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	HI02LTC050H	A. BUILDING: ______ B. WING ______	05/03/2023

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4 000	11-94.2-0 Initial Comments A re-licensure was conducted by the State Survey Agency, the Office of Health Care Assurance on May 03, 2023. The facility was found not in substantial compliance with Hawaii Administrative Rules, Title 11 Chapter 94.2 Nursing Facilities. Aspen complaint tracking system (ACTS) complaint #10099 was investigated during the re-licensure and the facility was found to not to be in substantial compliance with deficient practices related to abuse. Facility census: 1	4 000		
4 535	11-94.2-20 (a) In-service education (a) There shall be a staff in-service education program that includes the following: (1) Orientation for all new employees that shall include: (A) Information to acquaint them with the philosophy, organization, program, policies and procedures, practices, and goals of the facility; and (B) Competency evaluation to ensure that staff are able to carry out their respective duties; (2) In-service training for employees who have not achieved the desired level of competence, and continuing in-service education to update and improve the skills and competencies of all employees; (3) In-service training that shall include annually, at minimum, prevention and control of infections, fire prevention and safety, disaster	4 535		

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4 535	Continued From page 1	4 535		

preparedness for all hazards, accident prevention, resident rights including prevention of resident abuse, neglect and financial exploitation, and problems and needs of the aged, ill, and disabled;

(4) Competency testing for cardiopulmonary resuscitation to annually certify the nursing staff;

(5) Training in oral hygiene and denture care, which shall be given to the nursing staff at least annually; and

(6) Appropriate personal hygiene instructions at regular intervals shall be given to all personnel providing direct care and handling food.

This Statute is not met as evidenced by:
Based on record review and interview with staff member the facility failed to ensure seven of seven staff members sampled received the minimum in-service trainings required annually and failed to ensure six of six nursing staff members sampled received training in oral hygiene and denture care at least annually.

Findings include:

On 05/02/23, review of the State Agency's (SA) "INSERVICE RECORD REVIEW" log with list of seven chosen sampled staff members provided to the facility completed and returned to SA on 05/02/23 documented;

1) Staff Member (SM) 1's needs of the aged, ill, and disabled in-service training was last done on 08/01/08 and oral hygiene and denture care (dental) training was last completed on 10/08/19.

SM2's needs of the aged, ill, and disabled

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4 535	Continued From page 2 in-service training was last done on 09/13/21. SM3's needs of the aged, ill, and disabled in-service training was last done on 11/24/03 and dental training was last completed on 03/10/22. SM4's needs of the aged, ill, and disabled in-service training was last done on 07/09/07 and dental training was last completed on 12/11/20. SM5's needs of the aged, ill, and disabled in-service training was last done on 10/23/22 and dental training was last completed on 06/23/15. SM6's needs of the aged, ill, and disabled in-service training was last done on 05/14/14 and dental training was last completed on 10/27/21. SM7's needs of the aged, ill, and disabled in-service training was last done on 09/15/22 and dental training was last completed on 12/15/20. On 05/03/03 at 09:25 AM an interview with Director of Clinical Operations (DCO) confirmed the staff members' in-service training on needs of the aged, ill, and disabled and dental training were not completed annually and the in-service for aged, ill and disabled was done once during their orientation.	4 535		
4 560	11-94.2-22 (b) Medical record system (b) If the employee who supervises medical records is not a registered health information administrator or registered health information technician, there shall be regularly scheduled visits by a qualified consultant who shall provide reports to the administrator.	4 560		

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4 560	Continued From page 3 This Statute is not met as evidenced by: Based on interview with staff member, the facility did not assure acquisition of registered health information administrator or registered health information technician to oversee accurate processing, auditing and analysis, indexing, filing, and prompt retrieval of records, record data, and resident health information. Findings include: In a review of staff members' credentials on 05/02/23, the facility did not identify a medical records staff member. On 05/03/23, the Director of Clinical Operations confirmed the facility has not employed or contracted a registered health information administrator or technician.	4 560		
4 725	11-94.2-29 (a) Resident abuse, neglect and misappropriation a) The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to implement written policies and procedures that prohibit mistreatment and abuse of residents. After receiving reports of alleged mistreatment and potential abuse from staff and a resident representative, the facility failed to identify, investigate, and report the allegations as potential mistreatment and/or abuse, and instead investigated the incident(s) as professional misconduct. As a result of this deficient practice, resident safety was compromised, increasing the potential for harm. This deficient practice has the	4 725		

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4 725	Continued From page 4	4 725		

potential to affect all residents in the facility.

Findings include:

On 02/17/23 at 01:54 PM, an anonymous complaint was received by the State Agency (SA) involving allegations of staff-to-resident(s) mistreatment and potential abuse. The complaint was forwarded to the SA by another state agency/program providing protection for vulnerable adults. The complaint received documented allegations of physical abuse, psychological abuse, and mistreatment, from the alleged perpetrator (AP), a Certified Nurse Aide.

On 05/02/23, the SA entered the facility for a re-licensure survey, and to investigate the forwarded anonymous complaint.

On 05/02/23 at 11:40 AM, an interview was done with the Director of Clinical Operations (DCO). After being asked to provide the SA with all documentation related to the investigation of AP, DCO inquired about the dates for allegation(s) of abuse. DCO reported that the facility did not investigate AP for concerns of abuse or mistreatment, but rather investigated her for quality of care. DCO continued on to report that the facility had "let her [AP] go for poor staff interactions," and was unaware at the time of their investigation that there were allegations of physical and psychological abuse.

On 05/02/23 at 03:35 PM, DCO provided the SA with a copy of a written complaint from Staff Member (SM)15 dated "January 30, 2023," and a copy of a brief "Investigation Summary Report" conducted by the Director of Administrative Services (DAS) and " ... opened: 01/31/23."

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A review of the written complaint from SM15 noted the following:

" ... Last week ... [AP] yelled from the nurses [sic] station, " ... [to resident], stop ringing that frickin [sic] bell!... Incident date: 1/28/23 ... Throughout the day ... [AP] made derogatory comments about staff and inpatient family members ... Pt [patient] wife, in bed #5, cried and expressed to me that, "I want to remove my husband ... Why is she [AP] so mean. She told me I had to stay in the room and not come out. I never been treated [so] inhumanly like that" ... Pt wife mentioned that ... [AP] asked her to wait outside, in the rain, while pt husband was given a bath ..."

A review of the completed Investigation Report noted the following:

" ... Description of the allegation: On Tuesday 1/31/23 it was reported to HR [Human Resources], via an email from [SM15] ... [AP] was observed 1- yelling from down the hall, when a patient requested assistance, 2- making derogatory comments about staff and inpatient family members ..." There is no mention in the allegations of the alleged mistreatment of the resident representative.

The Investigation Report documents interviews conducted by DAS with SM15 (one by phone and one in-person), AP (in-person), and a video conference between DAS, DCO and the House Manager (HM) before the determination that "Disciplinary action was to be enforced toward [AP] ... for her unprofessional conduct, but due to her voluntary resignation the case was closed 2/16/2023." The Investigation Report does not document any interviews with residents or their representatives, or other staff members present

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during the time(s) of the alleged incident(s). The Investigation Report also does not document receipt or review of any other evidence or investigative notes regarding the allegations made. A second request for all documentation related to the investigation was made.

On 05/03/23 at 07:59 AM, an interview was done with DCO. When asked to describe her involvement in the investigation, DCO reported that prior to the investigation, she had been notified by HM that AP and SM15 "were having problems." On the morning of 01/31/23, DCO received a phone call from SM15 requesting a meeting to discuss her concerns with AP's behavior and resident care. DCO reported that she went to the house and interviewed SM15, HM, and a Resident Representative (RR). DCO stated that RR was very upset and complained about AP but that she seemed uncomfortable speaking to her. She remembers her saying that she wanted to take her husband out of the facility because of their experiences with AP. DCO stated she called DAS and requested an investigation be opened. At that point, DCO stated she believed it was still a quality of care and professional conduct issue. When asked specifically if she had documented any of this, DCO stated "Normally, I just call her [DAS] ... I did not put anything in writing, I just had a feeling that something more was there."

At 08:45 AM, DCO provided the SA with two additional investigation documents. One was DAS documentation of the complaint received from SM15. The second was a DCO e-mail to DAS, HM, and the Chief Executive Officer (CEO) documenting DCO's interview with RR the morning of 01/31/23. At this time DCO stated, "I knew I had to have written something."

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Review of DAS documentation noted the following:

" ... [SM15] reported the following regarding 01/28/23 ... [AP] was observed being "rough with patients" ... [AP] screamed ... "stop using your freaking bell" to a patient ... Bed 5 pt [patient] stepped out to use the restroom and ... [AP] said "What do you want now?" ... Bed 5 pt's spouse shared that she wants to leave ... and is not pleased with her husband's care ..." At the bottom of the document is the following notation: "NOTED 1/31/23 at 1105 am by ... [DAS]."

Review of DCO e-mail, dated 01/31/23 at 11:39 AM, revealed the following:

"I just met with the wife in bed #5 and it truly saddens me what occurred at the home on Saturday ... the wife became emotional during our conversation and was fearful to say anything due to repercussions ... It was very clear that the wife is fearful to speak up ..."

During interviews conducted with anonymous staff members (ASM) on 05/03/23 and 05/04/23, the following was reported:

ASM18 reported observing AP verbally abuse residents; received complaints from residents that they would wait a long time when calling AP for help, with AP stating "you're not the only patient here" when she did respond; observed AP tell a resident once "just do it in your diaper, we're not going to get you out of bed anymore ..."; witnessed and documented abusive and/or inappropriate behavior numerous times and submitted to HM;

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ASM22 made several observations of AP speaking rudely to residents and being unnecessarily rough while re-positioning them; observed AP swearing at residents; felt she was verbally and psychologically abusive to residents, all which she stated she reported to HM. ASM22 could not remember and did not document specific residents that were affected, stating that the behavior was ongoing and occurred mostly when HM was not around.

ASM26 reported that a few resident representatives had complained to her about AP being rude and/or yelling at them. Stated that she passed the information on to HM, and referred the representatives to follow-up with HM.

ASM33 reported that AP "intimidated the staff terribly", and that she received many complaints from several staff, all which were reported to DCO.

On 05/03/23 at 10:56 AM, a phone interview was done with DAS. DAS stated that she was not made aware of any complaints regarding AP prior to 01/31/23 when she received notice of SM15's complaint. DAS acknowledged receipt of SM15's concerns, as well as DCO's e-mail detailing her interview with RR prior to beginning her investigation. DAS stated that as part of her investigation, she interviewed SM15, AP, and HM. SM10 was also present at the facility on 01/31/23 and did provide DAS with some feedback on AP's work. DAS confirmed that she did not interview RR, any residents, or any other staff members who had worked with AP. DAS stated that she investigated the allegations as professional misconduct which was substantiated and reported that a determination had been made to terminate AP, however, she voluntarily

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resigned so no disciplinary action had been executed. When specifically asked about mistreatment and potential abuse, DAS acknowledged that she could see now that red flags were there, but at the time she did not investigate it that way.

A review of the facility's Abuse, Neglect, Mistreatment and Exploitation Policy and Procedure, last revised 02/2016, revealed the following:

"Definitions

Abuse: The intentional infliction of physical, emotional, or sexual pain or injury that results in physical harm, pain or mental anguish ...

Mistreatment: To treat someone or something roughly, wrongly or badly ...

Procedures:

... throughout the course of care, hospice personnel assess the potential/likelihood of abuse, neglect, mistreatment or exploitation in the patient's environment ...

... staff will adhere to all mandated State and Federal abuse, neglect and exploitation reporting requirements ...

... Alleged violations of abuse, neglect, mistreatment and/or exploitation involving a ... employee ... are brought to the attention of the ... [CEO] ...

[The CEO] ... or designee immediately investigates alleged violations ...

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4 725	Continued From page 10 [The CEO] ... documents all activities and conversations during the investigation related to the alleged violation ..."	4 725		
4 730	11-94.2-29 (b) Resident abuse, neglect and misappropriation (b) All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source or origin, and alleged misappropriation of resident property shall be reported immediately to the administrator of the facility, and to other officials in accordance with state law through established procedures. This Statute is not met as evidenced by: Cross-reference to 725 (11-94.2-29(a)) Develop and implement written policies and procedures that prohibit mistreatment and abuse of residents. Based on interview and record review, the facility failed to ensure that all alleged violations involving mistreatment and/or abuse were reported to the appropriate state agencies in accordance with state law.	4 730		
4 740	11-94.2-29 (d) Resident abuse, neglect and misappropriation (d) The facility shall maintain a record that all alleged violations were thoroughly investigated and shall take all reasonable steps to prevent further abuse while the investigation is in progress. This Statute is not met as evidenced by: Cross-reference to 725 (11-94.2-29(a)) Develop and implement written policies and procedures that prohibit mistreatment and abuse of residents. Based on interview and record review, the facility	4 740		

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4 740	Continued From page 11 failed to ensure that all alleged violations involving mistreatment and/or abuse were thoroughly investigated.	4 740		
4 760	11-94.2-36 (a) Admission, transfer and discharge (a) There shall be written policies and procedures available to staff, residents, and the public that govern: (1) All services provided by the facility; (2) The admission, transfer, and discharge of residents; and. (3) Notification to the resident, resident's representative, and the state long term care ombudsman of transfer or discharge initiated by the facility. This Statute is not met as evidenced by: Based on electronic health record (EHR) review and staff interview the facility failed to provide notification to the state long term care ombudsman of discharge initiated by the facility for one of two sampled residents. Findings include: On 05/02/23 at 01:30 PM an EHR review was conducted on a resident (R)1 discharged from the facility on 01/24/23. No documentation was found that the facility had notified the state long term care ombudsman. On 05/02/23 at 03:00 PM an interview was conducted with the Director of Clinical Operations (DCO), who confirmed that the state long term care ombudsman was not notified when R1 was	4 760		

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4 760	Continued From page 12 discharged from the facility. Furthermore, the DCO stated she was not aware that the state ombudsman needed to be notified for discharges involving hospice residents.	4 760		
4 815	11-94.2-39 (a) Nursing services (a) Each facility shall have nursing staff sufficient in number and qualifications to meet the nursing needs of the residents. There shall be at least one registered nurse at work full-time on the day shift, for eight consecutive hours, seven days a week, and at least one licensed nurse at work on the evening and night shifts, unless otherwise determined by the department. This Statute is not met as evidenced by: Based on interviews with staff members and review of the staff schedule, the facility failed to provide at least one registered nurse on a full-time basis on the day shift for eight consecutive hours, seven days a week. As a result of this deficient practice, one resident in the facility is at risk for potential adverse outcomes in his/her care. Findings include: On 05/02/2023 at 08:55 AM an interview was conducted with Staff Member (SM)13 regarding nursing care in the facility. She verbalized, "there is usually a house manager, who is a registered nurse (RN), on site from 08:00 AM to 04:30 PM. The facility is currently in the process of finding a replacement for a house manager, since the last one is no longer employed at the facility. In the meantime, the Director of Clinical Operations (DCO) is the acting house manager. The acting house manager is not on site. But is reachable	4 815		

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4 815	Continued From page 13	4 815		

through phone." SM13 further explains, "there are RNs on call 24/7 [24 hours a day, 7 days a week]."

On 05/02/2023 at 02:10 PM an interview was conducted with the DCO. She stated that the facility currently does not have a RN/house manager and they are in the process of finding a replacement.

Furthermore, during a review of the staff schedules on 05/03/23 at 11:00 AM, a RN was not scheduled at the facility since 02/17/2023.

4 870	11-94.2-41 (a) Storage and handling of food	4 870		

(a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions.

(1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and

(2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage.

This Statute is not met as evidenced by:
Based on observation and staff interview, the facility failed to label and date various food items. As a result of this deficient practice, one resident in the facility was at risk for possible foodborne illness.

Findings include:

On 05/03/23 at 08:14 AM surveyor observed the

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4 870	Continued From page 14 facility's fridge labeled "Patient's Food Only" filled with various unlabeled containers. Observation included an unlabeled mason jar filled with unknown liquid, unlabeled container with sliced fruit, and an unlabeled plastic container containing cooked food item. Observation of the freezer included an unlabeled food item. The item was in a sealed package, seperated from the box, without an expiration date. Surveyor also observed signage taped to the front of the fridge stating, "Label EVERYTHING WITH: 1. Patient's Name or Room #, 2. Date that food was cooked/purchased. Food items have a 3-day life span. After 3 days, food items will be discarded with the exception of condiments." On 05/03/23 at 08:50 AM an interview was conducted with Staff Member (SM)13 and Staff Member (SM)5 regarding fridge labeled "Patient's Food Only." SM13 and SM5 were shown unlabeled food items in the fridge (sliced fruit, mason jar filled with unknown liquid, plastic container containing cooked food) as well as unlabeled item in a sealed package found in the freezer. They both stated that those unlabeled items should have been labeled. SM5 further explained, "it's our food items brought in this morning, and we did not have a chance to label it." This surveyor asked about the label on the fridge that stated, "Patient's Food Only." SM13 then explained that the staff fridge has been broken and has not been fixed.	4 870		
41150	11-94.2-55 (g) Housekeeping (g) All combustible, potentially hazardous, or poisonous agents used for the cleaning of the	41150		

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Continued From page 15

facility shall be stored in a secured and locked area. [Eff] (Auth: HRS §§321-9, 321-11) (Imp: HRS §§321-9, 321-11)

This Statute is not met as evidenced by:
Based on observation and interview, the facility failed to ensure all potentially hazardous, or poisonous agents used for the cleaning of the facility were stored in a secured and locked area.

Findings include:

On 05/02/23 at 08:25 AM, an observation was made in the medication/laundry area of a bottle of laundry soap and a bottle of bleach stored on the bottom shelf of an unlocked cabinet.

On 05/02/23 at 08:45 AM, an interview was done with Staff Member (SM)5 in the resident bathroom next to rooms 1 and 2. SM5 showed the State Agency (SA) the locked cabinet in the bathroom where the "MSDS [potentially hazardous chemicals]" were secured. When the SA asked SM5 about the cleaning materials observed in the medication/laundry room, SM5 stated that normally they would be locked up in the cabinet with the other cleaning supplies but that she was still in the process of cleaning for the morning, and did not have a chance to put them away yet.

41150

41190

11-94.2-57 (f) Life safety

(f) Fire drills shall be conducted at least quarterly, for each shift, under varied conditions. At least twelve drills shall be held every year and reports filed in the facility and available for review by the department.

41190

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41190	Continued From page 16 This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure fire drills were conducted at least quarterly for each shift. Findings include: On 05/02/23, review of the facility's "Annual Fire Drill Log" for 2022-2023 was done. The log revealed there were no fire drill entries, during third quarter, from July to September 2022, and no second shift fire drill entries, during fourth quarter, from October to December 2022. On 05/03/23 at 09:25 AM an interview with Director of Clinical Operations (DCO) was done. DCO confirmed the facility did not complete fire drills during the third quarter and the second shift did not complete fire drills during the fourth quarter. DCO reported the facility usually conducts fire drills every month for all shifts.	41190		
41215	11-94.2-58 (b) Emergency preparedness (b) The facility shall develop and maintain a written disaster preparedness plan consistent with state and local civil defense guidelines that includes the evacuation capacity designation to be followed in case of an emergency or disaster. A copy of the plan shall be readily available at all times within the facility. The plan shall include procedures for evacuating all individuals in the facility to an approved point of safety as designated by the county authority or designated shelter as determined by the state or local civil defense unless the facility has been determined by the State to be capable of sheltering in place. The plan shall include the following:	41215		

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41215	Continued From page 17 (1) Fire drills that include the transmission of a fire alarm signal and that shall be held at least quarterly for each shift, under varied conditions. At least twelve drills shall be held every year and reports filed in the facility; (2) Specific provisions and plan for evacuating residents with specific details for residents with impaired mobility or cognitive impairments; (3) Specific provisions and plan for transporting all of the residents of the facility to a pre-determined appropriate facility or facilities that will accommodate all the residents of the facility in case of a disaster requiring evacuation of the facility; (4) Specific provision to determine the safety of the facility post-disaster prior to the return of evacuated residents; (5) Specific provisions for transfer of residents should the facility not be determined to be structurally sound post-disaster and plan for continuing operations; (7) Evacuation drills shall be conducted at least quarterly and documented; and (8) A written transfer agreement with the appropriate facility or facilities for accommodating all of the residents of the facility in case of a disaster requiring evacuation of the facility. [Eff] (Auth: HRS §§321-9, 321-11) (Imp: HRS §§321-9, 321 11) §§11-94.2-59 to 11-94.2-63 (Reserved).	41215		

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41215	Continued From page 18 This Statute is not met as evidenced by: Based on record review and interview with staff member the facility failed to ensure the facility's written disaster preparedness plan included fire drills to be conducted at least quarterly for each shift, under varied conditions, included provisions and plans for evacuating all individuals in the facility with specific details for residents with impaired mobility or cognitive impairment to an approved point of safety, and included specific provisions and plan for transporting all of the residents of the facility to a pre-determined appropriate facility in case of a disaster requiring evacuation of the facility. Findings include: Cross Reference to 11-94.2-57(f). The facility failed to ensure fire drills were conducted at least quarterly, for each shift, under varied conditions. On 05/02/23 review of the facility's disaster preparedness plan "Emergency Management Plan" revised on 09/20 did not document required details on fire drills to be conducted and the facility's evacuation plan. On 05/03/23 at 09:25 AM an interview with Director of Clinical Operations (DCO) was done. DCO confirmed the facility does specify how often fire drills are conducted in the disaster preparedness plan and the facility does not have a written evacuation plan.	41215		
41225	11-94.2-64 (b) Engineering and maintenance (b) The facility shall have an appropriate written preventive maintenance program.	41225		

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41225	Continued From page 19 This Statute is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement a written preventive maintenance program. As a result of this deficient practice, equipment essential for the health, safety, and comfort of the residents were not maintained appropriately. Findings include: On 5/2/23 at 01:26 PM, a phone interview was done with the company Facilities Manager (FM). FM stated he was covering as the Facilities Manager of the house/facility due to the vacancy of a House Manager. When asked, FM reported that he was unsure whether there was a written preventive maintenance program for the facility. At 01:35 PM, the Director of Clinical Operations (DCO) approached the State Agency (SA) and reported that in the absence of a House Manager, she was responsible for house maintenance. When asked, DCO also reported that she was unsure whether there was a written preventive maintenance program for the facility. At 02:00 PM, the DCO approached the SA again and confirmed that the facility had no written preventive maintenance program.	41225		
41235	11-94.2-64 (d) Engineering and maintenance (d) The facility shall maintain records that document that inspection of all devices essential to the health and safety of residents and personnel shall be carried out at sufficient intervals to ensure proper operational performance. [Eff]	41235		

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41235	Continued From page 20	41235		

(Auth: HRS §§321-9, 321-11) (Imp: HRS §§321-9, 321-11)

This Statute is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to maintain records that document the inspection of all devices essential to the health and safety of residents and personnel. As a result of this deficient practice, proper operational performance of essential equipment was placed at risk.

Findings include:

On 05/02/23 at 08:45 AM, an interview and partial facility tour was done with Staff Member (SM)5. It was observed that the facility washer and dryer were positioned in a tight space with no direct access to the dryer duct, and no outlet connecting the duct to the outside. SM5 described the process of cleaning out the dryer lint duct and stated that she physically moves the dryer so that she has access to the duct, then vacuums out the duct once a month. When asked, SM5 reported that she does not keep a log of this monthly cleaning.

On 05/02/23 at 02:00 PM, an interview was done with the Director of Clinical Operations (DCO) who reported that in the absence of a House Manager, she was responsible for house maintenance. The DCO explained that since February 2023, she had been visiting the facility and having staff check all the equipment, but they had not been keeping logs. Stated, "I guess we should have." When asked about the maintenance of the facility air conditioners (window units in each resident room), the DCO reported that all air conditioner units in the house/facility were "relatively new," so no one had

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41235	Continued From page 21 changed or checked the filters yet. When asked to define what relatively new meant, the DCO answered, "two years, one to two years." On 05/02/23 at 02:30 PM, during a review of the facility's Subchapter 7 Physical Facility Standards Policy and Procedure, revised: "Dec 2011, 2018, 2023," the following was noted: "L. Air conditioners are kept clean and in good operating condition with periodic filter checks and replacement as needed by a certified company. 1. Documentation of cleaning is kept in a log in the Policy & Procedure Manual."	41235		
41255	11-94.2-65 (d) Construction requirements (d) The facility shall have adequate toilet and bath facilities: (1) One toilet room shall serve not more than eight residents; (2) The toilet room shall contain a toilet and washbasin. The washbasin may be omitted from a toilet room that serves single or multi-bed rooms if each resident room contains a washbasin; (3) There shall be one shower or tub for each fourteen beds that are not otherwise served by bathing facilities within the resident room; (4) Appropriately placed and mounted safety-grab bars shall be provided in each toilet, bathtub, or shower enclosure; (5) Curtains or doors to ensure privacy shall be	41255		

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41255	Continued From page 22	41255		

Continued From page 22

provided;

(6) An adequate supply of potable running water shall be provided at all times. Temperatures of hot water at plumbing fixtures used by the residents shall be automatically regulated and shall not be below 100 or above 120 degrees Fahrenheit;

(7) Each toilet and bath facility shall have a call system that permits the occupant to signal the nursing station in an emergency;

(8) Where bedpans are used, equipment for their care shall be provided in an appropriate area of the facility;

(9) Provisions shall be made for disinfecting of permanent personal care equipment unless disposables are used; and

(10) Separate toilet facilities shall be provided for the use of residents and personnel.

This Statute is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure that each toilet/bathroom was equipped with a call system permitting the occupant to signal the nursing station in an emergency. As a result of this deficient practice, the safety of any resident left in the bathroom unattended would be compromised.

Findings include:

On 05/02/23 at 10:50 AM, an interview and partial facility tour was done with Staff Member (SM)13. When asked to describe the call system the residents used, SM13 reported that there is a

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41255	Continued From page 23 metal counter bell that is at kept at the bedside of each resident and carried into the bathroom when a resident goes to the bathroom. Observation of the two shared resident bathrooms at this time noted nowhere to place the metal counter bell when the resident is in the shower. Also noted that the metal counter bell would not be accessible or within reach if the resident fell to the floor. On 05/02/23 at 02:30 PM, during a review of the facility's Subchapter 7 Physical Facility Standards Policy and Procedure, revised: "Dec 2011, 2018, 2023," the following was noted: "6. Each bathroom is equipped with a call system which allows for the occupant to signal the staff in an emergency."	41255		
41290	11-94.2-65 (k) Construction requirements (k) The facility corridors shall: (l) Have a minimum clear width of forty-four inches, except that corridors serving one or more non-ambulatory or semi- ambulatory residents shall be not less than eight feet in width; and (2) Stationary handrails shall be installed along both sides of corridors. This Statute is not met as evidenced by: Based on observation and interview with staff member, the facility failed to ensure corridors have a minimum clear width of forty-four inches serving one or more non-ambulatory or semi-ambulatory residents. Findings include:	41290		

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41290	Continued From page 24 On 05/02/23 at 08:55 AM inquired with Staff Member (SM) 13 if the facility made any changes to widen the corridor near rooms 1 and 2, SM13 confirmed the facility did not make any changes. During observation and measurement of the corridor, the corridor measured less than forty-four inches.	41290		