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	125003	A. BUILDING _____ B. WING _____	06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 06/05/2023. The facility was found not to be in substantial compliance with the requirements of §42 CFR 483, Subpart B for Long Term Facilities. Four Complaints from the Aspen Complaints Tracking System (ACTS) #10096, #10212, #10217, and #10276 were investigated under 483.35(a) sufficient staff; 483.80 infection control; and 483.90(i)(4) maintain an effective pest control program and found not in compliance. Survey dates: May 30, 2023, to June 5, 2023. Census: 89 residents Sample Size: 19	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		7/15/23

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

Electronically Signed | 07/06/2023

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F 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a resident's right to a dignified existence for Resident (R)79. While providing care, Staff(S)45's interaction included verbal taunting which elicited a stressed response from R79. As a result of this deficient practice, residents are at risk for the potential of psychosocial harm. Findings include: While conducting observations on the second floor, observed S45 providing care and interacting with R79. The verbal interaction with the resident included staff informing the resident he/she was	F 550	This plan of correction is submitted as required by law. By submitting this plan of correction, the facility does not admit that the citations listed on the CMS 2567 exist nor does it admit to any statement, finding, facts or conclusion that forms the basis of alleged citations. We request this written Plan of Correction serve as our credible allegation of compliance. WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:	

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F 550	Continued From page 2 going to move into another position, when resident asked why, staff's response was "Why, What!" R79 stated "Owww, why you do that?" S45 responded to R79 in a sharp/harsh, irritated tone, "Why, what do you mean? I am going to cut all your hair off, lean your head forward" R79 began making whining noises. S45 then stated, "So I can brush the back of your hair, then I'm gonna cut your hair off!" R79 sounding upset and replied, "what? why?". S45 wheeled R79 into the hallway and saw this surveyor. After S45 became aware of this surveyor's presence, her overall interaction with R79 quickly changed to include a softer, sweeter tone and refrained from taunting statements. On 06/02/23 at approximately 10:45 AM, this surveyor informed the Administrator and the second floor Nurse Manager (NM)19 of S45's interaction with R79. Administrator and NM19 confirmed, although staff will joke with the resident, staff should refrain from interacting with the residents in a way that will elicit a stressed response and should not be telling the resident that she/he will cut off the resident's hair.	F 550	At the time of the survey, the Director of Nursing requested the name of the employee so education and counseling could be provided to the employee. The surveyor would not provide the name of the staff member. Therefore, education and counseling could not be provided to the staff member at the time of the occurrence. The resident is unable to provide information due to intellectual disabilities and legal blindness. Staff were interviewed to determine if this behavior has been observed. On 6/2/23, immediate focused education for resident rights and dignified communication was provided to all care staff on the unit that the resident resides. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have to potential to be affected. By 7/15/23, all clinical staff provided education on Resident Rights and dignified communication. WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Upon hire and annually, all clinical staff will receive additional education on dignified communication. Unit ambassadors will complete weekly audits of resident and staff interactions to ensure communication is dignified and	

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F 550	Continued From page 3	F 550	appropriate. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: Education records will be audited monthly to ensure all new hires have received education. Results of the audits will be reviewed at the QAPI meetings. Weekly, the Administrator will receive the ambassador audits. Ongoing validation by the Administrator.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 578		7/19/23

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F 578	Continued From page 4 (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to formulate an advance directive for two of three residents sampled. The deficient practice disregards the residents right to make important decisions about end-of-life treatment when the individual may be incapacitated. Findings include: On 05/31/23 at 12:01 PM during a review of the medical record for Resident (R)86, there was no Advanced Health Care Directive (AHCD) found. On 06/01/23 at 10:29 AM the minimum data set (MDS) admission assessment dated 12/30/2022 was reviewed. Section C reviewed. Brief interview for mental status (BIMS) score is 13 (which indicates high cognitive funtion). Active diagnosis, congestive heart failure, (CHF) and	F 578	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: By 7/3/23. the residents identified with the deficient practice who are capable of formulating an advanced directive were immediately offered the option to formulate advance directives. R86 is incapable of formulating an advanced directive due decreased cognitive abilities as documented by the physician. The Social Worker has documented this in the resident□s medical record. R72 is incapable of formulating an advanced directive due decreased cognitive abilities as documented by the physician. The Social Worker has	

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F 578	Continued From page 5 Non-traumatic brain injury. Admission History and Physical (H & P) dated 12/08/2022 was reviewed. 29-year-old male who suffered cardiac arrest, respiratory failure with resultant brain injury. R86 was admitted for skilled physical therapy (PT) services to increase strength and balance and increase safety and independence with transfers and ambulation to maximize function and improve quality of life. Reviewed the Social services (SS) notes. No documentation was found that social services discussed or addressed the AHCD. No notes were found in the IDT notes. On 06/01/23 at 11:42 AM, reviewed the social services assessment note date 12/16/2022. Physician order for life sustaining treatment (POLST) and AHCD: R86 surrogate is his girlfriend, will need to complete a POLST with surrogate. Currently, R86 code status is Full Code. Signed by SS10. Reviewed the social services assessment date: 03/13/2023. POLST & AHCD: Girlfriend is also R86 health care surrogate. A POLST will need to be completed with surrogate, and social work is reaching out to her for this. Currently, R86, code status is Full Code. Signed by SS11. On 06/01/23 at 12:01 PM During an interview with SS11, discussed the AHCD for R86 and whether there was any follow up with him or his surrogate. SS11 confirmed that she has been on board for only three months temporarily while SS10 was on leave, so she primarily works on the discharge planning for the facility. She stated that she could have a discussion with R86 although he may not understand, but she would try.	F 578	documented this in the resident□s medical record. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected. An audit of all residents□ charts was completed by 7/19/23 to ensure that all residents□ medical records have documentation that advance directive formulation was offered to the resident. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: At the initial Interdisciplinary Team (IDT) Conference for each new admission, Social Services will provide the documentation that advance directive formulation was offered or documentation as to why the resident cannot formulate an advanced directive. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: The newly admitted residents reviewed at each weekly IDT Conference will have their medical record reviewed to ensure there is documentation that the opportunity for advance directive formulation was provided to the residents.	

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F 578	Continued From page 6 SS11's last day working in the facility is tomorrow and the SS10 will be returning to the facility. 2) Record review of R72's paper chart. R72's face sheet revealed that he is a 79-year-old resident admitted to the facility on 04/29/23. A "Long-Term Care Admission H & P documented on 05/01/23 by his physician noted that R72 was transferred to the hospital's swing unit in April after his admission to the facility for "COVID-19 disease with acute respiratory failure." R72's diagnoses included, aortic insufficiency (heart valve not closing properly) with a replacement of the aortic (heart) valve, dementia with behavioral disturbance, coronary artery disease (plaque buildup in the arteries of the heart causing blockage of blood flow to the heart muscle), and history of post-polio syndrome (a group of potentially disabling signs and symptoms occurring 30 - 40 years after an infection with polio; includes muscle and joint weakness and pain, becoming easily fatigued, loss of muscle tissue, and breathing or swallowing problems.) No Advance Health Care Directive (AHCD) was found in his chart. A "Social Services Assessment" dated 05/30/23 revealed that Social Services (SS)11 spoke with R72's family member (FM), who is R72's guardian, but did not provide her with education regarding the importance of completing an AHCD for R72. On 06/02/23 at 11:09 AM, interviewed SS11. SS11 stated that no follow-up on the completion of R72's AHCD and education were done with R72's FM.	F 578	Results of the audits will be reviewed at the QAPI meetings. Ongoing validation by the Administrator at the QAPI meeting.	
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2)	F 604		7/21/23

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F 604	Continued From page 7 §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure the resident's right to be free from physical restraints was being followed for three of three residents (Resident (R)82, R33, and R193) sampled. Observed positioning wedges placed at the (lower end) of both bedrails, adjacent to the resident's body	F 604	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 6/5/23, the positioning wedges for R82, R33 and R193 were removed after	

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F 604	Continued From page 8 which restricted the resident's willful movements and confine the residents to their bed. Interviews with staff verified the wedges were used to prevent the residents from exiting the bed. The resident's medical record (MR) did not include any information in the assessment, physician orders, or care plan related to the use of wedges for positioning. As a result of this deficient practice, residents are at risk for potential or physical and psychosocial harm and/or serious injury. Findings include: (Cross Reference to F725- Sufficient Nurse Staffing) 1) On 05/30/23 at 11:58 AM, conducted an observation of R82 in the resident's room. Observed R82 lying in bed, flat on her back, both bed rails were up, at the bottom of the bedrail (approximately at the resident's waist to mid calve) the sides of the mattress were raised from under the fitted sheet. Surveyor lifted the fitted sheet and observed independent wedges were placed on top of the mattress (under the fitted sheet). The wedges were not used to reposition the resident (observed laying on her back) and were not part of a set-up to reposition the resident vertically or horizontally reposition the resident. The fitted sheet securely held the wedges in place at the in the bed creating a barrier to keep R82 from attempting to get out of bed. This surveyor attempted to interview R82, and observed the resident was alert to person only, behaviorally impulsive(throwing the call light), and attempted to get out of bed. R82 was not able to get out of the bed due to the wedges that were placed under the fitted sheet. Additional observations were made on 05/31/23 at 9:26 AM	F 604	determining that the use of positioning wedges is not needed for these residents. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected. By (6/9/23), an audit of all residents was performed by the Nurse Managers to ensure that the positioning wedges were being used appropriately. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: By 7/21/23, all nursing care staff will complete education as to the appropriate use and purpose of positioning wedges. By 7/21/23, all nursing care staff will complete education on restraints and their appropriate use. At the quarterly IDT meeting for each resident, the IDT will review the need for position wedges for those residents that have them in place. Only residents that are unable to independently move in the bed or have a clinical need for a positioning device will have position wedges. The medical record for all residents requiring position devices will include reason for use, device consent and care planning	

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F 604	Continued From page 9 and 6/02/23 at 09:08 AM of the wedges being used to prevent R82 from exiting the bed and not for repositioning the resident in any manner. Review of R82's medical chart documented the resident was admitted on 07/05/22 with diagnosis which include Dementia with behavioral disturbances. SBAR (Situation, Background, Assessment, and Recommendation) form documented R82 fell approximately eight (8) times since January 2023 because of impulsivity and cognitive impairment. Review of a physician note dated 05/03/23, documented R82, with multiple falls and advanced dementia, no longer able to care for herself. Diagnosis of dementia with behavioral disturbances, pre-diabetes, hypertension, and syncope (temporary loss of consciousness due to low blood pressure). R82's mobility status- she continues to attempt to walk on her own and often falls. 2) On 05/30/23 at 12:40 PM and on 6/02/23 at 09:10 AM, conducted an observation of R33 in the room and wedges were placed at the end of the side rails adjacent to the resident's body, on top of the mattress, not placed under the resident for repositioning, or as part of a system to reposition the resident vertically or horizontally. R33's was agitated and yelling at her roommate. Review of R33's medical chart documented a (hospice) 60-day physician note, dated 05/17/23, which documented R33 has Dementia with Depression, her cognitive status has also changed. She was having more periods of agitation and for safety reasons requires medications daily. Review of the resident's	F 604	HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: The unit manager or designee will perform a monthly audit of all residents with positioning wedges to ensure the position wedges are being utilized for positioning and not utilized in a manner that is to prevent the resident from exiting the bed. Results of the audits will be reviewed at the QAPI meetings to ensure the corrective action is sustained. Ongoing validation by the Administrator at the monthly QAPI meeting.	

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medical chart confirmed there was no documentation for the use of positioning wedges as restraints, no assessment for the use of restraint (except for the use of side rails).

3) Observations conducted on 05/30/23 12:58 PM, 05/31/23 09:33 AM, and 06/02/23 at 09:14 AM, documented positioning wedges were used in the same manner as R193.

On 05/31/23 at 11:07 AM, conducted an interview with R193. The resident was alert and oriented to person, place, time, and situation. R193 confirmed that he was able to get himself out of bed, by rolling off the bed to get to his personal items located away from his bed. He stated that staff started using the wedges at the edge of his side rails after the incident, probably so he does not fall off the bed again.

Review of the resident's medical chart documented R193 was admitted to the facility on 05/22/23 with Amyotrophic lateral sclerosis (ALS), also known as Lou Gehrigs disease. Review of progress notes and SBAR form documented shortly after R193 was admitted, the resident had an unwitnessed fall from the bed, and R193 reported that he got out of bed on his own to get his personal items located on a couch in the room.

Conducted interviews with two anonymous staff (AS)99 and AS56). Both AS99 and AS56 confirmed the intent of placing the wedges were used as a restraint at the edge of the side rails, adjacent to R82's, R33's, and R193's body to prevent them from exiting the bed due to the resident's high fall risk, recent falls, impulsive behavior, impaired cognition, and lack of safety

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awareness. Both anonymous staff confirmed due to R82 and R33 impaired cognition, the residents are unable to identify that the wedges are preventing R82 from exiting the bed and unable to remove the wedges safely and independently from under the fitted sheet. R193 is cognitive, but is impulsive and lacks the muscle coordination to safety get out of bed without assistance. AS56 and AS99 stated that the wedges were being used as restraints because there is not enough staff to properly monitor R82 due to her impulsivity and lack of staffing. AS56 and AS99 confirmed the resident's acuity and dependence on staff is not factored into the staff to resident ratio, so although you only have five to six residents, they could all be total care and staff is unable to provide the type of supervision R82 requires.

On 06/02/23 at 11:03 AM, conducted a concurrent record review and interview with Nurse Manager (NM)2 regarding observations of wedges being used as restraints for staff convenience. NM2 stated the wedges are part of a system used to reposition the residents, this surveyor stated the wedges were being used independently and was not observed to be used for repositioning as they were not placed under the any part of the resident's body, all wedges were placed at the end of the bed rails, and all residents had recent falls or were high falls risk. NM2 confirmed wedges should not be used to confine residents to the bed as that would be considered a restraint. NM2 reviewed R82's, R33's, and R193's medical charts and confirmed all residents were high risk for falls due to impulsive behavior and/or recent falls, no assessment was completed for the use of wedges as a restraint, and there were no

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F 604	Continued From page 12 consents or physician orders for the used of restraints for all mentioned residents. The Director of Nursing (DON) joined in the interview and was informed of this surveyor's observations made of positioning wedges used as a restraint related to impulsive behaviors for R82, R33, and R193 and wedges were used by staff in response the acuity of the resident not factored into the staff to resident ratio. The DON confirmed position wedges should be placed under the resident for repositioning and should not be used to confine residents in the bed.	F 604		
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) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline	F 655		7/14/23

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F 655	Continued From page 13 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 observation, interview, and record review (RR), the facility failed to develop a baseline care plan that provided effective and person-centered care for one Resident (R)41 of 19 residents in the sample. Specifically, despite identifying the residents' immediate needs, the facility failed to develop and implement resident-specific interventions that addressed those needs. This deficient practice has the potential to affect all newly admitted residents at the facility. Findings include: R41 is a 91-year-old female originally admitted to the facility on 05/30/17. R41 was briefly transferred to the swing unit and readmitted to the long-term care unit on 05/26/23.	F 655	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Immediately on 5/31/23 a care plan that addressed the high risk for elopement was implemented for R41 HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents with a high-risk score for elopement have the potential to be affected. By 7/14/23 care plans for	

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F 655	Continued From page 14 On 05/30/23 at 11:35 AM, observations were done in the room of R41. The entire room was on isolation related to COVID-19, with the room door closed. R41's bed alarm was loudly alarming as R41 was observed steadily walking towards the room door. Hospital Aide (HA)108 attempted to stop her, however, R41 was angry, argumentative, and insistent on leaving. Observed HA108 call for "help" on her walkie-talkie, as she continued to try to calm, redirect, and stop R41 from getting to the room door. On 05/30/23 at 1:46 PM, observed R41 trying to leave her room again. A concurrent interview done with HA108 at this time revealed that she was a "sitter" for the room and stayed in the room for her entire shift because three of four residents in the room were "falls risk [including R41]." Surveyor shared observation that R41 appeared quite steady on her feet and seemed more of an elopement risk than a falls risk. As part of her re-admission to the long-term care unit, an Elopement Risk Assessment was conducted on 05/26/23, with R41 scoring a 15. During a review of the 05/26/23 Elopement Risk Assessment on 05/31/23 at 08:40 AM, it was noted that a score greater than seven was considered "High," and that "For Elopement Risk score... [greater than or equal to] 12, consider placing resident on the Code Silver List. Document in progress notes whether the resident is on the Code Silver List and the rationale ..." A review of R41's progress notes showed no acknowledgement or documentation regarding her high elopement risk. A review of R41's baseline care plan (BCP) did not reveal any	F 655	residents admitted within the past 60 days with a high-risk score for elopement will be reviewed to ensure a care plan was in place to address the high risk for elopement WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The template for the Baseline Care Plan will include an elopement risk component. This will ensure that it is addressed in each newly admitted resident□s Baseline Care Plan. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: The RAI Coordinators will perform a monthly audit of all newly admitted residents Baseline Care Plans to ensure that the elopement risk is addressed. Results of the audits will be reviewed at the QAPI meetings to ensure the corrective action is sustained. Ongoing validation by the Administrator at the monthly QAPI meeting.	

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information about elopement risk either.

On 05/31/23 at 08:42 AM, an interview was done with Charge Nurse (CN)106 at the second floor Nurses' Station. CN106 confirmed that R41 coded "high" on her last Elopement Risk Assessment. CN106 also confirmed that she was not placed on Code Silver. When asked to describe what Code Silver was, CN106 stated that normally when the assessment score is above 12, the resident is put on Code Silver which means the resident's name, picture, and Code Silver status, otherwise known as elopement risk, should be communicated throughout the facility. In addition, the resident's name, picture, and description is placed in a silver binder at the Nurses' Station. CN106 confirmed that the elopement risk should be care planned as well. During a concurrent review of R41's medical record and the Code Silver binder, CN106 confirmed that there had been no care plan initiated or other action documented in response to R41 being assessed as a high elopement risk on 05/26/23.

On 06/01/23 at 03:20 PM, observed R41 get up from her bed, and ambulate steadily towards the door. The assigned HA for the room was in the bathroom assisting another resident. Surveyor stepped in front of R41 and attempted to redirect her verbally. R41 pushed SA out of her way, stating "move!" As surveyor repeatedly called out to assigned HA for help, R41 approached the room door. Another HA and a housekeeper managed to stop R41 at the room door, and redirect her. R41 reluctantly returned to her bed.

On 06/02/23 at 08:08 AM, an interview was done with Nurse Manager (NM)136 in her office.

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F 655	Continued From page 16 NM136 stated she was not aware that R41 was still trying to actively get out of her room. During a concurrent review of R41's medical records, NM136 acknowledged that R41's BCP did not address the behavior and that her comprehensive care plan did, but had not been carried over from her old chart.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's 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)-	F 656		7/21/23

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F 656	Continued From page 17 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure a comprehensive person-centered care plan was developed and/or implemented for three of nineteen residents (Resident (R)34, R27, and R21) sampled. An intervention to apply compression stocking to reduce swelling in R34's lower extremities was not implemented as documented in the comprehensive care plan. Behavioral and skin care interventions were not implemented for R27. R21's chronic joint pain and refusals of care were not addressed. As a result of this deficient practice residents are at risk of negative outcomes and a potential for harm. Findings include: 1) Multiple observations (05/30/23 at 12:54 PM and 01:45 PM; 05/31/23 at 09:15 AM, 11:21 AM, and 01:42 PM) were made of R34 with no	F 656	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: a)On 6/30/23, the care plan for R34 was reviewed with all staff members on the unit to ensure knowledge and compliance with the care plan b)On 5/30/23, the care plans for R27 were immediately placed in the medical record and copies placed in the communication book for staff to review. c)On 5/31/23, a care plan for R21 was developed to address the refusal of care due to chronic pain. Updated care plan placed in staff communication book for review. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE	

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F 656	Continued From page 18 compression stockings applied to the resident's lower extremities. On 05/31/23 at approximately 11:21 AM, Physician (P)1, Licensed Nurse (LN)128, and Nurse Manager (NM)19 were at R34's bedside evaluating a wound on the resident's foot. R34 informed all staff present that staff has not been applying compression stockings to her lower extremities. NM19 inquired if R34 has compression stocking. R34 informed NM19 that she had bought her own supply of compression stockings, but they were dirty and needed to be washed. On 05/31/23 at 01:15 PM, R34 confirmed that staff are not consistent with applying the compression stockings and have not applied them in a while because the stockings are dirty and need to be washed. On 06/02/23 at 09:15 AM, conducted a review of R34's medical chart. Review of R34's Physician Orders documented an order for, Patient to wear compression stocking socks on LE [lower extremity] bilateral as tolerated for poor venous return, which was started on 03/20/23. Review of the Certified Nurse Aide (CNA) Treatment Book documented for staff to, "Apply black Sigvaaris compares liner socks to BLE (bilateral lower extremities) before re OOB (out of bed) In the morning, ensure no wrinkles around ankle feet, remove in the evening, DX: compression liners". Review of staff's documentation for the application of compression stockings on 06/01/23 was not signed as applied. On 06/01/23 at 12:09 PM, R34 was observed to be OOB in a wheelchair and no compression stockings were applied.	F 656	POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: a)All residents with orders for compression stockings have the potential to be affected. By (7/7/23), all residents with care plans for compression stockings will be identified. All staff caring for these residents will be provided a copy of the care plan via a communication book to ensure staff□s knowledge and compliance the care plan(s). b)All residents that are readmissions to the facility have the potential to be affected. By (7/14/23), a care plan review of all readmissions within the past 3 months will be conducted to ensure that all previous comprehensive care plans are incorporated into the care plan of the present admission c)All residents with chronic pain have the potential to be affected. By (7/21/23), all residents with chronic pain will be identified. The care plans of these residents will be reviewed to ensure a care plan is in place to address the refusal of care due to chronic pain. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: a)The Charge Nurse will review residents with orders for compression stockings to ensure the care plan is carried out as indicated on the treatment record. b)At the next daily stand up after	

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F 656	Continued From page 19 On 06/02/23 at 12:09 PM, conducted a concurrent record review and interview with Nurse Manager (NM)19 regarding application of R34's compression stockings. NM19 confirmed the compression stockings should be placed on daily but has not, staff took the compression stocking upstairs to the fourth floor to be washed. Inquired where staff would document the application of the stockings and NM19 responded in the CNA Treatment Book. Review of the CNA Treatment Book documented the stockings were not applied on April 26, 2023. May and June 2023 documentation could not be found. Requested a copy of the CNA Treatment Book for May and June 2023 from NM19, this surveyor did not receive requested documents while at the facility or via email after leaving the facility. 2) On 04/11/23, the state agency (SA) received an anonymous complaint (ACTS #10217) regarding skin tears, bruising, and quality of care for R27. On 05/30/23, the SA entered the facility to conduct a recertification survey and investigate the complaint. Resident (R)27 is a 92-year-old male originally admitted to the facility on 08/05/22. R27 was briefly transferred to the swing unit and had just been readmitted to long-term care. On 05/30/23 at 11:18 AM, observations were done at the bedside of R27. R27 was noted to be wearing a facility gown with multiple skin tears and old bruises to both lower legs, the left leg being slightly worse than the right. On 05/31/23 at 09:15 AM, observations were done at the bedside of R27. Hospital Aide	F 656	readmission, the review of current care plans will be performed by clinical leadership. At the quarterly IDT meeting for each resident, the IDT will review residents with readmission since last IDT to ensure all previous comprehensive care plans were incorporated into the care plan of the present admission. c)At the quarterly IDT meeting for each resident, the IDT will review all residents with chronic pain to ensure a care plan is in place to address refusal of care due to chronic pain. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: a)Charge Nurses will review residents with orders for compression stockings to ensure the care plan is carried out as indicated on the treatment record. Results of the audits will be reviewed at the QAPI meeting to ensure the corrective action is sustained. Ongoing validation by the Administrator at the monthly QAPI meeting. b)At the quarterly IDT meeting for each resident, the IDT will review residents with readmission since last IDT to ensure all previous comprehensive care plans were incorporated into the care plan of the present admission. Results of the audits will be reviewed at the QAPI meeting to ensure the corrective action is sustained. Ongoing validation by the Administrator at the monthly QAPI meeting. c)At the quarterly IDT meeting for each resident, the IDT will review all residents	

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F 656	Continued From page 20 (HA)74 woke R27 for breakfast. As HA74 prepared R27 for breakfast from the right side of the bed, it was noted that R27 was very hard of hearing. Despite using a loud, clear voice and repeating herself several times, R27 could not hear much of what HA74 said. Noted large (8.5x11) sign hanging at the bedside containing very specific instructions for staff to put an "amplifier" into R27's right ear and to get low to his ear when speaking to him. At 09:19 AM, asked HA74 about R27's amplifier. HA74 stated "yes, he has a hearing aide, it's in the drawer," pointing with her right hand towards a drawer beneath the TV at the foot of R27's bed. Despite the reminder, HA74 made no move to get the amplifier out of the drawer, or ask R27 if he wanted to put the amplifier in. HA74 continued unsuccessfully to try to communicate with R27, with R27 getting noticeably frustrated and repeatedly stating "What?! Just leave me alone!" Concurrent observations noted several other 8.5x11 signs posted in R27's care area containing various detailed and specific instructions for staff. On 06/02/23 at 08:12 AM, an interview was done with Nurse Manager (NM)136 in her office. NM136 confirmed that R27 had an extensive, very specific, comprehensive care plan (CCP) that had not been transferred into his current chart when he was re-admitted. When asked about R27's skin tears, NM136 shared that the facility had developed a detailed care plan for skin care that included putting R27 in pants to protect his legs. NM136 stated that R27 had special pants to wear that accommodated his indwelling urinary catheter. NM136 agreed that the CCP should always be carried over into the current chart. When 05/30/23 and 05/31/23 observations were shared, NM136 confirmed that whether the	F 656	with chronic pain to ensure a care plan is in place to address refusal of care due to chronic pain. Results of the audits will be reviewed at the QAPI meeting to ensure the corrective action is sustained. Ongoing validation by the Administrator at the monthly QAPI meeting.	

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CCP was in the current chart or not, staff should still be implementing and following the interventions posted in R27's room, as well as continuing to place R27 in pants to protect his legs.

On 06/02/23 at 08:48 AM, observations done at the bedside of R27 as he lay there alone noted he was again not wearing pants, leaving his legs exposed and unprotected.

3) On 05/31/23 at 09:07 AM, interviewed R21. R21 was sitting in her wheelchair, and she stated that she has chronic joint pain for which she takes scheduled pain medication around the clock for and tries to minimize generalized movement for pain management.

Record review of R21's paper chart revealed the document, "Pain Management Drug Review" with an assessment date of 04/07/23 for the month of March 2023. R21's diagnoses included, history of stroke, right hip surgery, and chronic pain. It also noted that R21 had "Occasional episodes of pain in month of March 2023." The same document for review of February 2023 stated, "2-3x [times] daily episodes of pain in month of February 2023" and review of January 2023 noted, "115 episodes of pain in month of January 2023." All "Pain Management Drug Review" documents stated to offer non-pharmacological interventions for pain which included offer resident to change position, offer food/drinks, or to offer activities of choice (i.e., book or newspaper to read, assist with attendance of group activities, visit, or talk on the phone with family.) A "Maintenance Exercise Program Record" with an order date of 05/03/22 included instructions to assist R21 to ambulate using a front wheel walker outside of the room

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F 656	Continued From page 22 and to do shoulder exercises. There was frequent documentation of R21's refusals to do the exercises because she was complaining of shoulder pain, or back pain, or of not feeling well, and the last entry with date 03/31/23, "never." Care plans were reviewed. There was no care plan to specifically address R21's refusals to exercise due to chronic pain which she will risk a decrease in activities of daily living and will possibly develop limitations in her range of motion. On 06/01/23 at 3:02 PM, Charge Nurse (CN)139 was interviewed. CN139 stated that if a resident was refusing care, it would be reported to the other nurses, management, and to the rehabilitation department, if applicable. CN139 further stated that R21 should be assessed for the reason of refusing care, would provide education as appropriate, and would develop a care plan addressing the resident's refusals of care.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a resident who is unable to carry out Activities of Daily Living (ADLs) received the necessary services to maintain good personal hygiene for one Resident (R)12 sampled. R12 is dependent on staff for showers, did not receive a shower for two weeks and reported feeling unkept	F 677	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: By 6/30/23, education provided to all staff providing care for R12. The education	7/21/23

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F 677	Continued From page 23 and unclean. As a result of this deficient practice, dependent residents are at a potential risk of psychosocial harm and potential physical harm because of unmet needs. Findings include: On 05/30/23 at 12:35 PM, conducted an interview with R12. During the interview R12 was alert and oriented to person, place, time, and situation, and responded to questions cognitively appropriate. R12 reported he/she is scheduled to have showers twice a week (Wednesdays and Saturdays) and had not recently received a shower. R12 confirmed he/she had not refused the opportunity to shower and looks forward to the task as it makes him/her feel good. R12 reported that he/she looks forward to showering. R12 stated that he/she is dependent on staff for showers, requires total assistance to transfer from the bed to the shower, and needs staffs help with washing as he/she is functionally unable to complete the task independently. Inquired if staff provided an explanation as to why the showers did not occur, R12 responded, "They didn't tell me why I didn't get a shower, they just didn't do it. They never tell you why, you just don't get a shower." R12 stated that if the resident has an "accident", soils themselves, then staff provide a bed bath to the peri area, only, they do not wash my hair. Review of R12's most recent Quarterly Minimum Data Set (MDS) with an assessment reference date of 02/08/23. Section C: Cognitive Patterns, Brief Interview for Mental Status (BIMS) score was 14 indicating the resident is cognitively intact. Section G. Functional Status documented A. Bed Mobility- extensive assistance, one person	F 677	provided was a review of the resident□s care plan and the need to follow the care plan with documentation of completion of the showers or refusal by the resident. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected. By (7/21/23), shower flowsheets for all residents will be audited to determine if residents are receiving the showers as indicated on their care plans WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Weekly, the Charge Nurse on each unit will review residents care plans and shower flowsheets to ensure that residents are receiving the showers as indicated on their care plan. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: Weekly, the Charge Nurse on each unit will review residents care plans and shower flowsheets to ensure that residents are receiving the showers as indicated on their care plan. Results of the audits will be reviewed at the QAPI	

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F 677	Continued From page 24 support B. Transfer- activity did not occur. G0120. Bathing- Physical help in part of bathing activity. G0400. Functional Limitation in Range of Motion- A. Upper extremity (shoulder, elbow, wrist, hand)- Impairment on one side B. Lower extremity (hip, knee, ankle, foot)- impairment on both sides. Section GG. Functional Abilities and Goals. GG0130. Self-Care E. Shower/bathe self- Dependent (dependent on staff, unable to perform). On 06/02/23 at 10:27 AM, conducted a concurrent record review of R12's medical chart and interview with Nurse Manager (NM)19 regarding R12's showers. Review of R12's May 2023 Resident Care Record, Bathing, documented the last bath/shower the resident had been on 05/22/23. R12 should have received baths/showers on 5/24, 5/26, 5/31, and 6/1 but did not. NM19 confirmed R12 did not receive a bath/shower in two weeks and could not provide documentation of the resident's refusal or information as to why the task was not performed.	F 677	meeting to ensure the corrective action is sustained. Ongoing validation by the Administrator at the monthly QAPI meeting.	
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required	F 725		7/26/23

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F 725	Continued From page 25 at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure there was sufficient nursing staff to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, in addition to their physical, mental, and psychosocial well-being. As a result of this deficient practice, the residents were placed at risk of a decreased quality of life and were unable to attain their highest practicable well-being. Findings include: (Cross Reference to F604- Physical Restraint) 1) The Office of Health Care Assurance received an anonymous compliant, Aspen Complaints Tracking System (ACTS) #10212, which included an allegation of insufficient staffing.	F 725	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: As indicated on the deficiency report, R73 did receive his morning medication late by 30 minutes. No adverse outcomes were noted for R73. On 6/5/23, the positioning wedges for R82, R33 and R193 were removed after determining that the use of positioning wedges is not needed for these residents. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be	

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F 725	Continued From page 26 Observations were made throughout the survey of wedges used as restraints to prevent three high fall risk residents (Resident (R)82, R33, and R193) from exiting the bed. Interview with four facility staff occurred throughout the recertification survey. Facility staff requested to remain anonymous (Anonymous Staff (AS)1, AS2, AS3, and AS4). All staff interviewed confirmed the use of the positioning wedges were intended to restrict the resident from getting off their beds unassisted. R82 and R33 are highly impulsive, cognitively impaired, and are high fall risk in addition to Dementia with behavioral disturbances. Staff stated that the ratio of nursing staff to resident does not take into account the acuity of the resident and the amount of time needed to provide adequate care for the residents. Observations of day staffing for the second-floor unit documented one registered nurse for twenty-two residents and four certified nursing aides (CNAs), resulting in a 1: 5. CNA to resident ratio. During an interview with the second-floor nurse manager, it was confirmed that the day shift should have had a total of three RNs, (two floor nurses and 1 charge nurse) but did not and acuity of the residents is not taken into consideration when staffing the unit. Review of the facility's Facility Assessment 2022, dated as revised on 03/0422 documented the Facility assessment had not been updated, does not include how the staffing ratios will be adjusted depending on the acuity of the residents, and in Section 1.5 Acuity to refer to Federal Form #672 for complete list. 2) On 02/16/23 a complaint (ACTS #10096) was received by the state agency (SA) with allegations	F 725	affected. On 06/28/2023, the DON reviewed the staffing records between 3/01/2023 and 05/31/2023 and conducted a per-patient-day (PPD) calculation of staffing to evaluate the appropriateness of staffing. The average PPD during that time on was found to be 4.14 hours. This PPD exceeds industry standards within the state of Hawaii and the nation. Upon receipt of the deficiency report on 6/26/23, there were no resident rooms within the facility in Enhanced Droplet Precautions. Therefore, no additional staffing was indicated at that time. The DON reviewed the facility policy for sick calls. Kula Hospital has sick leave policies that are non-punitive and flexible. Regularly, and in particular to maintain a COVID-19 free environment, Kula Hospital's sick leave policy allows sick healthcare personnel to stay home and is in line with recommendations from the Hawaii Department of Health and Centers for Disease Control and Prevention (CDC) and complies with the Hawaii Department of Labor. The Human Resources Department oversees staff labor practices. The scheduling of all staffing hours at Kula Hospital complies with all local, state, and federal guidelines, as well as both labor union contracts. Overtime shifts worked comply with local, state, and federal labor laws, as well as the labor union contracts. WHAT MEASURES WILL BE PUT INTO	

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F 725	Continued From page 27 of insufficient staffing affecting care. On 05/30/23, the SA entered the facility to conduct a recertification survey and investigate the complaint. On 05/31/23 at 08:42 AM, an interview was done with Charge Nurse (CN)106 at the third floor Nurses' Station. CN106 confirmed that normal staffing for the third floor with a census of 27 residents was four CNA's or Hospital Aides (HA) and one Licensed Nurse. Of the 27 residents on the unit, CN106 reported that "6 to 7" of them required assisted feedings. In addition, CN106 confirmed that due to a current COVID-19 outbreak, with 13 positive residents on the floor, the entire unit had been placed on Enhanced Droplet Isolation, meaning all the doors were kept closed, and all staff needed to ensure they were wearing a gown, gloves, an N-95 respirator, and a face shield prior to entering any resident room. CN106 also confirmed that one of the four CNAs/HAs was a 'sitter' in room 308, meaning the staff member stayed in that room for his/her entire shift, leaving three CNAs to care for the remaining 23 residents on the unit, a one to seven+ ratio. When asked if there was extra staff due to the isolation status/higher acuity of the whole unit, CN106 stated "no." A review of the Facility Assessment provided to the surveyor, last revised on 03/04/22, noted the following regarding staffing ratios: "The CNA schedules are made by the unit managers with the workload of the unit in mind. Our goal for Days and Evenings is a 1:6 ratio." 3) On 05/31/23 at 09:15 AM, an interview was done with Resident (R)73 at his bedside. R73	F 725	PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: By 7/26/23 the facility assessment will be updated to include: acuity identified for the residents that typically reside in the facility; the acuity of residents with a COVID-19 infection in addition to their primary diagnoses; contingency staffing plan in the event of a COVID-19 infection outbreak. By 7/31/2023, the facility will onboard 10 travel CNAs and 3 licensed staff to maintain and supplement the staffing matrix. To permanently fill vacant CNA positions, five (5) nurse aide trainees are currently in the Facility□s training program and will be ready for certification exam in 7/2023. Recruitment efforts are underway for additional nurse aide training cohorts to be held in 7/2023, 9/2023 and 12/2023. Four (4) new part time requisitions for RNs have been submitted for new hires to add to the existing staffing matrix for the facility. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: A weekly audit of staffing levels on all shifts will be conducted by the nursing supervisor. Results of the audits will be reviewed at the QAPI meeting to ensure the corrective action is sustained. Ongoing validation by the Administrator at the monthly QAPI meeting	

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verbalized a complaint that he was "still waiting for my pills, it's 09:15 and I don't have my pills, that's not OK." Observed that R73 had completed 90 percent (%) of his breakfast. When asked, R73 stated that he had finished eating a while ago, but no one had come in to pick up his meal tray. At 09:30 AM, the licensed nurse was observed entering to give R73 his morning medication.

On 06/01/23 at 03:51 PM, a record review was done of R73's medication administration record (MAR) and medication orders. It was noted that R73's morning medications were due at 08:00 AM, and included the following: Amlodipine five milligrams (mg) for high blood pressure, Stimulant Laxative Plus [a stool softener] to regulate his bowel movements, Vitamin K-2 plus D-3, and a Multivitamin. It was also noted that the Vitamin K-2 plus D-3 should be given with food for maximum absorption.

On 06/02/23 at 08:48 AM, an interview was done with CN106 near the third floor Nurses' Station. CN106 confirmed that medication(s) are considered late if given more than one hour after they are due.

4) On 05/31/23, a confidential interview was done with ASM2. When asked about sufficient staffing, ASM2 reported that the facility frequently operates with staffing levels that she considers to be dangerously low and "unsafe for the residents." ASM2 also reported that "this morning" at 07:00 AM, all staff were called into a huddle, informed about the recertification survey, and were instructed not to speak to the SA "about short staffing, unsafe conditions and other care issues." ASM2 stated, "I'm not going to lie for

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nobody." When queried if staff were asked to lie, ASM2 stated "yes." When queried to whom were they asked to lie, ASM2 stated "to you guys, the Surveyors." ASM2 continued on to report that the facility is "always short-staffed," stating that staff are frequently asked to work double shifts to cover. ASM2 stated he/she is asked to work extra "on average 4 times per week." When asked if he/she knew if the residents usually received their medication on time, ASM2 reported that licensed nurses are often behind on giving medications. So much so that he/she has observed nurses "leave it [medication cup with prescribed medications] at the bedside and ask ... [the CNAs/HAs] to make sure the resident takes it."
Cross reference to F838 Facility Assessment

5) On 06/01/23 at 11:27 AM, observed ward clerk (WC)159 calling for staff via telephone to work overtime (OT) in the evening shift.

On 06/02/23, a confidential interview was done with Anonymous Staff Member (ASM)3. ASM3 stated that it is nearly every day that the facility is asking for someone to work OT. ASM3 further stated the staff are getting burned out from working so much because they are being "mandated" to stay and work and that only a few management staff will help with the care of residents to prevent staff burn out.

On 05/30/23 during the entrance conference, the facility census was identified to be 89 residents - 22 residents on the second floor, 27 residents on the third floor, and 40 residents on the 4th floor. The third floor nursing unit was the dedicated COVID-19 isolation area, with 13 of the 27 residents infected with the COVID-19 virus.

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F 725	Continued From page 30 Record review of the Facility Assessment, revised on 03/04/22. Average daily census was 80 - 100 residents. There was no acuity described for the residents that typically lived in the facility nor was there acuity identified for residents infected with COVID-19 in addition to their primary diagnoses. Direct care staff per unit was planned for one Registered Nurse (RN) on each shift for day, evening, and nights and Certified Nursing Assistants (CNA) were planned for one CNA to six residents ratio (1:6) for the day shift, 1:6 for the evening shift, and 1:12 for the night shift. Record review of the staffing schedules for the week of 05/28/23 to 06/03/23. For the second floor on the night shift of 05/28/23 and 05/30/23, Hospital Aide (HA) to resident ratio was one HA for 22 residents (1:22). For the third floor, there was no RN assigned on the evening shift of 05/30/23 and there was a one HA to nine resident ratio (1:9) on the evening shifts of 05/28/23, 05/31/23, and 06/03/23. On every night shift of the week, 05/28/23 through 06/03/23, the ratio was one HA for 13.5 residents (1:13.5). The fourth floor night shifts for the week of 05/28/23 through 06/03/23 all had a one HA to 13 resident ratio (1:13).	F 725		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked	F 732		7/21/23

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F 732	Continued From page 31 by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure its nurse staffing information posted on the third floor contained the required data elements. Specifically, the posted nurse staffing information did not contain the facility name, unit census, and actual hours worked, on any of the survey days, and did not contain the date on the first day of the survey.	F 732	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No residents were identified as being affected.	

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F 732	Continued From page 32 Findings include: On 05/31/23 at 08:42 AM, an interview was done with Charge Nurse (CN)106 at the third floor Nurses' Station. When asked about the required posting of nurse staffing information, CN106 directed the state agency to an 8 x 12 inch white board placed at the beginning of the unit near the elevators. CN106 explained that normally the night shift completes the staffing board before the end of their shift. Observed four columns and two rows on the board. The top row was left blank. The second row had "D [day shift], E [evening shift], N [night shift]." The first column had position titles, and the remaining columns had whole numbers ranging from 0 to 4 written under the "D, E, N" for the three shifts. No unit census, date, or actual hours worked were observed on the board. When asked if it looked correct to her, CN106 picked up a pen and corrected the RN [registered nurse] count for day shift, then stated that now it was correct. When asked how one would know that the numbers were for today, CN106 apologized and wrote in the date in the top row. Observations made on 06/01/23 and 06/02/23 noted that the nurse staffing information posted on the third floor still did not contain the facility name, unit census, or actual hours worked.	F 732	HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: No residents have the potential to be directly affected. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: A centralized posting of Nursing staffing will be maintained in the main hallway entrance to the facility. This is accessible to residents and visitors. The required elements of: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: Weekly audits of the staff posting will be performed by the Nursing Operations	

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	125003	A. BUILDING _____ B. WING _____	06/05/2023

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F 732	Continued From page 33	F 732	Manager. Results of the audits will be reviewed at the QAPI meeting to ensure the corrective action is sustained. Ongoing validation by the Administrator at the monthly QAPI meeting.	
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that	F 838		7/26/23

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F 838	Continued From page 34 may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to update their facility assessment as required annually or when there is a change that would require a substantial modification to any part of the assessment (i.e. staffing shortage, COVID-19 outbreak). The facility assessment provides a comprehensive inventory of resources that are necessary to care for its residents competently during day-to-day	F 838	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: By 7/26/23 the facility assessment was updated to include: a) The resident population as defined in terms of disease predominance, culture,	

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F 838	Continued From page 35 operations and during emergencies. This deficient practice renders the administrative and management staff the inability to assess for potential system failure(s). Findings include: Cross reference to F725 Sufficient Nursing Staff. On 05/30/23 at 10:30 AM, the state agency (SA) was informed that the facility had an ongoing COVID-19 outbreak, with 13 of 27 residents positive for the infection on a nursing unit. The entire nursing floor was placed on Enhanced Droplet Isolation, meaning all the doors were kept closed, and all staff needed to ensure they were wearing a gown, gloves, an N-95 respirator, and a face shield prior to entering any resident room. Record review of the entity's Facility Assessment document was done. The year printed on the top stated, "2022" with a revised date of 03/04/22. The resident population was not clearly defined in terms of disease predominance, culture, religion, and dietary needs. There also was no acuity identified for the residents that typically reside in the facility. The Facility Assessment did not comprehensively address the care for residents infected with the COVID-19 virus, the acuity of residents with a COVID-19 infection in addition to their primary diagnoses, the staff competencies that are necessary to provide safe care, the physical environment, equipment, and services needed to deliver competent care to these residents, and how it may potentially affect the care provided by the facility (i.e. activities). "Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies"	F 838	religion, and dietary needs. b) Acuity identified for the residents that typically reside in the facility. c) The acuity of residents with a COVID-19 infection in addition to their primary diagnoses d) The staff competencies that are necessary to provide safe care, the physical environment, equipment, and services needed to deliver competent care to these residents e) Updated current staffing for Nurse Managers and Social Services f) The extended use of direct patient care traveling staff g) Contingency staffing plan in the event of a COVID-19 infection outbreak HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected. By 7/26/23 the facility assessment was updated to include: a) The resident population as defined in terms of disease predominance, culture, religion, and dietary needs. b) Acuity identified for the residents that typically reside in the facility. c) The acuity of residents with a COVID-19 infection in addition to their primary diagnoses d) The staff competencies that are necessary to provide safe care, the physical environment, equipment, and services needed to deliver competent	

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F 838	Continued From page 36 listed "Nursing Leadership" to have four Registered Nurse (RN) managers, but the facility currently only had two employees fulfilling that role, with one RN manager overseeing two nursing units of the long-term care facility. The "Social Services" department was planned for two staff, but there was only one currently working and she was also an interim (traveling) employee. The Facility Assessment also did not address the extended use of direct patient care traveling (interim) staff which included 28 individuals on their current employee roster. On 06/02/23 at 09:35 AM, interviewed the Director of Nursing (DON). DON stated that the Facility Assessment was not updated in March 2023 because the Administrator that completes that document left that month. DON further stated that there was no contingency plan identified for staff and the comprehensive care of residents in the event of a COVID-19 infection outbreak and/or a staffing shortage.	F 838	care to these residents e) Updated current staffing for Nurse Managers and Social Services f) The extended use of direct patient care traveling staff g) Contingency staffing plan in the event of a COVID-19 infection outbreak WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The Director of Nursing and Administrator will review the Facility yearly and in the event of a significant change to resident needs such as during an outbreak of an infectious disease HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: Annually and as needed for significant changes, the Facility Assessment will be reviewed at the QAPI meeting to ensure the corrective action is sustained. Ongoing validation by the Administrator at the monthly QAPI meeting.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent	F 842		7/21/23

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F 842	Continued From page 37	F 842		

agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained

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F 842	Continued From page 38 for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to provide a complete and accurately documented medical record of one resident (R), R21, out of a sample of 19 residents. Rehabilitation Services Supervisor (RSS)22 did not document that R21's referral for an occupational therapy (OT) evaluation for R21's complaint of pain was received and the reasons for the delay of services. This deficient practice could potentially have R21 be lost to appropriate follow up of necessary services. Findings include: On 05/31/23 at 09:07 AM, observation and interview were done with R21. R21 was sitting in her wheelchair, and she stated that she has chronic joint pain for which she takes scheduled	F 842	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On (6/5/23) a progress note was entered into R21's medical record to indicate the receipt of the referral and the reason for the delay. On (6/5/23) the Occupational Therapy evaluation was completed. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents that have a referral for OT	

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F 842	Continued From page 39 pain medication around the clock for and tries to minimize joint movement for pain management. Record review of R21's paper chart revealed a Situation-Background-Assessment-Recommendation-Communication document from nurse to physician dated 04/26/23 at 3:00 PM. The document noted that R21 had left shoulder pain related to a torn rotator cuff (a group of muscles and tendons surrounding the shoulder joint), rating it a "10" on a pain scale from 0 to 10 (numerical rating given for 0- no pain to 10-extreme pain). R21 was not able to propel herself in her wheelchair. A recommendation (order) received from the physician was to refer R21 to occupational therapy (OT) to evaluate her left shoulder. A progress note documented on 04/26/23 at 11:45 PM stated, " ...This PM [night] nurse sent a Rehab Screen request via email this evening ..." There was no progress note found documenting that the rehabilitation services department received the email referral, and no OT evaluation of R21's complaint of left shoulder pain was located. On 06/01/23 at 3:02 PM, a concurrent observation of R21's paper chart and interview were done with Charge Nurse (CN)139. CN139 could not find any documentation that acknowledged R21's OT referral and an OT evaluation. Progress notes for "Rehab Screen" revealed last written entry for 06/29/22 at 3:06 PM and a printed progress note by the physical therapist (PT) on 03/27/23 at 11:20 AM. On 06/02/23 at 08:45 AM, interviewed the Rehabilitation Services Supervisor (RSS)22. RSS22 stated that she received R21's referral for OT services in April, but the evaluation had not	F 842	have the potential to be affected. By 7/21/23, all OT referrals for May 2023 and June 2023 will be reviewed to ensure the consultation was completed or if unable to complete there is documentation of the receipt of the referral and reason for the delay in providing the consultation. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: On 7/3/23, the process was implemented to ensure new OT referrals are acknowledged and address promptly. After receiving the referral, OT will provide the consultation or document in the resident's medical record receipt of the referral and reason for delay in providing the consultation. This process will occur within (2) business days. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: Weekly, the OT Supervisor will audit all referrals received the previous week to ensure after receiving the referral, OT provided the consultation or documentation in the resident's medical record receipt of the referral and reason for delay occurred within (2) days of receiving the referral. Results of the audits will be reviewed at the QAPI meeting to ensure the corrective action is sustained. Ongoing validation by the Administrator at the monthly QAPI	

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F 842	Continued From page 40 been done because of ongoing COVID-19 infections of her staff and of R21's COVID-19 infection on 04/27/23. RSS22 acknowledged that receipt of the referral and delay of the OT evaluation should have been documented in R21's progress notes.	F 842	meeting	
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 infections before they can spread to other	F 880		7/21/23

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F 880	Continued From page 41 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 observation, interview, and record review, the facility failed to ensure appropriate protective and preventive measures for	F 880	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN	

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F 880	Continued From page 42 COVID-19, linen is processed as to prevent the spread of communicable diseases and infections. This is evidenced by the facility failing to ensure staff followed transmission-based precautions (TBP) by wearing the proper personal protective equipment (PPE), as well as follow standard precautions by consistently performing hand hygiene. In addition, the facility failed to track and monitor that staff's COVID-19 testing was consistently conducted to minimize the risk of continued transmission of COVID-19 during a facility outbreak. These deficient practices have the potential to affect all residents in the facility, as well as all healthcare personnel, and visitors at the facility. Findings include: 1) On 05/10/23 an anonymous complaint (ACTS #10276) was received by the state agency (SA) alleging infection control concerns. On 05/30/23, the SA entered the facility to conduct a recertification survey and investigate the complaint. Upon entrance, the SA was informed that the facility had a COVID-19 outbreak, with 13 of 27 residents positive on the third floor. As a result, the entire long-term care unit on the third floor had been placed on Enhanced Droplet Isolation, meaning all the doors were kept closed, and all staff needed to ensure they were wearing a gown, gloves, an N-95 respirator, and a face shield prior to entering any resident room. A review of the facility Policy and Procedure Standard and Transmission-based Precautions, last revised 02/2021, noted the following: "5.2.5.c. Enhanced Droplet Isolation - The healthcare worker must:	F 880	AFFECTED BY THE DEFICIENT PRACTICE: No residents were identified as being affected by the deficient practice. a) By (7/21/23) PPE donning and doffing education was provided to all staff b) On (6/1/23) the hand sanitizer was refilled c) On (6/29/23) the process was initiated for staff to sign next to their name on a copy of the daily staffing sheet when they have completed testing. d) On (6/30/23) the washer and dryer were removed from the 4th floor. All resident laundry is sent to Maui Memorial Medical Center Laundry Department for laundering unless the resident□s family chooses to do the laundry at their private home. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected. a) By 7/21/23 all staff provided PPE donning and doffing education. b) By (5/8/23) Environmental Services (EVS) audited all of the hand sanitizer dispensers to ensure adequate sanitizer was available. c) In the event of COVID-19 outbreak, managers will ensure that all staff have signed the copy of the staffing sheet on the day of testing to ensure that all staff have tested.	

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F 880	Continued From page 43 (1) Perform hand hygiene with ABHR [alcohol-based hand rub] or soap and water when entering room. Note that ABHR is preferred method for hand degerming." "5.2.5.e. When exiting the patient room/area (1) Remove and discard gloves and gown in room (2) Clean hands with ABHR or soap and water and leave or exit patient room." On 05/30/23 at 12:17 PM, 05/31/23 at 11:55 AM, and 06/01/23 at 09:20 AM, observations were made that the ABHR dispenser inside room 304 near the trash receptacle and room door was out of ABHR. The nearest soap and water inside the room was in the residents' shared bathroom, and was placed well away from the room door. The nearest ABHR dispenser outside the room was diagonally across the hall, at least 20 feet from the room door. On 06/01/23 at 09:23 AM, an interview was done with Hospital Aide (HA)104 inside of room 304. HA104 confirmed that the ABHR dispenser was empty, and stated "oh, you saw that." When asked how staff have been able to do hand hygiene for the past 3 days that the dispenser has been empty, HA104 stated "yeah, I don't know." HA104 reported that housekeeping was supposed to round daily, cleaning and ensuring the dispensers were filled, but that "sometimes" they were short. At 09:30 AM observed HA104 exit room 304 with no gloves on, carrying a filled trash bag from the room in each hand. When she saw the SA outside the room door, HA104 grabbed a pair of gloves and donned them without performing hand hygiene. When asked if	F 880	d) On 6/30/23 the washer and dryer were removed from the 4th floor. All resident laundry is sent to Maui Memorial Medical Center Laundry Department for laundering unless the resident□s family chooses to do the laundry at their private home WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: a) By 7/21/23, all staff provided PPE donning and doffing education. b) By (5/7/23) Environmental Services created as part of their daily cleaning service, to ensure the hand sanitizer dispenser contain hand sanitizer. c) In the event of COVID-19 outbreak, managers will ensure that all staff have signed the copy of the staffing sheet on the day of testing to ensure that all staff have tested. d) On 6/30/23, the washer and dryer were removed from the 4th floor. All resident laundry is sent to Maui Memorial Medical Center Laundry Department for laundering unless the resident□s family chooses to do the laundry at their private home HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: a) During a COVID-19 outbreak, PPE audits will be performed on the unit to ensure proper donnig and doffing is being	

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	125003	A. BUILDING _____ B. WING _____	06/05/2023

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F 880	Continued From page 44 she performed hand hygiene before exiting the room, HA104 admitted that she did not, stating, "no, because there wasn't anything [ABHR]." On 06/01/23 at 09:11 AM, observations were made outside of room 308. As Staff Nurse (SN)129 prepared to enter the room to administer medications, observed no hand hygiene immediately prior to donning (putting on) gloves and a disposable gown. SN129 then proceeded to change her N-95 respirator with no glove change between the dirty and clean respirator. Wearing the same pair of gloves, SN129 donned a face shield that was hanging outside the door, and entered the room. 2) On 06/02/23 at 08:58 AM, an interview was done with the Infection Preventionist (IP) in the conference room. When asked about outbreak testing for staff, the IP reported that Nurse Manager (NM)136 conducted the COVID-19 testing and monitoring for all staff working on the third floor since all the positive residents were placed there. On 06/02/23 at 10:00 AM while comparing the third floor staffing schedules with the line listing of staff test results for the week of 05/28/23 - 06/02/23, at least two Hospital Aides were noted to have worked on 05/28/23 (HA165) and 05/30/23 (HA166) with no test results. HA165 was noted to be part of the float pool, and HA166 was also noted to be part of the float pool, working an extra shift, labeled as "OT [overtime]." On 06/02/23 at 11:12 AM, an interview was done with NM136 in her office. When asked about staff testing, NM136 stated all staff who work on the third floor should know, and sign a form	F 880	performed. b) Hand sanitizer dispenser audits will be performed by the Supervisor of EVS on a weekly basis c) During a COVID-19 outbreak, managers will confirm all staff have tested and send the staff testing sign-in sheets to the Infection Preventionist for monitoring and reporting. Results of the audits will be reviewed at the QAPI meeting to ensure the corrective action is sustained. Ongoing validation by the Administrator at the monthly QAPI meeting.	

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F 880	Continued From page 45	F 880		

acknowledging, that they are to rapid (antigen) test and PCR test (COVID-19 test which are more likely to detect the virus than antigen tests) themselves every other day at the beginning of the shift. NM136 reported that even the travelers (temporary contract staff) take the training and sign an attestation that they will test when required to. When asked about monitoring staff to ensure everyone tests/conducts the tests properly, including staff in the float pool, or working an extra shift outside of their 'home' floor, NM136 stated "I'm not sure if maybe ... [the IP] is tracking the tests [and monitoring for compliance as part of the outbreak testing], but I am not."

2) On 06/01/23 at 11:25 AM, conducted an observation of the stacked washer/dryer (W/D) located on the 4th floor unit. The W/D unit was located in an open room next to a sink and open storage stand with resident snacks, and approximately three feet away from the unit refrigerator with perishable foods for the residents. There were no clean supplies in the area to sanitize the W/D and no separation of the W/D for the food area. There was resident hair on top of the washer cover and in the washer drum. The lint trap of the dryer had not been cleaned after used and appeared to not have been cleaned for an extended time as evidence of an excess of lint and hair coming out of the dryer door and lint trap. Staff informed me that multiple residents use the W/D, and it is used to wash soiled clothes. On 06/02/23, this surveyor was informed that a resident from the second floor had also had personal clothing washer in the W/D unit.

On 06/01/23 at 11:32 AM, while conducting an observation of the 4th floor resident's

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F 880	Continued From page 46 nourishment kitchen with Licensed Nurse (LN)62. LN62 was not clear on who was supposed to clean the W/D or what was used to clean it. LN62 confirmed the W/D had hair on top and inside of the washer portion and the lint trap had overflowing with lint and hair from multiple residents and the unit was not kept in a sanitary condition. While conducting an observation of the W/D, a female cockroach crawled out from behind the top of the paper towel dispenser, up the wall, then back behind the dispenser. LN62 confirmed facility does have roaches. At 11:41 AM, conducted a concurrent observation of the 4th floor nourishment kitchen and interview with the Infection Preventionist (IP). Inquired with IP regarding how the facility ensures staff are maintaining, cleaning, and auditing for appropriate infection control practices for the W/D on the fourth floor. IP was unaware that there was a W/D on the fourth floor used for residents and confirmed the facility is not monitoring the W/D unit and does not have a plan for maintaining the W/D for appropriate infection control practices. IP inspected the W/D, resident snack area, and the proximity of the W/D to the resident snacks and refrigerator and confirmed it was not a sanitary practice and was unsure of how staff cleaned the washer after using it for soiled items.	F 880		
F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility	F 925	WHAT CORRECTIVE ACTION WILL BE	6/23/23

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F 925	Continued From page 47 failed to implement an effective pest control program so that the facility is free of pest. As a result of this deficient practice, residents are at risk for potential harm related to disease spread by pest. Findings include: The Office of Health Care Assurance received an anonymous compliant, Aspen Complaints Tracking System (ACTS) #10212, which included an allegation of a cockroach infestation throughout the hospital. On 06/01/23 at 11:32 AM, while conducting an observation of the 4th floor resident's nourishment kitchen with Licensed Nurse (LN)62. The nourishment kitchen includes resident snacks, resident refrigerator, stacked washer dryer, a sink, and trash bin. While inspecting the stacked washer/dryer, LN62 and this surveyor observed a German cockroach crawl out from behind the paper towel dispenser, go up the wall approximately on foot, then return behind the paper towel dispenser. On a wire storage rack (with clear heavy-duty hard plastic plexi shelves on top of the wire rack) and plastic storage bins with drawers on top of it which contained snacks and condiments used by the residents. Observed the plexi-glass to be soiled with an excessive amount of food crumbs. LN62 confirmed the area was dirty and there was an excessive amount of food crumbs. LN62 stated housekeeping and/or staff (as they see it) was responsible for cleaning the area. In addition, the type of cover on trash bin, could not be securely closed to keep out cockroaches and other pest from accessing discarded food.	F 925	ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 6/6/23, the kitchen area on the 4th floor was sprayed for cockroaches HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected. On 6/23/23, all kitchen areas on the care units were sprayed for cockroaches. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: In addition to the facility wide monthly professional pest control program, all kitchen areas on the care units will be sprayed weekly for cockroaches. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: The maintenance department will provide the weekly assignment check off in addition to the confirmation of the monthly facility wide professional pest control. This will be reviewed at the QAPI meeting to ensure the corrective action is sustained. Ongoing validation by the	

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F 925	Continued From page 48 At 11:41 AM, conducted a concurrent observation of the 4th floor nourishment kitchen and interview with the Infection Preventionist (IP). Informed the IP of this surveyor's and LN62's observation of the cockroach crawling from behind the paper towel dispenser and the food crumbs. IP confirmed that the area was not kept in a clean and sanitary condition. On 06/02/23 at 11:50 AM, Maintenance Staff (MS)7 provided the Pest Control agreement. Surveyors inquired if there were any reports (staff/residents) of pest reported to the maintenance department. MS7 reviewed March, April, and May 2023 documents, and confirmed no issues or concerns related to cockroaches were reported to the maintenance department. Surveyors informed MS7 of observation and MS7 confirmed he was unaware of the incident; staff had not reported it to the maintenance department.	F 925	Administrator at the monthly QAPI meeting.	