STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(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 05/02/23 - 05/05/23. The facility was not in compliance with 42 CFR 483 Subpart B. Survey Census: 84 Sample Size: 31	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the	F 561		6/9/23

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

Electronically Signed | 05/26/2023

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F 561	Continued From page 1 facility. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the resident's right to self-determination through support of a resident's choice was facilitated for one of seven (Resident (R)189) residents sampled. R189 had previously selected to have miso soup with lunch and did not receive the item. As a result of this deficient practice, there is the potential for psychosocial harm. Finding include: On 05/02/23 at 12:49 PM, conducted an observation of Resident (R)189 during lunch. Review of R189's lunch ticket located on the resident's tray, documented R189 had circled and selected to have miso soup with lunch. Observation of the food items on the resident's tray revealed there was no miso soup. Inquired with R189 about the missing miso soup. R189 confirmed the circled miso soup on his/her lunch ticket indicated that the resident wanted it for lunch, but the item was not on his/her lunch tray. The resident stated that staff did not check or notice the miso soup was not his/her lunch tray. R189 stated "I usually have soup with all of my meals at home, so I was really looking forward to it for lunch, it's comfort food for me, plus it helps me to warm up. That's why I picked it on my lunch ticket, it's important to me and helps me to feel good. There have been other times when I chose something for my meal and did not get the food." 05/04/23 at 1:15 PM, conducted an interview with R189 regarding the resident's lunch preferences.	F 561	Corrective Action R189 continues to be a resident at KPO. Food Service Director (FSD) interviewed resident on 5/22/2023 and no changes to choice menu/preferences. Identification of Others Residents who have a choice menu or preferences have the potential to be affected by this finding. A 100% audit was conducted on 5/23/2023 and 31 of 85 residents have a choice menu/preferences. Systemic Change All residents have the right to self-determination through support of a resident’s choice. FSD initiated staff education on 5/23/2023 to emphasize meal tray audits to ensure accuracy of resident requests. Operational changes have been implemented to ensure better communication with resident. Monitoring Change The Food Service Director and/or designee will audit 10 random trays per week to ensure residents’ choices are honored. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 1 month to ensure compliance is achieved	

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F 561	Continued From page 2	F 561		

R189 stated he/she did not receive any soup on 05/02/23 and did not receive a bun as requested with lunch today (05/04/23). Inquired if the resident informed staff of the missing food items from his/her tray. R189 stated that he/she did not want to be a burden or cause any issues for staff and did not feel comfortable reporting the missing food items even though it was important to him/her. R189 explained that it was part of her cultural background to not "complain or speak out" about things.

On 05/04/23 at 11:05 AM, conducted a review of R189's Electronic Health Record (EHR). Review of R189's admission Minimum Data Set (MED with an Assessment Reference Date (ARD) of 04/12/23, Section F, documented it was very important for the resident to have snacks between meals". Section C, Cognition, the resident scored a 13 on the Brief Interview for Mental Status (BIMS), indicating the resident is cognitively intact and able to make decisions.

On 05/04/23 at 03:12 PM, conducted an interview with the Food Service Director (FSD) at the nursing station. Inquired with FSD regarding the facility process of checking the resident's meal trays to ensure the residents receive their preference of food. FSD explained that there are several checks of the resident's trays in the kitchen prior to going out to the unit and floor staff (CNA and Nurses) should also check the resident's trays when it is delivered to the resident. FSD stated that there is a choice card (is done daily) and will override any dislikes the resident had previously reported. Informed FSD of this surveyor's observation of R189's miso soup missing from the resident's lunch tray and of the missing bun reported by the resident today.

and maintained.

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F 561	Continued From page 3 FSD replied, residents were given his direct telephone line and can call to report any issue with the kitchen. Informed FSD of R189's cultural background and the impact of his/her cultural background that prevents the resident from speaking out. FSD responded, there are new staff in the kitchen and the kitchen will do a better job of ensuring the residents receive the food items they selected.	F 561		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (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	F 623		6/9/23

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F 623	Continued From page 4	F 623		

be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

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

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F 623	Continued From page 5 and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interviews and record review (RR), the facility failed to provide written transfer/discharge notice upon hospitalization for one of three (Resident(R)88) residents sampled. Findings include: (Cross-Reference to F625 - Notice of Bed Hold Policy and Return) On 05/04/23 at 02:20 PM, conducted RR of R88's	F 623	F623 Notice Requirements Before Transfer/Discharge Corrective Action R88 was discharged on 2/27/2023 and has not returned to the facility. Identification of Others All residents who are transferred/discharged have the potential	

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F 623	Continued From page 6 electronic health record (EHR) of hospitalization. Nursing progress notes documented R88 transferred to hospital on 02/24/23, but review of EHR progress notes, miscellaneous documentation, and social services notes, did not find documentation of facility providing written notice of transfer or discharge to R88 or resident's representative. On 05/04/23 at 04:16 PM, conducted an interview and concurrent RR with Administrator. The Administrator stated following R88's transfer to the hospital on 02/24/23, the facility informed the resident's representative by telephone but did not provide written notice of R88's transfer or discharge.	F 623	to be affected by this finding. Systemic Change Education provided to Admissions department on 5/5/2023 regarding finding. Residents or responsible parties have the right to be notified by written notice of transfer or discharge. Effective 3/20/2023 facility implemented new Notice of Transfer/Discharge documentation; new process to include facility to provide written notice of transfer/discharge and to be uploaded in facility electronic medical record. Monitoring Change The Admissions Director or designee will audit up to 5 random residents per week to ensure the residents or responsible parties were provided with the notice of transfer/discharge. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 1 month to ensure compliance is achieved and maintained.	
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	F 625		6/9/23

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F 625	Continued From page 7 nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and review of policy, the facility failed to provide written notice of bed-hold policy for two Residents (R): 1) R139 of four residents sampled, 2) R88. As a result of this deficiency, there was potential for miscommunication. Findings include: 1) Review of the Electronic Health Record indicated that R139 was transferred to the hospital on 01/29/23 for a fall, hip fracture. Further review did not show any written notice of bed-hold policy to the resident and/or	F 625	F625 Notice of Bed Hold Policy Before/Upon Transfer Corrective Action R88 was discharged on 2/27/2023 and has not returned to the facility. R139 continues to reside at KPO. Admissions Director emailed bed hold notification on 5/22/2023 to resident's responsible party. Identification of Others All residents who are transferred/discharged have the right to	

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F 625	Continued From page 8 representative. During staff interview on 05/05/23 at 09:20 AM, Admissions Assistant (Admit1) acknowledged that the facility did not provide written notification of bed-hold policy to R139 and/or representative. Admit1 also said that the facility recently started a new process to provide written notification of bed-hold policy to resident and/or representative. Review of facility policy on Discharge Process and Bed Holds read the following: Bed-hold, holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization. 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. Bed-hold policies will be provided and explained to the resident or responsible party upon admission and explained to the patient before each temporary absence. Before the resident transfers to a hospital or the resident goes on therapeutic leave, the facility will provide written information to the resident or responsible party that specifies: the duration of the state bed-hold policy, if any during which the resident is permitted to return and resume residence in the nursing facility, the reserve bed payment policy in the state plan, if any, the facility policies regarding bed-hold, in cases of emergency transfer, notice "at the time of transfer" means that the family, surrogate, or responsible party are provided with written notification within 24 hours of the transfer. (Cross-Reference to F623 - Notice Requirements Before Transfer/ Discharge)	F 625	receive a written notice of the facility's bed-hold policy. Systemic Change Education provided to Admissions department on 5/23/2023 regarding finding. Residents or responsible parties have the right to be notified by written bed hold policy/notification. Effective 3/20/2023 facility implemented new procedure for Notice of Transfer/Discharge and bed hold notification; new process to include facility to provide written notice of transfer/discharge and bed hold notification to resident/responsible party. Documents to be uploaded in facility electronic medical record. Monitoring Change The Admissions Director or designee will audit up to 5 random residents per week to ensure the residents or responsible parties were provided with the notice of transfer/discharge. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 1 month to ensure compliance is achieved and maintained.	

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F 625	Continued From page 9 2) On 05/04/23 at 02:20 PM, conducted RR of R88's electronic health record (EHR) of hospitalization. Nursing progress notes documented R88 transferred to hospital on 02/24/23, but review of EHR progress notes, miscellaneous documentation, and social services notes, did not find documentation of facility providing written notice of bed-hold policy to R88 or resident's representative. On 05/04/23 at 04:16 PM, conducted an interview and concurrent RR with Administrator. The Administrator stated following R88's transfer to the hospital on 02/24/23, the facility informed the resident's representative by telephone but did not provide written notice of facility's bed-hold policy.	F 625		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services.	F 655		6/9/23

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F 655	Continued From page 10 (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review (RR), the facility failed to develop and implement a baseline care plan to provide effective and person-centered care of the resident that meets professional standards of quality care for one Resident (R)340. Findings include: (Cross-Reference to F697 - Pain Management) On 05/02/23 at 10:15 AM, interviewed R340. R340 underwent right knee surgery and was admitted to the facility on 04/29/23. Observation of R340 confirmed swelling to the right knee and	F 655	F655 Baseline Care Plan Corrective Action R340 was discharged on 5/6/2023. Identification of Others All residents who have pain management have the potential to be affected by this finding. Systemic Change Facility to develop and implement a baseline care plan to provide effective and person-centered care of the resident.	

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F 655	Continued From page 11 right lower leg. Regarding pain, R340 stated that staff have been providing pain medication every 4-6 hours based on resident's reported pain level but resident prefers to minimize opioid use and has been attempting to decrease amount of opioid medication taken. R340 denied being advised by care provider or facility staff of non-pharmacological or non-opioid interventions for treating pain or edema. On 05/04/23 at 10:42 AM, RR of R340's medical orders in resident's electronic health record (EHR) documented: "Attempt non-med interventions prior to administering PRN pain medications: 1. Rest, 2. Reposition, 3. Diversional activity, 4. Warm/cold pack, Do not arouse from sleep. Do not exceed 3,000 mg Acetaminophen in a 24 hour period from all sources. -Order Date-04/29/2023"; "Acetaminophen Tablet 325 MG, Give 2 tablet by mouth every 4 hours as needed for pain, Acetaminophen NTE 3G/24 hours-Order Date-04/29/2023"; "Percocet Oral Tablet 5-325 MG (Oxycodone w/ Acetaminophen), Give 1 tablet by mouth every 4 hours as needed for moderate (score 5-7), -Order Date-04/29/2023." On 05/04/23 at 12:00 PM, conducted concurrent staff interview and RR with Nurse Manager (NM)2 regarding R340 care plan for swelling and pain management. NM2 confirmed that R340's care plan did not identify non-pharmacological interventions for swelling or pain nor did the care plan include attempting non-opioid analgesic medications for pain control prior to using opioid analgesics as ordered. RR of resident's Medication Administration Record (MAR) documented that facility staff had not administered acetaminophen prior to opioid medication per physician's orders. NM2 stated	F 655	Director of Nursing initiated new process effective 5/8/2023 to include all non-pharmacological interventions prior to administering pain medication on baseline care plan. After further record review on R340, facility could not locate a physician order to administer non-opioid medication prior to administration of opioid. Physician order dated 4/29/2023 for Percocet Q4hours PRN for moderate to severe pain. Monitoring Change The Director of Nursing and/or designee will audit 5 random staff per week to ensure non- pharmacological interventions are entered into the baseline care plan. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 1 month to ensure compliance is achieved and maintained.	

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F 655	Continued From page 12 that the resident's care plan should document non-pharmacological interventions for pain as well as using non-opioid medications prior to opioids.	F 655		
F 656 SS=D	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 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	F 656		6/9/23

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F 656	Continued From page 13 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: Based on interviews and record review, the facility failed to ensure comprehensive person-centered care plans were developed/implemented for two residents (Resident (R)191 and R4) sampled. R191 wandered unsupervised out of the facility on 04/15/23 and the facility did not develop a care plan until 05/02/23. Review of monitoring sheets documented staff did not implement 30-minute checks of R191 for wandering behavior in accordance with the resident's interventions listed on the care plan. R4 was not being monitored for side effects of prescribed psychotropic (drugs affecting behavior, mood, thoughts, or perception) medications. This deficient practice has the potential to affect all residents with wandering behavior or those psychotropic medications and has the potential to result in harm. Findings Include: (Cross reference to F689 Accident Hazard) 1) R191 was admitted to the facility on 04/07/23	F 656	F656 Develop/Implement Comprehensive Care Plan Corrective Actions R191 care plan updated on 5/2/2023 to reflect potential risk for elopement. 30-minute checks continued until discharge on 5/20/2023. Resident had no further episodes of wandering. R4 care plan was created on 2/21/2023, day of admission for psychotropic medication. On 5/5/2023, obtained physician order to reflect monitoring Qshift for side effects of psychotropic medication use. Identification of Others Residents with wandering behavior or those on psychotropic medications have the potential to be affected by this finding. A 100% facility audit was conducted on 5/5/2023 to determine if any other	

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F 656	Continued From page 14 with diagnosis that include congestive heart failure, hemiplegia and hemiparesis following a cerebral infarction affecting the dominant right side, pneumonitis due to inhalation of food and vomit, glaucoma, atrial fibrillation, and memory deficit following cerebrovascular disease. On 05/03/23 at 1:07 PM, conducted a review of R191 Electronic Health Record (EHR). Review of R191's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/13/23, Section C. Brief Interview for Mental Status (BIMS) score was 5 indicating the resident has severe cognitive impairment. Review of progress notes documented R191 had episodes of getting out of bed without activating the call light (04/10/23 at 07:35 AM). A progress note on 04/15/23 at 2:24 PM documented, "Received update from unit manager that resident was found by another staff in parking lot in wheelchair. Resident immediately brought inside, in no distress, no changes in condition, baseline mentation AxOx1, confused and forgetful. Brought back inside into room to use bathroom and then back into bed. Resident location checks started every 30 minutes. Resident stayed in bed, ate lunch in bed, only got out of bed to work with therapy and brought back into bed after. Current staff and oncoming staff aware." Review of R191's care plan documented a care area for elopement due to disoriented to place, impaired safety awareness, and resident wandering aimlessly was not developed until 17 days (on 05/02/23) after the resident eloped/wandered from the facility without staff being aware that the resident was missing. On 05/05/23 at 11:05 AM, conducted an interview with the Director of Nursing (DON) regarding	F 656	residents were at risk for elopement/wandering to further establish presence of a care plan. There were no other residents identified in this audit at risk for elopement/wandering. A 100% facility audit was conducted on 5/5/2023 for all resident on psychotropic medications to ensure there is a monitoring for side effects order as indicated in care plan. Upon review, 1 other resident identified that did not have a physician order to monitor side effects. Order obtained also on 5/5/2023. Systemic Change Staff education initiated with IDT on 5/5/2023 regarding elopement/wandering and updating care plan. Discussion in IDT meetings to determine at risk residents. Staff education initiated on 5/23/2023 to ensure all resident with psychotropic medications have an order to monitor for side effects QShift. Nursing leadership will include audit in chart checks. Monitoring Change The Director of Nursing and/or designee will audit up to 5 random staff per week to determine if any residents are elopement risks and or exhibiting wandering behaviors. Update care plan as needed. The Director of Nursing and/or designee will audit up to 5 residents per week on psychotropic medications to ensure their psychotropic care plans are being followed.	

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F 656	Continued From page 15 R191's elopement and care plan. Inquired with DON regarding the 15-day delay in the developing an elopement/wandering care plan for R191. DON confirmed a care plan with person centered interventions should have been developed sooner than 15 days to ensure the resident's safety but was not. Reviewed interventions for R191's potential for eloping, and it documented an intervention for frequent monitoring (every 30 minutes). Requested to view the documentation of the 30-minute checks. At 11:55 AM, went with DON to the unit nursing station to review the monitoring sheet. The Unit Care Coordinator (UCC) informed us that R191's 30-minute monitoring checks sheet was located on a medication cart. Reviewed of the 30-minute monitoring sheet with the DON, which documented staff had not complete the monitoring for 05/05/23 from 07:00 AM to 10:30 AM. DON confirmed the 30-minute monitoring should have been completed but was not most likely due to staff having to abruptly leave. 2) Cross Reference to F757 (Drug Regimen is Free from Unnecessary Drugs). Facility failed to monitor for side effects of antidepressant. R4 is an 89-year-old resident admitted on 02/06/23. Diagnoses include diabetes (high blood sugar), congestive heart failure (condition where the heart is not able to pump blood efficiently), cancer to inner cheek and depression. Review of electronic health record (EHR) under "Orders" revealed that R4 was on duloxetine HCL (antidepressant medication) 30 mg (milligrams) once a day for depression. Common side effects	F 656	The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 1 month to ensure compliance is achieved and maintained.	

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F 656	Continued From page 16	F 656		

for this medication include blurred vision, feeling dizzy, difficulty sleeping, dry mouth, headache, constipation and nausea or vomiting. Review of care plan updated on 03/24/23 documented that R4 uses antidepressant medication and interventions include "Administer ANTIDEPRESSANT medication as ordered by physician. Observe for side effects and effectiveness Q-SHIFT (every shift)." Review of medication administration record (MAR) revealed that the licensed staff documented monitoring for signs and symptoms of hypoglycemia (low blood sugar) and bleeding since R4 was also taking insulin (medication to lower blood sugar) and warfarin (medication that prevents blood from clotting). Surveyor was not able to find where the licensed staff documented their observations for the side effects of antidepressant.

On 05/05/23 at 10:37 AM, concurrent interview and records review conducted with the Nurse Manager (NM) 1 by the nurse's station. Asked NM1 if the staff monitored R4 for side effects of the antidepressant. NM1 replied that they do, and it is documented in the MAR. NM1 then opened R4's MAR on the computer but was not able to find any documentation for the monitoring. Asked NM1 if the licensed staff would document their observations anywhere else in the EHR, she replied "No." NM1 then looked in the "Orders" tab and stated that since there was no order to monitor for the side effects of antidepressant, it would not show up it in the MAR. NM1 stated that there should be an order and she will input one in the EHR.

Review of EHR under "Orders" on 05/05/23 at 01:23 PM, revealed that monitoring for side effects of the antidepressant initiated on

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F 656	Continued From page 17 05/05/23.	F 656		
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 by: Based on interviews and record review, the facility failed to ensure adequate supervision to prevent an elopement for a resident (Resident (R)191) with wandering behavior. R191 exited the facility unsupervised and without staff's knowledge and only became aware of the resident's absences after another resident alerted staff. As a result of this deficient practice, there was the potential for serious harm to the resident. Findings include: (Cross reference to F656 Develop/Implement a Comprehensive Care Plan) R191 was admitted to the facility on 04/07/23 with diagnosis that include congestive heart failure, hemiplegia and hemiparesis following a cerebral infarction affecting the dominant right side, pneumonitis due to inhalation of food and vomit, glaucoma, atrial fibrillation, and memory deficit following cerebrovascular disease. On 05/03/23 at 1:07 PM, conducted a review of	F 689	F689 Free Accident Hazards/Supervision/Devices Corrective Actions R191 care plan updated on 5/2/2023 to reflect potential risk for elopement. Resident had no further episodes of wandering. Elopement assessment was updated and resident representative notified by Assistant Director of Nursing on 5/5/2023. Resident discharged on 5/20/2023. Identification of Others Residents with wandering behavior have the potential to be affected by this finding. A 100% facility audit was conducted on 5/5/2023 to determine if any other residents are at risk for elopement/wandering. There were no other residents identified in this audit at risk for elopement/wandering.	6/9/23

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F 689	Continued From page 18 R191 Electronic Health Record (EHR). A progress notes on 04/15/23 at 2:24 PM documented, "Received update from unit manager that resident was found by another staff in parking lot in wheelchair. Resident immediately brought inside, in no distress, no changes in condition, baseline mentation AxOx1, confused and forgetful. Brought back inside into room to use bathroom and then back into bed. Resident location checks started every 30 minutes. Resident stayed in bed, ate lunch in bed, only got out of bed to work with therapy and brought back into bed after. Current staff and oncoming staff aware." Review of R191's care plan documented a care area for elopement due to disoriented to place, impaired safety awareness, and resident wandering aimlessly was not developed until 17 days (on 05/02/23) after the resident eloped/wandered from the facility without staff being aware that the resident was missing. Further review of progress notes documented on 04/10/23 at 07:35 AM (5 days prior to eloping) R191 had episodes of getting out of bed without activating the call light and staff was aware of the resident's impulsivity and cognitive deficits. Review of R191's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/13/23, Section C. Brief Interview for Mental Status (BIMS) score was 5 indicating the resident has severe cognitive impairment On 05/05/23 at 11:05 AM, conducted a concurrent record review and interview with the Director of Nursing (DON) regarding R191's elopement. Reviewed the progress note written on Sunday, 04/15/23 at 02:24 PM (previously mentioned) and asked DON for more information/details of the event. DON stated staff	F 689	Systemic Change Elopement drill scheduled for 5/30/2023 at 2:30pm. Staff education initiated with IDT on 5/5/2023 regarding elopement/wandering updating the Elopement Risk Evaluation UDA in electronic health record Point Click Care, care plan, and notifying responsible parties, if indicated. Monitoring Change The Director of Nursing and/or designee will audit up to 5 random staff per week to determine if any residents are elopement risks and or exhibiting wandering behaviors. If indicated, will update the Elopement Risk Evaluation UDA, care plans, and notify responsible party. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 1 month to ensure compliance is achieved and maintained.	

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F 689	Continued From page 19	F 689		

was in the parking lot coming into the building, spotted R191, and brought the resident back into the facility without incident. Regarding the location where staff saw R191, DON stated that the resident was approximately 5-10 feet away from the entrance to the facility's entrance gate, within the area of the roundabout. DON emphasized that the resident had wandered from the facility looking for a bathroom. Review of R191's EHR with the DON and confirmed an elopement assessment was not completed after the incident, no staff interviews were conducted, no root cause analysis was conducted to determine how the resident was able to leave the facility and prevent other elopement attempts, and a care plan was not developed until 05/02/23 (17 days after the incident). DON stated further inquiry into the incident was not done because R191 did not leave the facility with the intent to leave, which would have been worse, but wandered from the facility looking for a bathroom. This surveyor queried the DON if there is a greater chance of injury or the potential for injury for a resident with impaired cognition due to a lack of awareness of their abilities and inability to make safe decisions. Discussed with the DON the foot traffic of homeless residents that frequently pass through the facility grounds and shared two surveyors had observed a homeless female approximately 20 feet from the entrance of the facility talking to herself, putting her hands down her pants, and appeared to have a bowel moment on the facility's sidewalk. The surveyors were able to view this incident through the windows of the conference room in the administrative office building. The DON stated that the resident was found by staff not that far from the entrance. Inquired which staff had found the resident and DON stated she was unsure of

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F 689	Continued From page 20	F 689		

which staff it was exactly but that it was one of the front receptionists. Inquired if R191's representative had been notified of the resident's elopement and the DON could not verify if the family notified.

On 05/05/23 at 12:05 PM, conducted an interview with Receptionist (RP)45 regarding R191's elopement. RP45 stated that he/she found the resident in the parking lot to the right (after exiting). RP45 confirmed that R191 was not found 5-10 feet from the entrance to the facility by staff, but another resident who was sitting out front alerted RP45 that he thought he recognized another resident, and he/she was heading toward the parking lot. RP45 took this surveyor out into the parking lot and showed this surveyor exactly where R191 was. RP45 stated that he/she called the resident and R191 began to wheel the wheelchair faster in an attempt to go away saying, "I'm looking for the bathroom." RP45 confirmed that R191 appeared confused and was not aware of his/her own abilities and was not in a safe situation. RP45 confirmed staff did not identify R191 in the parking lot but was alerted by another resident and no other staff was involved in returning the resident to the facility.

On 05/05/23 at 12:15 PM, conducted an interview with R191's Resident Representative (RR)3 via telephone. During the interview, RR3 confirmed that she was not aware that R191 had eloped from the facility and had not been notified of any of the details of the event or what the facility has done to ensure the resident's safety.

On 05/05/23 at 01:15 PM, reviewed the facility's policy and procedure, "Area of Focus: Elopement" (last reviewed 11/23/2022),

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F 689	Continued From page 21 documented the interdisciplinary team (IDT) will review unsafe wandering and/or elopement risk indicators and revised the resident's care plan, a specific system will be implemented to notify staff the exit doors have been opened: -Documented and routine testing of door alarms -Documented and routine testing of staff's response to alarms -Monitoring practices when door alarms are disabled or during instances of higher traffic -Monitoring practices for exits that are not visible to staff but readily accessible to residents. Also, family members will receive education on the resident's unsafe wandering and elopement management care plan and provided an opportunity for feedback and with any unsafe wandering or elopement event the resident will be assessed for indicators utilizing the Elopement Risk Evaluation UDA in PCC (Point Click Care).	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews (RR), the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and	F 697	F697 Pain Management Corrective Action R340 was discharged on 5/6/2023. R71 is alert and oriented x 3. Director of	6/9/23

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F 697	Continued From page 22 the residents' goals and preferences for two of two (Resident (R)71 and R340) residents sampled. Findings include: (Cross-Reference to F655 - Baseline Care Plan) 1) On 05/02/23 at 10:15 AM, interviewed R340. R340 underwent right knee surgery and was admitted to the facility on 04/29/23. Observation of R340 confirmed swelling to the right knee and right lower leg. Regarding pain, R340 stated that staff have been providing pain medication every 4-6 hours based on resident's reported pain level but resident prefers to minimize opioid use and has been attempting to decrease amount of opioid medication taken. R340 denied being advised by care provider or facility staff of non-pharmacological or non-opioid interventions for treating pain or edema. On 05/04/23 at 10:42 AM, RR of R340's medical orders in resident's electronic health record (EHR) documented: "Attempt non-med interventions prior to administering PRN pain medications: 1. Rest, 2. Reposition, 3. Diversional activity, 4. Warm/cold pack, Do not arouse from sleep. Do not exceed 3,000 mg Acetaminophen in a 24 hour period from all sources. -Order Date-04/29/2023"; "Acetaminophen Tablet 325 MG, Give 2 tablet by mouth every 4 hours as needed for pain, Acetaminophen NTE 3G/24 hours-Order Date-04/29/2023"; "Percocet Oral Tablet 5-325 MG (Oxycodone w/ Acetaminophen), Give 1 tablet by mouth every 4 hours as needed for moderate (score 5-7), -Order Date-04/29/2023." On 05/04/23 at 12:00 PM, conducted concurrent staff interview and RR with Nurse Manager (NM)2	F 697	Nursing and unit manager RN met with resident on 5/23/2023 to discuss current pain medication regimen. No changes were made to plan of care. Per R71, she does reposition herself and staff help her by elevating her legs and provide ice packs at her request. Resident prefers to continue Tylenol PRN and Oxycodone QD PRN, prior to therapy. Identification of Others All residents who have pain management have the potential to be affected by this finding. A 100% audit completed on 5/24/2023 on residents to ensure non-pharmacological interventions are in place in the care plan. One resident identified and care plan was updated to reflect non-pharmacological interventions. Systemic Change Staff education initiated by Director of Nursing on 5/8/2023; Nursing meeting scheduled for 6/1/2023 to further emphasize non-pharmacological/opiod interventions (i.e. repositioning, rest, diversional activities, relaxation, heat/cold, elevation, etc). prior to administering pain medications. Monitoring Change The Director of Nursing and/or designee will interview 5 random residents to determine if staff are offering non-pharmalogical/opiod interventions prior to administering pain medications.	

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F 697	Continued From page 23 regarding R340 care plan for swelling and pain management. NM2 confirmed that R340's care plan did not identify non-pharmacological interventions for swelling or pain nor did the care plan include attempting non-opioid analgesic medications for pain control prior to using opioid analgesics as ordered. RR of resident's Medication Administration Record (MAR) documented that facility staff had not administered acetaminophen prior to opioid medication per physician's orders. NM2 stated that the resident's care plan should document non-pharmacological interventions for pain as well as using non-opioid medications prior to opioids. 2) On 05/03/23 at 10:51 AM, interviewed R71. R71 confirmed receiving pain medication to control pain and expressed a preference to minimize opioid medication use. R71 stated that facility staff had not offered non-pharmacological or non-opioid therapies for pain. On 05/04/23 at 10:59 AM, conducted RR of R71's care plan in resident's electronic health record (EHR) which documented the following non-pharmacological and non-opioid interventions for resident's pain: "Attempt non-med interventions prior to administering PRN pain medications: 1. Rest, 2. Reposition, 3. Warm/Cold pack, 4. Diversional activities. Do not arouse from sleep. Do not exceed 3,000 mg Acetaminophen in a 24-hour period from all sources. Date Initiated: 03/13/2023." On 05/04/23 at 12:10 PM, conducted a concurrent staff interview and RR with NM2 of R71's care plan. NM2 confirmed that R71's care plan identified non-pharmacological interventions	F 697	The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 1 month to ensure compliance is achieved and maintained.	

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F 697	Continued From page 24 and use of non-opioid medications for pain control prior to using opioid analgesics as ordered by the resident's physician. RR of resident's Medication Administration Record (MAR) and Treatment Administration Record (TAR) documented that facility staff did not implement non-pharmacological interventions nor had acetaminophen been administered prior to opioid analgesics per care plan and provider's orders. NM2 stated that non-pharmacological interventions as well as non-opioid medications should have been used to treat resident's pain in accordance with the care plan, physician's orders, and resident preference.	F 697		
F 713 SS=D	Physician for Emergency Care Available 24 hrs CFR(s): 483.30(d) §483.30(d) Availability of physicians for emergency care The facility must provide or arrange for the provision of physician services 24 hours a day, in case of emergency. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews (RR), the facility failed to provide or arrange for the provision of physician services 24-hours a day, in case of emergency for one of two residents (Resident (R)342) sampled. As a result of this deficient practice, the facility failed to adequately assess a resident for a potentially contagious condition. Findings include: (Cross-Reference to F880 - Infection Prevention and Control) On 05/02/23 at 09:46 AM, observed R342. No	F 713	F713 Physician for Emergency Care Available 24 hours Corrective Actions R342 rash was assessed by Advanced Practice Nurse Practitioner on 5/2/2023 and ordered Hydrocortisone BID x 7 days. Rash improved and resident discharged on 5/11/2023. Identification of Others All residents who reside in the facility have the potential to be affected by this finding.	6/9/23

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F 713	Continued From page 25 enhanced-barrier precautions (EBP) or other transmission-based precautions (TBP) sign was posted at resident's room. R342 had diffuse red rash covering both legs and was being evaluated by resident's Advance Practice Registered Nurse (APRN)1. Upon completing the evaluation, APRN1 stated that the resident was the one who identified the rash to her, and this was the first time APRN1 was informed of R342's condition. On 05/02/23 at 01:09 PM, interviewed R342. R342 stated that she identified the rash to the nurse "last week". On 05/04/23 at 12:32 PM, conducted a RR of R342's Electronic Health Record (EHR). Resident progress notes showed that nursing staff documented redness to resident's bilateral legs and feet on 04/30/23 at 02:11 PM. Registered Nurse (RN)2 documented applying Miconazole to feet as well as calling and leaving message for R342's medical provider. Progress notes did not document implementation of TBP or other intervention at that time. Rash was not documented on 05/01/23 progress notes. On 05/04/23 at 03:19 PM, conducted a concurrent RR and staff interview with Nurse Manager (NM)2. NM2 stated that on 04/30/23 when R342 identified the rash to RN2, RN2 attempted to contact R342's medical provider per provider's medical group protocol rather than facility policy or procedure. When asked how long facility staff will wait if they receive no response before calling the provider again, NM2 stated that after making the initial phone call, staff waited for the provider to come on the provider's usual day to visit facility residents and that the rash "was not really bothering" R342. When asked how facility	F 713	Systemic Change Nursing staff education initiated on 5/5/2023 regarding call back expectations related to medical concerns. Call guidelines posted at each nursing station to include Medical Director's contact information if/when primary provider does not return call/page. Monitoring Change The Director of Nursing and/or designee to interview 5 nurses per week to determine if a medical provider was called/paged, did not call back, and if a call was made to the facility Medical Director. The Director of Nursing and or designee to interview 5 nurses per week to determine if any of their residents has signs and symptoms of a communicable disease and was MD notified. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 1 month to ensure compliance is achieved and maintained.	

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F 713	Continued From page 26 staff determine whether a new rash is a sign of an infectious or contagious condition, NM2 stated, "We kind of just go off the nurse's assessment." NM2 confirmed that it is beyond nursing scope of practice to diagnose whether a rash is infectious or contagious. On 05/05/23 at 02:25 PM, interviewed Medical Director. When asked about the time frame he would expect for a resident's treating provider to respond to a message concerning a new, undiagnosed rash, he stated, "Within half an hour to an hour." When asked what nursing staff should have done to address a new rash, the Medical Director stated that staff should have attempted to contact the resident's provider again and if there was no response, staff should have attempted to contact him.	F 713		
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- §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	F 757		6/9/23

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F 757	Continued From page 27 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 staff interview, facility failed to provide adequate monitoring for one of the residents (R) sampled. R4 was not being monitored for side effects of prescribed psychotropic (drug effecting behavior, mood, thoughts or perception) medication. As a result of this deficient practice, there is a potential for negative impact on R4's quality of life. This deficient practice has the potential to affect all residents on psychotropic medications. Findings Include: Cross reference to F656 (Develop/Implement Comprehensive Care Plan). Facility failed to implement intervention to monitor resident for side effects of antidepressant. Review of electronic health record (EHR) revealed that R4 was prescribed duloxetine HCL (antidepressant medication) 30 mg (milligrams) once a day for depression. Common side effects for the medication include blurred vision, feeling dizzy, difficulty sleeping, dry mouth, headache, constipation and nausea or vomiting. Surveyor was not able to locate documentation in the EHR if the staff were monitoring R4 for side effects of the antidepressant. Concurrent record review and interview with the nurse manager (NM) 1 on 05/05/23 at 10:37 AM revealed that there was no order inputted into the	F 757	F757 Drug Regimen is Free from Unnecessary Drugs Corrective Actions R4 continues to be a resident at KPO. Resident's care plan was created on 2/21/2023, day of admission for psychotropic medication. On 5/5/2023, obtained physician order to reflect monitoring Qshift for side effects of psychotropic medication use. Identification of Others All residents on psychotropic medications have the potential to be affected by this finding. A 100% facility audit was conducted on 5/5/2023 for all resident on psychotropic medications to ensure there is a monitoring for side effects order as indicated in care plan. Upon review, 1 other resident identified that did not have a physician order to monitor side effects. Order obtained also on 5/5/2023. Systemic Change Staff education initiated on 5/23/2023 to ensure all residents with psychotropic medications have an order to monitor for side effects QShift. Nursing leadership will include audit in chart checks.	

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F 757	Continued From page 28 EHR to monitor R4 for side effects of the antidepressant. NM1 stated that since there was no order, it would not show in the medication administration record (MAR) to monitor R4 for side effects of the antidepressant. NM1 stated that all monitoring is documented in the MAR.	F 757	Monitoring Change The Director of Nursing and/or designee will audit up to 5 residents per week on psychotropic medications to ensure their psychotropic care plans are being followed. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 1 month to ensure compliance is achieved and maintained.	
F 808 SS=E	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure a resident (Resident (R)50) received a therapeutic diet as prescribed. As a result of this deficiency, R50 could have experienced harm due to aspiration had this surveyor not intervened prior to staff administering water that was not nectar thickened. Findings include:	F 808	F808 Therapeutic Diet Prescribed by Physician Corrective Action Upon discovery of the expired Imperial Thickened Lemon flavored water (46 oz) on medication cart and in refrigerator, staff disposed of both containers. R50 was discharged on 5/10/2023.	6/9/23

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F 808	Continued From page 29 On 05/03/23 at 11:14 AM, this surveyor was seated outside of R50's room. R50 was coughing and one of the resident's visitors (V)1 approached this surveyor and requested a cup of water for the resident. V1 was encouraged to activate R50's call light as no staff were visible in the hallway. V1 activated the call light and Licensed Nurse (LN)22 answered the call light at 11:17 AM and was informed that R50 was coughing and needed some water. At 11:22 AM, LN22 approached R50's room with a cup of water and proceeded to don Personal Protective Equipment (PPEs) and this surveyor observed the water in the cup did not appear to be nectar thickened and stopped LN22 from giving R50 the water. Had this surveyor not intervened at this time, R50 could have potentially aspirated the fluid and result in harm to the resident. Inquired with LN22 if the water in the cup was nectar thickened. LN22 stated the water was poured from a carton of nectar thickened water located on the medication cart. This surveyor requested that LN22 observe the viscosity of the water in the cup and confirm if it appears to be nectar thickened. LN22 examined and moved around the water in the cup and concluded the consistency was not nectar thickened. Requested LN22 to show this surveyor the box of nectar thickened water that he/she poured from. LN22 showed this surveyor an opened carton of SYSCO Imperial Thickened Lemon-Flavored Water (46 fluid ounces (oz.)) which felt approximately 1/3 full. Further inspection of the carton documented the manufacturer's expiration date was 03/19/23 and staff had written 05/01 (at) 01:00 (01:00 AM) which LN22 verified was when the carton was opened. Directions on the carton documented, "Refrigerate prior to serving. Shake	F 808	Identification of Others Residents with a thickened liquids order have the potential to be affected by this finding. A 100% facility audit was conducted in kitchen, nursing units to include refrigerators on 5/3/2023. No additional containers were found in the facility. Systemic Change Facility nursing staff will begin using 4 ounce, individually packed thickened liquids. Stock refrigerator in unit’s nourishment room will be checked daily. Monitoring Change The Director of Nursing and/or designee will randomly audit 5 medication carts per week to ensure 4 ounce thickened liquids are being used. The Food Service Director and/or designee will audit stock refrigerator in unit’s nourishment room 5-7 times per week to ensure no expired thickened liquids and no 46oz containers. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 1 month to ensure compliance is achieved and maintained.	

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F 808	Continued From page 30	F 808		

well before using. Twist cap to open then pour and serve. After opening, may be kept up to 7 days under refrigeration. Storage and handling: Store at room temperature. Do not freeze. Serve chilled. A medical food for the dietary management of dysphagia (swallowing problems). For use under medical supervision. " LN22 confirmed the 46 oz. carton of thickened water usually remains on top of the medication cart and is not refrigerated after opening. Unit Care Coordinator (UCC)2 came to the medication cart and inquired if the consistency of the water in the carton was nectar thickened consistency. UCC2 confirmed that the water was thinner than nectar thickened. LN22 and this surveyor inspected the unit stock refrigerator and found one carton of expired thickened water in the unit stock refrigerator. UCC2 confirmed the carton should have been disposed of but was stored in the refrigerator for future use.

On 05/03/23 at 11:34 AM, this surveyor went to the other unit to and inspected all cartons of SYSCO Imperial Thickened Lemon-Flavored Water (46 fluid ounces (oz.) in the unit stock refrigerator with LN35. The cartons were not expired and were stored appropriately in the refrigerator. LN35 to pour some of the thickened water into a cup and observed it to be thicker than previously observed from the expired unrefrigerated carton. At 11:45 AM, informed the Director of Nursing (DON) this surveyor's observation of the expired/unrefrigerated nectar thickened water not observed to be nectar thickened and the notable difference in the viscosity of the unexpired/refrigerated thickened water. DON later inquired with the manufacturer and confirmed the 46 oz. cartons of SYSCO Imperial Thickened Lemon-Flavored Water

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F 808	Continued From page 31 should be refrigerated after opening and served chilled. On 05/04/23 11:36 AM, conducted a review of R50's Electronic Health Records (EHR). Review of R50's physician orders documented the resident was ordered to receive nectar consistency for liquids on 04/20/23 at 09:30 AM.	F 808		
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 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 and staff interview, the facility failed ensure that all foods were stored in a closed container and provide a clean area to prepared food. As a result of this deficient practice, there is an increased potential for a food-borne illness that could affect all residents,	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary Corrective Action Upon discovery, container with thickener was covered and fan was cleaned	6/9/23

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F 812	Continued From page 32 staff and visitors that the facility kitchen serves meals to. Findings Include: 1) On 05/02/23 at 08:02 AM, initial tour and observation was done in the kitchen with the Food Services Director (FSD). Observed an uncovered plastic container filled with a white powdered substance by the juice dispenser. Next to the container was a clear plastic cover that was of the same size. Asked FSD what the clear cover was for, he said it was for the uncovered container next to it that was filled with the powdered thickener they use to thicken liquids. FSD then proceeded to cover the open container of powdered thickener. Interview with FSD conducted on 05/04/23 at 09:34 AM in his office. Asked FSD if the container of powdered thickener observed on 05/02/23 was supposed to be covered. FSD stated that all containers are supposed to be covered immediately after use to prevent contamination. 2) On 05/02/23 at 08:22 AM, observed a stand-up fan directed at an area the FSD identified as the food preparation area. Noted both front and back areas to be covered in dust. Observed a bigger fan that was lower to the floor close to the dishwashing area without any dust on it. On 05/04/23 at 09:34 AM, concurrent observation and interview conducted with the FSD in the kitchen area. Showed FSD the fan that was directed at the area the staff were preparing food. Asked FSD who is tasked with cleaning the fans in the kitchen area and how often do they perform this. The FSD responded the kitchen staff clean	F 812	immediately by Food Service Director on 5/2/2023. Surrounding food prep areas were also cleaned. Identification of Others All residents have the potential to be affected by this finding. Systemic Change Staff education was initiated on 5/2/2023 to emphasize the need to cover containers after use to prevent contamination; monitoring and cleaning of stand up fan added to monthly cleaning schedule. Monitoring Change The Food Service Director and/or designee will randomly audit up to 5 containers per week to ensure containers are covered immediately after use to prevent contamination. The Food Service Director and/or designee will audit fan cleanliness up to 3-5 times per week to ensure there is no dust build up. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 1 month to ensure compliance is achieved and maintained.	

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F 812	Continued From page 33 them weekly. FSD confirmed that the fan is dusty and proceeded to turn it off and removed the cover and blades. He then stated that he will clean the cover and the blades and tell the kitchen staff not to point it directly towards the area where food is prepared to prevent the food from being contaminated with dust.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		6/9/23

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	125051	A. BUILDING _____ B. WING _____	05/05/2023

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F 880	Continued From page 34 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff, and review of the facility's infection control policy,	F 880	F880 Infection Prevention & Control	

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F 880	Continued From page 35 procedures, and protocols 1) the facility failed to ensure appropriate protective and preventive measures for COVID-19 and other communicable diseases and infections were implemented, 2) the facility failed to ensure measure to prevent the spread and transmission of communicable diseases were followed. Facility staff did not perform hand hygiene between glove use and did not disinfect shared equipment after use. This deficient practice has the potential to affect all residents, staff and visitors at the facility. Findings include: (Cross-Reference to F713 Availability of Physicians for Emergency Care) 1) On 05/02/23 at 09:18 AM, observed Resident(R)37 with an indwelling urinary catheter. No Enhanced Barrier Precaution (EBP) or other transmission-based precautions (TBP) sign was posted at the door of the room and appropriate EBP/TBP personal protective equipment (PPE) supplies were not located outside of R37's room. 2) On 05/02/23 at 09:46 AM, observed R342. No enhanced-barrier precautions or other transmission-based precautions (TBP) sign was posted at resident's room. R342 had diffuse red rash covering both legs and was being evaluated by resident's Advance Practice Registered Nurse (APRN)1. Upon completing the evaluation, APRN1 stated that the resident was the one who identified the rash, and this was the first time APRN1 was informed of R342's condition. 3) On 05/02/23 at 10:45 AM, observed APRN1 evaluating R339's wound to left foot. EBP sign was posted with appropriate PPE outside R339's doorway. APRN1 was masked with face shield	F 880	Corrective Action 1. R37 continues to reside in the facility and Enhanced Barrier Precaution (EBP) sign was posted at the door on 5/22/2023 by Director of Nursing. Cart with appropriate PPE was in place outside of room at that time. 2. R342 was seen and evaluated on 5/2/2023 by APRN and new order made for Hydrocortisone for Rash. No Transmission based precaution warranted. 3. APRN was educated on 5/24/2023 by Executive Director and confirmed PPE was available and accessible outside of room. 4. R341 was discharged on 5/17/2023. 5. CNA is not identifiable; staff education to be completed by 6/1/2023. 6. Nursing staff education initiated on 5/5/2023 regarding call back expectations related to medical concerns. Call guidelines posted at each nursing station to include Medical Director□s contact information if/when primary provider does not return call/page. 7. R37 continues to reside in the facility and Enhanced Barrier Precaution (EBP) sign was posted at the door on 5/22/2023 by Director of Nursing. Cart with appropriate PPE was in place outside of room at that time. APRN was educated on 5/24/2023 by Executive Director and	

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F 880	Continued From page 36 but not gowned with a glove on right hand only. While evaluating R339's wound, APRN1 removed R339's sock from the affected foot with an ungloved left hand to visually assess R339's wound. 4) On 05/02/23 at 12:19 PM, observed Registered Nurse (RN)1 flushing R341's peripherally inserted central catheter (PICC) line. No EBP or TBP sign was posted at resident's room and no PPE was located outside of room. 5) On 05/03/23 at 08:56 AM, observed Certified Nursing Assistant (CNA)47 changing linens in resident's room. EBP sign was posted with PPE supplies located outside resident's doorway. CNA47 was wearing mask and gloves but was not gowned at this time. 6) On 05/04/23 at 03:19 PM, conducted concurrent RR and staff interview with Nurse Manager (NM)2. NM2 stated that on 04/30/2023 when R342 identified the rash to the RN, the RN attempted to contact R342's medical provider per provider's medical group protocol rather than facility policy or procedure. When asked how long facility staff will wait if they receive no response before calling the provider again, NM2 stated that after making the initial phone call, staff waited for the provider to come on the provider's usual day to visit facility residents and that the rash "was not really bothering" R342. When asked how facility staff determine whether a new rash is a sign of an infectious or contagious condition, NM2 stated, "We kind of just go off the nurse's assessment." NM2 confirmed that it is beyond nursing scope of practice to diagnose whether a rash is infectious or contagious.	F 880	confirmed PPE was available and accessible outside of room. 8. CNA is not identifiable; staff education to be completed by 6/1/2023. 9. CNA is not identifiable; staff education to be completed by 6/1/2023. 10. LPN is not identifiable; staff education to be completed by 6/1/2023. Identification of Others All residents have the potential to be affected by this finding. Facility conducted 100% audit on 5/26/2023 to ensure all those on EBP have appropriate signage and a PPE cart. 22 residents (out of 87) have Enhanced Barrier Precautions with signage and a PPE cart. Systemic Change Facility identified that signs were falling off the metal frame of the doors; Facility reinforced signs with heavy duty magnets. Staff education including review of core principles of infection including, hand hygiene, proper donning/doffing of PPE, and Transmission Based Precautions on 6/1/2023. Monitoring Change The Infection Preventionist and/or designee will randomly audit up to 5 residents who are on transmission based precautions per week to ensure sign is	

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F 880	Continued From page 37 7) On 05/05/23 at 09:38 AM, conducted RR and concurrent staff interview with Infection Preventionist (IP) and Assistant Director of Nursing (ADON). IP stated that EBP is implemented for residents that either have known multi-drug resistant organism (MDRO) colonization or any resident with an indwelling medical device or chronic wound (regardless of MDRO colonization or infection status). The IP confirmed that R37 and R341's rooms should have had EBP signs posted with PPE available outside of their rooms based on their medical conditions. IP also confirmed that R339's medical provider should have been gowned and wearing gloves on both hands when entering R339's room to assess a chronic wound. The IP confirmed that RN1 should have been gowned when conducting direct care to R341's PICC and that CNA47 also should have been gowned when changing linens of a resident identified for EBP. The IP and ADON stated that R342's rash could have been a sign of a potentially contagious condition and EBP or TBP should have been implemented to prevent potential spread to other residents until the resident's condition was diagnosed by a medical provider. 8) On 05/02/23 at 09:10 AM, observed Certified Nursing Assistant (CNA) 22 as she finished providing care for resident (R) 56. CNA22 walked to the trash bin close to the door and removed her gown and gloves. She then took two gloves from the box by the door and donned them without performing hand hygiene, grabbed the used linens on R56's bed, and placed them in the used linen receptacle. CNA22 then removed her gloves and performed hand hygiene. 9) On 05/02/23 at 12:45 PM, observed CNA22	F 880	posted and PPE cart is set up outside of room. The Infection Preventionist and/or designee will randomly audit up to 10 instances of hand hygiene per week to ensure proper adherence. The Infection Preventionist and/or designee will randomly audit up to 5 staff per week to ensure proper adherence to transmission based precautions. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 1 month to ensure compliance is achieved and maintained.	

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F 880	Continued From page 38 and CNA29 as they repositioned R68 in his bed. After performing the task, CNA22 removed her gloves, performed hand hygiene, and exited the room. CNA29 also removed her gloves, took the towel that was on the foot of R68's bed, exited the room and placed the towel in the used linen receptacle. CNA29 then entered R25's room, donned new gloves and repositioned R25 as she was leaning slightly to her left while sitting up in her bed. CNA29 then removed her gloves, exited the room and walked over to R13's room. 2 other staff members were in the room and had the mechanical lift next to R13 as she sat on her wheelchair. CNA29 donned new gloves and proceeded into the room to assist in transferring R13 back to her bed. CNA29 was not observed performing hand hygiene between glove changes. 10) On 05/02/23 at 01:47 PM, observed Licensed Practical Nurse (LPN) 3 as she was checking the blood pressure of R239. After obtaining R239's blood pressure reading, LPN3 removed her gloves, performed hand hygiene, walked to the medication cart, and placed the blood pressure equipment on top of the medication cart without disinfecting it. LPN3 then documented the blood pressure reading and prepared her medications. On 05/05/23 at 11:09 AM, interview was conducted with the Infection Preventionist (IP), and the above observations were mentioned. IP confirmed that staff were supposed to perform hand hygiene after removal of gloves and all shared equipment are supposed to be wiped with disinfecting wipes after each use. IP also stated that she will be doing weekly infection control audits.	F 880		
F 908 SS=D	Essential Equipment, Safe Operating Condition	F 908		6/9/23

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F 908	Continued From page 39 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, record review, and review of equipment service manual, the facility failed to ensure routine maintenance cleaning of the cabinet filter, based on the manufacturer's recommendation, for one out of three oxygen concentrators reviewed. This deficient practice put Resident (R) 44 at risk for the development and transmission of communicable diseases and infections. Findings include: During resident observation, on 05/03/23 at 09:00 AM, R44 was receiving oxygen via a Perfecto2 V Oxygen Concentrator. The cabinet filter of that oxygen concentrator appeared to have dirt and/or dust on the cabinet filter. A review of Electronic Health Record showed that R44 was admitted with a diagnosis of Dementia, Stroke, Hypertension, Atrial Fibrillation, Hypothyroidism, Hyperlipidemia, Anxiety, Encephalopathy, Palliative Care. R44 had a doctor's order to use oxygen as needed for shortness of breath. During staff query on 05/03/23 at 10:30 AM, Director of Nursing (DON) acknowledged that the cabinet filter was dirty and that there was no routine maintenance cleaning. DON immediately had the cabinet filter cleaned and said that they would coordinate with hospice for future routine	F 908	F908 Essential Equipment, Safe Operating Condition Corrective Action R44 continues to be a resident. Oxygen cabinet filter was cleaned immediately upon discovery by Director of Nursing on 5/3/2023. Physician order obtained on 5/3/2023 for weekly external filter wash. Identification of Others All residents who have oxygen have the potential to be affected by this finding. Upon further review, all KPO owned concentrators do not have external filters; further, facility has identified that hospice agencies contract with outside vendors for oxygen concentrators. A 100% audit was completed on hospice residents who receive oxygen concentrators from an outside vendor. Six residents were identified with oxygen. Only two concentrators have external filters and both were not in use at that time related to PRN order. Systemic Change All hospice residents with an oxygen order will have a physician order in place for weekly routine maintenance cleaning of	

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F 908	Continued From page 40 maintenance cleaning. A 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	external filters. Monitoring Change The Director of Nursing and/or designee will audit up to 5 hospice residents to determine if external filter has been cleaned and order in place for weekly cleaning. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 1 month to ensure compliance is achieved and maintained.	