AM, conducted a review of R90's EHR documented the resident was transferred to the hospital on 05/26/23 due to the potential of sepsis related to unstable vital signs and increased fever. The Discharge/Transfer Notice form was not documented in the resident's EHR. During staff interview on 09/13/23 at 01:50 PM, SW1 acknowledged that the facility did not provide written notification of discharge to R90 and/or representative. Review of facility policy titled Transfer/Discharge Requirements and Documentation read Purpose; to ensure transfer and discharge requirements are met and documented in the medical record, as well as written notice provided to the resident and resident's family and/or resident's representative for transfer or discharge from the facility. Policy; Residents will be transferred or discharged from the facility for the following reasons: The transfer or discharge is necessary for the resident's welfare and the resident's needs	F 623		

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F 623	Continued From page 15 cannot be met in the facility ... A written notice will be given to the resident, resident's responsible party, and/or resident's legal representative at least 30 days or as soon as practicable prior to, or upon, transfer or discharge of the resident. The notice must be in a language and manner understandable to the resident, and will include the reason for transfer/discharge, the effective date of transfer or discharge, location to which the resident was transferred/discharged, right of appeal, and information on how to notify the Ombudsman and appropriate protection and advocacy agencies...	F 623		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format.	F 732		

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F 732	Continued From page 16 (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and review of policy procedure, the facility failed to post staffing information for one Nursing Unit, 4th floor Young, out of three Nursing Units sampled. As a result of this deficiency the facility failed to follow regulation to make nurse staffing data available to the public for review. Findings include: During observation of the 4th floor Young Nursing Unit on 09/11/23 at 10:15AM, the staffing information form posted at the nurse's station was not completed. There was no information to show the total number and actual hours worked by licensed and unlicensed nursing staff as required. During staff interview on 09/11/23 at 02:30PM, the Director of Nursing acknowledged that the staffing information was not completed as previously mentioned.	F 732		

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F 732	Continued From page 17 Review of facility procedure on Revised Procedure for Staff Posting read the following: Effective immediately, units are required to complete the Daily Staff Posting sheet by 0700 hours and post in the designated area (white board). At the beginning of each shift, the Charge Nurse for the on-coming shift will verify the census and staffing, and make changes as needed on the Daily Staff Posting sheet. The sheet will be changed at 0700 hours daily and submitted to the Nursing Supervisor/Nursing Office for record keeping ...	F 732		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761		

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quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff interview and review of policy, the facility failed to secure a padlock that was attached to the medication refrigerator door on the 3rd floor Young Nursing Unit. As a result of this deficiency, the facility failed to properly store the refrigerated medications.

Findings include:

During observation of the 3rd floor Young Nursing Unit, on 09/11/23 at 11:20AM, the medication refrigerator was not secured. There was a padlock there to secure the door, but the padlock was not locked. There was no staff in the immediate vicinity, and anyone could remove the padlock and have access to the medications in the refrigerator.

Staff interview on 09/11/23 at 11:45AM with the 3rd floor Head Nurse acknowledged that the padlock should have been locked and always secured. Head Nurse then locked the padlock and secured the refrigerator.

Review of policy on Storage of Medication read Policy; Medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications ... Procedures; In order to limit access to

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F 761	Continued From page 19 prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medications carts. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access ... Medication storage conditions are monitored on a regular basis as a random quality assurance (QA) check. As problems are identified, recommendations are made for corrective action to be taken ...	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		

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F 880	Continued From page 20 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the 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.	F 880		

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F 880	Continued From page 21 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to perform proper hand hygiene and follow infection control protocol. This deficient practice places the residents and visitors at risk for the development and transmission of communicable disease and infections. Findings include: 1) Observation was conducted on 09/11/23 at 07:54 AM on the first-floor visitor check-in station. A Health Screener (HS) was observed conducting self-swab Covid testing on three state surveyors. After the first surveyor performed self-swabbing, HS collected the test swab and placed it on the table. HS then removed his gloves and threw them in the trash can. HS proceeded to don new gloves without hand hygiene and assisted the second surveyor with self-swabbing. Once the second surveyor finished self-swabbing, HS collected the test swab and placed it on the table. HS then removed his gloves and placed it in the trash can. HS proceeded to perform tasks near the table containing the test kits. A couple minutes later HS walked away from the testing station. 2) Observation was conducted on 09/13/23 at 08:50 AM on the fourth-floor hallway. A Registered Nurse (RN) 1 was prepping medications at the medication cart with gloves on. RN1 entered room 407 with the same gloves and administered medication via gastrostomy tube to R34. Following medication administration, RN1 removed the gastrostomy tube dressing and	F 880		

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F 880	Continued From page 22	F 880		

threw it in the trash. RN1 also removed her gloves at the same time and walked out of the room. A minute later, RN1 returned to the room and donned new gloves to finish the dressing change. She applied ointment and new dressing on the gastrostomy tube site. Once dressing change was completed, RN1 proceeded with medication administration without removing and changing her gloves.

Interview was conducted on 09/13/23 at 09:46 AM in the fourth-floor hallway. RN1 stated that facility staff are supposed to change their gloves when performing different tasks.

Interview was conducted with the facility's Infection Preventionist (IP) on 09/13/23 at 10:17 AM via telephone. IP stated that facility staff should be performing hand hygiene in between glove changes and change gloves when performing different tasks.

A review of the facility policy titled, "Hand Hygiene," dated 02/03/23 was conducted. The policy indicated, "Indications for Antiseptic Hand Rubbing or Antiseptic Handwashing...before putting on and after removing gloves (wearing gloves is not a substitute for hand hygiene) ...before administering medications...Before performing sterile or clean procedures such as but not limited to urinary catheterizations, IV insertions, dressing changes..."