STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125057	A. BUILDING _____ B. WING _____	06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULANA MALAMA	91-1360 KARAYAN STREET EWA BEACH, HI 96706

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 06/20/23 - 06/23/23. The facility was not in compliance with 42 CFR 483 Subpart B. Facility Reported Incident (ACTS #9760) was also investigated and unsubstantiated. Survey Census: 26 Sample Size: 15	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		7/7/23

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

Electronically Signed | 07/07/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 656	Continued From page 1 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review. The facility failed to implement interventions in a care plan to provide effective and person-centered care that meet professional standards of quality care for one of the three residents sampled (Resident (R) 2). Findings Include: Cross tag with F693. The facility failed to provide appropriate treatment and services to prevent complications for a resident who receives enteral feeding. R2 was admitted to the facility on 03/02/19. R2's diagnosis included dysphagia, respiratory disorder, and gastroesophageal reflux disease without esophagitis.	F 656	Cross tag with F693 Care plans and orders for Resident R2 were reviewed by the Director of Nursing. Care plan was amended to reflect the usage of 30-degree wedge placed under the mattress to elevate the head of the resident to the recommended angle. The wedge will be used until the Resident's new bed, which was ordered prior, arrives. (07/03/23) All care plans were reviewed by the Director of Nursing for all Residents for the head of bed elevated 30 degrees as standard practice. Subsequently, all Residents were assessed by the Director of Nursing for proper equipment to allow	

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F 656	Continued From page 2 Observation was conducted on 06/20/23 at 01:50 PM in R2's room. R2 was lying flat in bed on his left side. Enteral feeding bag was attached and infusing. Observation was conducted on 06/21/23 at 01:21 PM in R2's room. R2 was observed lying flat in bed on his left side. R2's enteral feeding bag was attached and infusing. Interview with Registered Nurse (RN) 1 was conducted in R2's room on 06/21/23 at 01:27 PM. RN1 was asked about R2's flat position during enteral feedings. RN1 replied, "supposed to be elevated to prevent aspiration but because he is on a special bed, you can't elevate him." On 06/20/23 at 02:20 PM an Electronic Health Record (EHR) review of R2's care plan, dated 04/18/23, indicated that R2 was, "at risk for respiratory distress/ineffective breathing/airway and infections r/t: tracheostomy placed ..." One of the interventions listed for this focus area was, "POSITIONING ...Keep HOB [head of bed] raised at least 30 degrees to facilitate optimum breathing pattern and during tube feeding up to 1 hour after to prevent aspiration." A second focus area in R2's care plan indicated, "altered GI [gastrointestinal] function/difficulties r/t [related to] gastrostomy dependence ...chewing and swallowing difficulties requiring total GT [gastrostomy tube] feed, altered GI function, GERD, possible emesis." One of the interventions for this focus area indicated "elevate HOB at least 30 degrees during TF and1 hour after TF to prevent aspiration." Concurrent observation and interview were	F 656	the head of bed to be elevated to the recommended angle. (07/05/23) Staff was in-serviced on the need for elevating the head of bed for each resident during feeding and for one hour after. (07/07/23) Audits for all Residents will be done by the Director of Nursing or designee to ensure the head of bed is elevated at least 30 degrees during feeding and up to one hour after feeding. Audits will be done every shift x 1 week for all residents, then a random sample of at least 50% of the residents for all shifts x 2 weeks, then alternating shifts once a week x 1 month. Spot checks will be done by the Director of Nursing or designee periodically to ensure compliance. (07/07/23) Any discrepancies will be corrected immediately and any patterns will be reported to the QA Committee for further follow up. (Ongoing)	

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F 656	Continued From page 3 conducted with the Director of Nursing (DON) on 06/22/23 at 01:27 PM in R2's room. R2 was observed lying flat in bed slightly on his stomach receiving his scheduled tube feeding. DON was questioned about R2's flat position in bed during enteral feedings. DON answered, "he is okay he can tolerate that. His trust bought this bed, and it doesn't go up. But we did get him a new bed." DON was informed of R2's care plan indicating elevating R2's head of the bed at least 30 degrees during feeding. DON replied, "just got to update the care plan." An interview was conducted with the DON on 06/23/23 at 11:08 AM at the nurse's station. DON was asked if there was a nursing assessment, MD assessment, or MD order that supported R2's position of lying flat during his enteral feedings. DON answered, "that just comes from the daily nursing assessment charting and there is no MD order."	F 656		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and	F 693		7/7/23

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F 693	Continued From page 4 §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to provide appropriate treatment and services to prevent complications from enteral feeding for one of the three residents sampled (Resident (R) 2) Findings Include: Cross tag with F656. The facility failed to implement interventions in a care plan to provide effective and person-centered care that meet professional standards of quality care. R2 was admitted to the facility on 03/02/19. R2's diagnosis included dysphagia, respiratory disorder, and gastroesophageal reflux disease without esophagitis. Observation was conducted on 06/20/23 at 01:50 PM in R2's room. R2 was lying flat in bed on his left side. Enteral feeding bag was attached and infusing. Observation was conducted on 06/21/23 at 01:21 PM in R2's room. R2 was observed lying flat in bed on his left side. R2's enteral feeding bag was attached and infusing. Interview with Registered Nurse (RN) 1 was	F 693	Cross tag with F656 Care plans and orders for Resident R2 were reviewed by the Director of Nursing. Care plan was amended to reflect the usage of 30-degree wedge placed under the mattress to elevate the head of the resident to the recommended angle. The wedge will be used until the Resident's new bed, which was ordered prior, arrives. (07/03/23) All care plans were reviewed by the Director of Nursing for all Residents for the head of bed elevated 30 degrees as standard practice. Subsequently, all Residents were assessed by the Director of Nursing for proper equipment to allow the head of bed to be elevated to the recommended angle. (07/05/23) Staff was in-serviced on the need for elevating the head of bed for each resident during feeding and for one hour after. (07/07/23) Audits for all Residents will be done by the Director of Nursing or designee to ensure the head of bed is elevated at least 30	

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F 693	Continued From page 5 conducted in R2's room on 06/21/23 at 01:27 PM. RN1 was asked about R2's flat position during enteral feedings. RN1 replied, "supposed to be elevated to prevent aspiration but because he is on a special bed, you can't elevate him." On 06/20/23 at 02:20 PM an Electronic Health Record (EHR) review of R2's care plan, dated 04/18/23, indicated that R2 was, "at risk for respiratory distress/ineffective breathing/airway and infections r/t: tracheostomy placed ..." One of the interventions listed for this focus area was, "POSITIONING ...Keep HOB [head of bed] raised at least 30 degrees to facilitate optimum breathing pattern and during tube feeding up to 1 hour after to prevent aspiration." A second focus area in R2's care plan indicated, "altered GI [gastrointestinal] function/difficulties r/t [related to] gastrostomy dependence ...chewing and swallowing difficulties requiring total GT [gastrostomy tube] feed, altered GI function, GERD, possible emesis." One of the interventions for this focus area indicated "elevate HOB at least 30 degrees during TF and1 hour after TF to prevent aspiration." A review of the facility's policy titled, "G-tube/Peg-tube Feeding/Medication Nursing Policy and Procedure" dated 11/2018 was conducted. The policy documented, "Ask the resident to sit, or assist him/her into semi-Fowler's position [30 to 45 degrees], for the entire feeding (this helps to prevent esophageal reflux and pulmonary aspiration of the formula). For an intermittent feeding, have the resident maintain this position throughout the feeding and for 30 minutes to 1 hour afterward."	F 693	degrees during feeding and up to one hour after feeding. Audits will be done every shift x 1 week for all residents, then a random sample of at least 50% of the residents for all shifts x 2 weeks, then alternating shifts once a week x 1 month. Spot checks will be done by the Director of Nursing or designee periodically to ensure compliance. (07/07/23) Any discrepancies will be corrected immediately and any patterns will be reported to the QA Committee for further follow up. (Ongoing)	

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F 693	Continued From page 6 Concurrent observation and interview were conducted with the Director of Nursing (DON) on 06/22/23 at 01:27 PM in R2's room. R2 was observed lying flat in bed slightly on his stomach receiving his scheduled tube feeding. DON was questioned about R2's flat position in bed during enteral feedings. DON answered, "he is okay he can tolerate that. His trust bought this bed, and it doesn't go up. But we did get him a new bed." DON was informed of R2's care plan indicating elevating R2's head of the bed at least 30 degrees during feeding. DON replied, "just got to update the care plan." An interview was conducted with the DON on 06/23/23 at 11:08 AM at the nurse's station. DON was asked if there was a nursing assessment, MD assessment, or MD order that supported R2's position of lying flat during his enteral feedings. DON answered, "that just comes from the daily nursing assessment charting and there is no MD order."	F 693		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		7/7/23

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F 761	Continued From page 7 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview with staff members the facility failed to ensure one of six medication/respiratory (containing medication) carts were kept locked or under direct observation of authorized staff. Findings include: On 06/20/23 at 01:32 PM observed a cart containing medication unlocked and unattended located next to a resident's room and a main walkway used by staff members, residents and/or visitors. Observed staff members including the Director of Nursing (DON) walk past the cart. During the observation, there were no staff members in direct observation of the cart and were busy doing other assignments and duties. At 01:42 PM this surveyor was able to open and close the unlocked cart with no supervision from an authorized staff member. At 01:44 PM observed Respiratory Therapist (RT) 5 return to the unlocked cart, inquired with RT5 if the cart contained resident medications, RT5 confirmed	F 761	Once it was pointed out that the cart was unlocked, the Respiratory Therapy (RT) staff locked the cart and the Respiratory Therapy Director educated the staff about securing the cart. (06/22/23) At the time of the finding, the facility only had one key to the cart. Extra keys were created by the Environmental Services Coordinator and locksmith and distributed to the RT staff on duty. These keys will always be carried by the on-duty staff. (06/23/23) As there is only one RT cart shared amongst three therapists, no other carts were affected. (06/22/23) An in-service for RT staff about locking the cart and not leaving the cart unlocked and unattended was held by the RT Director on 06/22/23.	

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F 761	Continued From page 8 the cart had medications and should have been locked. Review of the facility's policy and procedure "Storage of Medication" Section 4.1 dated 01/21, documents "In order to limit access to prescription medications, only licensed nurses pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medications carts. Medication rooms, cabinets, and medications supplies should remain locked when not in use or attended by persons with authorized access."	F 761	An audit will be done by the RT Director or designee at random times daily x 2 weeks, then once a week x 1 month, then once a month x 2 months. (07/07/23) Any discrepancies or repeat patterns involving staff will be brought to the QA Committee meetings. (Ongoing)	
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;	F 880		6/23/23

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F 880	Continued From page 9 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 10 §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 record review and staff interview, the facility failed to maintain an infection prevention and control program (IPCP) to provide a safe environment to help prevent the transmission of communicable diseases and infections. The facility did not ensure that the IPCP was reviewed annually and updated as national standards change. As a result of this deficient practice, all the residents in the facility were placed at potential risk for developing communicable diseases and infections. Findings Include: On 06/22/23, review of the facility's "Infection Control Policy and Procedure" manual was conducted. Noted the first page in the inside cover titled, "Kulana Malama - IP (infection prevention) Manual Approval Signature Sheet" did not have any signatures on it. At 01:46 PM, a concurrent interview and record review was conducted with the Director of Nursing (DON) in his office. Asked DON when was the last time the Infection Control Policy and Procedure manual was reviewed. DON said it was reviewed last year and proceeded to show a copy of the manual that was in his office with the "Approval Signature Sheet" dated, 06/14/22. When asked if the manual was reviewed for 2023, DON responded, "Not yet, but we have it scheduled this month." DON did not provide a date for when the manual will be reviewed. On 06/23/23 at 11:15 AM, the DON provided a	F 880	The Infection Control Policy and Procedure manual Approval Signature Sheet was signed by all involved personnel. A meeting was scheduled prior but had to be postponed due to scheduling conflicts. (06/23/23) The facility has been working closely with the State of Hawaii, Department of Health, Disease Outbreak Control Division to periodically visit the facility to review and consult on infection control policies, practices and areas for improvement. Their last visit to review policies, procedures and walk through the facility was on June 1, 2023. (06/01/23) It has been determined by the Director of Nursing that the Infection Control Policy and Procedure manual will be reviewed, edited and/or accepted, and signed off at the first QA Committee meeting of the year, which usually occurs in April. Should the QA Committee meeting occur after the annual date of the signature sheet, the manual will be circulated by the Director of Nursing amongst involved staff prior to the meeting. (Ongoing) The Director of Nursing will ensure the timely signing of the Infection Control Policy and Procedure manual Approval Signature Sheet with oversight by the Administrator. (Ongoing)	

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F 880	Continued From page 11 meeting agenda dated 06/12/23. The agenda included, " ... III. Discuss any changes to Infection Control Policy and Procedure manual". Asked DON if minutes were taken for the meeting. DON responded, "No, the meeting did not happen because something came up."	F 880		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a	F 887		7/6/23

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	125057	A. BUILDING _____ B. WING _____	06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULANA MALAMA	91-1360 KARAYAN STREET EWA BEACH, HI 96706

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F 887	Continued From page 12 COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure documentation of COVID-19 vaccine refusal education providedd was included in the medical records for one of the five residents (R) 11 sampled. As a result of this deficiency, the facility did not meet the regulation for documenting the reason R11 did not receive the COVID-19 vaccine and education provided regarding the benefits and potential risks associated with the vaccine. Findings Include:	F 887	A letter dated 07/03/23 was sent to Resident 11's family by the Director of Nursing. The letter requested a written confirmation of consent or declination of the COVID-19 Bivalent vaccine. The Emergency Use Authorization Fact Sheet was sent along with the risk, benefits and side effects for the Pfizer Bivalent vaccine approved for 5-11 years of age. (07/03/23) A follow up letter was sent by the Director	

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F 887	Continued From page 13 On 06/22/23 at 07:48 AM, review of Electronic Health Records (EHR) was conducted. R11 is a 10-year-old resident admitted on 06/17/22. Diagnoses include chronic respiratory failure, tracheostomy (surgical opening through neck into the windpipe to allow air into lungs) and ventilator (breathing machine) dependence. Vaccination records revealed that there was no documentation if R11 received the COVID-19 vaccine. Furter review of EHR under "Misc" (section of EHR where documents are scanned into the chart) done and was not able to locate documentation of COVID-19 vaccine declination, and education provided regarding the benefits, risks and potential side effects associated with the vaccine. R11's paper chart that is kept in the nurse's station was also checked but no documentation was found. On 06/22/23 at 01:46 PM, a concurrent interview and record review was conducted with the Director of Nursing (DON) in his office. DON stated that the vaccine consent forms including education materials regarding COVID-19 vaccine are given to the resident's representatives for signature and then scanned into the EHR. DON added that the resident representatives do not always bring the document back and the staff would have to keep reminding them to bring it in or note consent or declination to the vaccine in the progress notes. DON then looked in R11's record but was not able to find documentation of vaccine declination. Asked DON if there is any other place in the EHR where the staff would document a resident's consent or declination for the COVID-19. DON said he will continue to look in the EHR and notify the survey team when he finds it.	F 887	of Nursing to families who declined previously. The follow up letter will allow them another chance to consent or decline, and also provide educational material about the risk, benefits and side effects for the Pfizer or Moderna Bivalent vaccine. (07/03/23) The Social Services Director followed up with families to obtain the written declination of the COVID-19 vaccines. (07/06/23) Any admission to the facility will have documented evidence of consent or decline of the COVID-19 vaccine and educational materials provided. An audit will be done by the Director of Nursing or designee to ensure compliance after admission paperwork is obtained. (Ongoing) Any discrepancies will be immediately rectified with documented consent or declination by Resident and/or family. (Ongoing)	

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F 887	Continued From page 14 On 06/23/23 at 07:55 AM, DON provided a printout of a "Late Entry" progress note for 11/16/21 created on 06/23/23 at 07:42 AM. The note text stated: "Covid Vaccine Consent: Mom refused covid vaccine for resident today. Stated she will return form." A 10:24 AM, DON confirmed there was no documentation in the EHR for COVID-19 vaccine declination for R11 prior to the late entry note done on 06/23/23. DON also provided a copy of the Care Conference Summary dated 11/16/21 that stated: "DON discussed the option for vaccine and mom stated she received it in the mail and would be returning the document." There was no mention of the R11's representative refusing the COVID-19 vaccine. Review of facility policy, "COVID-19 Vaccine Mandate and Exemptions" stated: ". . . Documenting COVID-19 Vaccine for Staff and Residents . . . For residents, the information will be documented in their medical record . . . Whether the employee or resident/representative was provided education regarding the benefits and potential risks. . . Whether the employee or resident/representative consented to the vaccine . . . If no, date(s) and reason for and documentation of refusal . . ."	F 887		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and	F 908	According to the manufacturer's	7/14/23

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F 908	Continued From page 15 review of the Ventec Life Systems User Manual, the facility failed to clean the VOCSN (Ventilator) Air Intake Filter every two weeks as recommended by the Manufacturer. As a result of this deficiency, the facility put the residents at risk for further complications. Findings include: On 06/21/23 at 10:45 AM, an observation of the VOCSN Air Intake Filter showed dust/dirt appearing build up on the surface of the filter. Concurrent staff interview with Respiratory Services Director (Resp Dir) revealed that the facility would only clean the filter once a month. During staff interview on 06/21/23 at 11:00 AM, Resp Dir acknowledged that the facility was not aware of the filter cleaning recommendation for every two weeks. Resp Dir said they would make the necessary change for filter cleaning to follow the Manufacturer's recommendation. Review of the Ventec Life Systems User Manual read the following: Cleaning and Maintenance, the organization responsible for the use and maintenance of VOCSN should perform all adjustments, cleaning, and disinfection of VOCSN. Follow all instructions provided in this Clinical and Technical manual to prevent damage to VOCSN during cleaning and maintenance procedures ... Cleaning the Air and Fan Filters, clean the air and fan filters every two weeks to ensure VOCSN internal components are protected from dirt and dust ...	F 908	recommendations, the VOCSN ventilator air and fan filter should be cleaned and checked every 14 days. The facility was doing it once a month. After our error was pointed out, all ventilator filters were checked, cleaned and replaced by the Respiratory Therapy (RT) staff. (06/21/23) As all ventilator filters were changed that day, any other residents affected would have been included. (06/21/23) A task reminder was created by the RT Director in PointClickCare (EHR) to remind RT staff to check and clean the air and fan filters every 14 days. A weekly task was also created for the staff to check the cleanliness and integrity of the filter every 7 days. The filters will be replaced every six months, or as needed due to damage. (07/07/23) All staff will be in-serviced by the RT Director on proper filter maintenance and potential for infections if filters are not sufficiently clean. (07/14/14) An audit will be done by the RT Director to check all filters weekly x 1 month, then bi-weekly x 1 month, then monthly x 2 months for cleanliness and integrity. (07/14/14)	