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	125009	A. BUILDING _____ B. WING _____	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 07/27/23. The facility was not in substantial compliance with 42 CFR §483 subpart B. Survey dates: 07/24/23 to 07/27/23. Survey Census: 77 Sample Size: 18	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to provide the right to reside and receive services in the facility with reasonable accommodations to one of 18 residents sampled (Resident (R) 57). As evidence by, not ensuring R57's call light was within reach and assessable. This deficient practice has the potential to negatively contribute to resident outcome. Findings Include: R57 is an 85-year-old male admitted to the facility on 05/20/21. He is Cantonese speaking but understands a small amount of the English language.	F 558	HEAD NURSE (HN) WILL IMPLEMENT CORRECTIVE FOR R57 FOUND TO BE AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: 1) HN removed Call light from the wall panel and placed within resident□s reach. Completed 07.28.23 HEAD NURSES (HN), LICENSED NURSES (LN), CERTIFIED NURSES AIDE (CNA), AND DIRECTOR OF NURSING (DON) WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS DEFICIENT PRACTICE INCLUDING: 1) HNs/LNs educated all staff during shift report the importance of placing all	8/29/23

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

Electronically Signed | 08/29/2023

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F 558	Continued From page 1 Observation was conducted on 07/24/23 at 08:46 AM. R57 was in his room, awake, and sitting at the edge of his bed having breakfast. He greeted this surveyor with a wave. R57's call light was wrapped up and hanging on the wall. The placement of the call light was not within reach for R57. Observation was conducted on 07/24/23 at 01:30 PM. R57 was asleep in his room and his call light was still hanging on the wall. Observation was conducted on 07/25/23 at 07:37 AM and 01:11 PM. R57 was lying in bed and his call light was still hanging on the wall, not within reach for the resident. Observation was conducted on 07/26/23 at 10:18 AM. R57 was up in bed finishing his meal. His call light remained hanging on the wall. Interview with Registered Nurse (RN) 53 was conducted on 07/26/23 at 10:20 AM in the nurse's station. RN53 was asked if the call lights should be near residents and be accessible to the residents. RN53 stated that the call light should be near and accessible to all the residents. Informed RN53 that R57's call light has been hanging on the wall and has been inaccessible to the resident for the past 3 days. RN53 stated that the call light should be accessible to R57 even though he probably wouldn't use it.	F 558	call light buttons within resident□s easy reach. Start 07.28.23-Completed 08.29.23 2) HNs/LNs/CNAs checked all residents call lights are within resident□s reach to call for assistance. Completed 07.29.23 3) DON checked all residents to ensure call light placed within reach of resident. Completed 08.04.23 DIRECTOR OF NURSING (DON), NURSING SUPERVISOR (SRN), EDUCATION NURSE (EN), HEAD NURSES (HN), LICENSED NURSES (HN), QUALITY ASSURANCE NURSE (QA), AND CERTIFIED NURSES AIDE (CNA) WILL IMPLEMENT MEASURES OR SYSTEMIC CHANGES TO ENSURE THAT THIS DEFICIENT PRACTICE DOES NOT RECUR, INCLUDING: 1) DON/SRN/HN/LN will educate the CNAs to check before leaving resident□s room that call lights are within reach for residents to call for help and communicate their needs. Completed 08.11.23 2) CNAs will place call buttons within easy reach for residents to call for help and communicate their needs and document in POC every shift. Completed 08.12.23 3) HNs/SRNs/DON will make rounds to check proper placement of call lights and give immediate feedback to staff when call light is not properly placed. Start 08.14.23-Ongoing 4) EN will include in the next annual in-service training the skill competency on Able to Demonstrate Respectful, Proper	

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F 558	Continued From page 2	F 558	Manner of Entering Resident□s Room. This will include placing/checking residents call light within resident□s reach. Completed 11.2023 5) QA will conduct weekly random audits on all shifts to ensure proper placement of call lights and provide report to DON. Start 08.11.23-Ongoing DIRECTOR OF NURSING (DON) AND QUALITY ASSURANCE RN (QA) WILL MONITOR CORRECTIVE ACTIONS TO ENSURE THAT THIS DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR, INCLIDING: 1) QA will summarize findings of the weekly audits on a quarterly basis. Report findings to the quarterly QAPI committee. Start 08.22.23-Ongoing	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F 584		8/28/23

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F 584	Continued From page 3 the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a clean environment as evidenced by a supply shelf, in the second-floor storage room, found covered with spider webs. As a result of this deficiency, the facility increased the risk for infestation. Findings include: Observation on 07/25/23 at 08:30 AM of the supply storage room on the second floor revealed a shelf covered with spider webs. The shelf contained a seat cushion and a splint. The shelf below contained boxes of disposable gloves.	F 584	ENVIRONMENTAL SERVICES (EVS) WILL IMPLEMENT CORRECTIVE ACTION FOR 2 MAKAI MEDICAL SUPPLY CLOSET AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: 1) Medical supply closet cleaned and cobwebs removed from top shelf. Completed 07.28.23 ENVIRONMENTAL SERVICES (EVS) WILL IDENTFY ALL MEDICAL SUPPLY CLOSETS HAVING THE POTENTIAL TO BE AFFECTED BY THIS DEFICIENT	

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F 584	Continued From page 4 During staff interview on 07/25/23 at 08:35 AM, Registered Professional Nurse (RN)29 acknowledged that the shelf was covered with spider webs. RN29 said that they would have housekeeping immediately remove the spider webs and have the room cleaned.	F 584	PRACTICE, INCLUDING: 1) EVS staff assigned to nursing units conducted visual checks and cleaned all medical supply closets, including wiping down of all shelves and removal of any debris (i.e. cobwebs, dust). Completed 07.28.23 2) EVS Supervisor conducted rounds on each nursing unit to inspect all medical supply closets to ensure that corrective action was completed. Start 07.28.23 □ Completed 07.31.23 ENVIRONMENTAL SERVICES (EVS) AND QUALITY ASSURANCE RN (QA) WILL IMPLEMENT MEASURES OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, INCLUDING: 1) EVS Supervisor will update EVS staff□s environment of care checklist to include weekly visual checks and weekly cleaning of medical supply closets on nursing units. Completed 07.28.23 2) EVS staff will use daily EOC checklist to conduct visual checks and document the cleaning of each medical supply closet. Start 07.28.23 □ Ongoing 3) EVS Supervisor and QA to conduct weekly spot checks of medical supply closets. Start 07.28.23 □ Ongoing ENVIRONMENTAL SERVICES (EVS) AND QUALITY ASSURANCE RN (QA) WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR, INCLUDING: 1) EVS Supervisor will summarize all	

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F 584	Continued From page 5	F 584	findings from EOC rounds and submit to QA for review and compiling of data for submission to QAPI. Start 11.28.23 - Ongoing 2) EVS and QA to summarize findings to report quarterly to QAPI committee. Start 11.28.23 □ Ongoing (Audit plan will be discussed at the next QAPI meeting on 08.22.23).	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		8/29/23

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F 656	Continued From page 6 (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: On 07/24/23 observations of R30 were made. At 08:45 AM, R30 was observed lying in bed on her right side, a pillow propped under the left side of her back. R30 was very thin and frail and slowly responded to her name by nodding. At 10:00 AM, R30 laid on her back in bed with her eyes closed. At 11:38 AM, R30 was observed still lying on her back, sitting up with the head of bed raised. R30 was grimacing. On 07/25/23 at 07:30 AM, R30 was observed to be sitting up in bed eating breakfast. No verbal response was made when state agency (SA) greeted her. On 07/25/23 at 09:48 AM, interviewed R30's family member (FM) via phone. FM stated that R30 needed to exercise her upper extremities because of her limited mobility.	F 656	DIRECTOR OF NURSING (DON), HEAD NURSE (HN), CERTIFIED NURSES AIDE (CNA), RECREATIONAL THERAPY MANAGER (RTM), ACTIVITY COORDINATOR (AC), RECREATIONAL THERAPY ASSISTANT (RTA) WILL IMPLEMENT CORRECTIVE ACTIONS FOR R22 FOUND TO BE AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: 1) DON/HN discussed with CNA caring for resident what had happened. CNA stated that R22 and her roommate both require recliner to get out of bed. CNA explained that since R22 was assisted to recliner on 07/25/23 to participate in bingo, she assisted the roommate to the recliner on 07/26/23. It was determined that there was not sufficient	

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F 656	Continued From page 7 Record review of R30's electronic health record (EHR) revealed a "Transfer/Discharge Report" documenting that R30 was an 86 year old resident admitted to the facility on 06/22/23. R30's diagnoses included "Adult Failure to Thrive," "Mild Cognitive [brain] impairment of Uncertain or Unknown Etiology, and "Traumatic Subarachnoid Hemorrhage [bleeding in the brain] ..." Review of the "Progress Notes" documented on 06/22/23 by the respective therapists, revealed that R30 was not appropriate for physical therapy (PT) and occupational therapy (OT) interventions due to her " ... frail condition, and limited activity tolerance ..." and recommended a maintenance program for upper and lower extremity range of motion (ROM) exercises. Care plan problem, "I am at risk for further falls and fall related injury associated with my medical condition, impaired mobility and cognition and history of falls prior to admission," had the intervention of maintenance OT/PT for upper and lower extremity ROM ..." "Tasks" revealed that active ROM and passive ROM were to be done by the Certified Nurse Aide (CNA) on every shift. Active ROM flowsheet for 06/28/23 to 07/21/23 showed exercises were done with R30 on three days and R30 refused one day out of the 24 days documented. "Not Applicable" was marked for the rest of the 20 days. Passive ROM flowsheet for 06/28/23 to 07/21/23 indicated that it was done on seven days, refused by R30 for eight days, and marked "Not Applicable" for 15 days. On 07/27/23 at 10:54 AM, a concurrent review of the task flowsheets for active and passive ROM and interview were done with Registered Nurse (RN)19. RN19 stated that the expectation is for R30 to have these exercises done with her every	F 656	number of recliners for the residents in that unit for all requiring recliner to get out of bed. Available Maluhia Adult Day Health Center□s recliners will be used until recliners are purchased for 3 Makai.Completed 08.28.23 2) AC/RT Manager reviewed resident□s care plan. Care plan was updated on 08/01/23 and reviewed during IDT meeting on 08/02/23. Completed 08.02.23 3) RTA/AC have been visiting Res22 and asking her almost daily if she would like to participate in the activity or not. R22 will be assisted to recliner to attend activities.Start 8.01.23□Ongoing HEAD NURSES (HN), LICENSED NURSES (LN), RECREATIONAL THERAPY ASSISTANT (RTA), AND CERTIFIED NURSE AIDE (CNA) WILL ASSESS OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE. 1) RTA will continue to send activity schedule on the unit. HNs and LNs will inform CNAs activities and time of the day to prepare residents to attend in house activities based on their preferences. Start 08.01.23□Ongoing RECREATIONAL THERAPY ASSISTANT (RTA), ACTIVITY COORDINATOR (AC), CERTIFIED NURSE AIDE (CNA), HEAD NURSE (HN), LICENSED NURSE (LC), AND INTERDISCIPLINARY TEAM (IDT) WILL IMPLEMENT MEASURES TO ENSURE THAT THIS PRACTICE DOES NOT RECUR, INCLUDING: 1) IDT Meetings will resume in person to review and revise care plan as	

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F 656	Continued From page 8 day on every shift and documenting an entry "Not Applicable" was unacceptable. 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 two of the 18 residents sampled (Resident (R) 22 and R30). This deficient practice has the potential to negatively impact the resident's quality of life. Findings Include: R22 has a medical history that includes but not limited to cerebrovascular disease with hemiplegia (paralysis of one side of the body) and hemiparesis (one sided muscle weakness), and dementia. R22 has also been receiving hospice care since 06/14/23. Observation and interview were conducted on 07/26/23 at 07:53 AM in R22's room. R22 just finished having her breakfast and was lying in bed. This surveyor asked R22 how she did in bingo yesterday. R22 responded that she didn't win anything but was happy to be out of her room since she has been in isolation for the past 10 days. R22 was informed by this surveyor that there was another bingo activity scheduled for 10:00 AM that morning. R22 became excited and expressed interest in wanting to go. Observation and interview were conducted on 07/25/23 at 10:15 AM in R22's room. R22's curtains were drawn, and she was receiving personal care from Certified Nurse Aide (CNA) 32. This surveyor asked through the curtain why	F 656	appropriate for the residents. Start 08.02.23□Ongoing 2) RTA to send list of residents to attend group activity schedule and CNAs will assist residents to wheelchair or recliner. Start 08.01.23□Ongoing 3) LN/HNs will monitor that CNAs are getting residents up to attend activities based on their preferences as listed on RTA□s group activity list. Start 08.01.23□Ongoing 4) RTA will provide alternative activities when a resident declined to participate activities of the day and when on isolation. Start 08.01.23□ Ongoing 5) AC will review the activity flow sheets monthly to ensure residents are participating in the activities of their choice. Start 08.10.23□Ongoing. RECREATION THERAPY MANAGER AND QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) WILL MONITOR CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICES BEING CORRECTED AND WILL NOT RECUR, INCLUDING: 1) RT will monitor resident□s participation to activities based residents□ activities preferences per care plans and report findings to the quarterly QAPI committee. Start 08.22.23□Ongoing HEAD NURSE (HN), NURSING SUPERVISOR (SRN), MDS COORDINATOR (RAI), AND	

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F 656	Continued From page 9 R22 was missing bingo. CNA32 responded, "She already went yesterday." Interview was conducted on 07/27/23 at 07:45 AM with R22 in her room. R22 explained that she had missed bingo the day prior because she was told by staff that it was not her turn to go and that it was her roommates turn. R22 stated she wanted to go because she likes playing bingo. Interview was conducted with CNA32 on 07/27/23 at 08:20 AM on the third-floor hallway. CNA32 explained that residents are assisted to get up every other day. R22 was assisted to get up into a recliner to attend bingo on 07/25/23. On 07/26/23 it was another resident turn to get up into the recliner. Therefore, R22 missed bingo on 7/26/23. Interview was conducted on 07/27/23 at 08:20 AM with Recreational Aide (RA) 12. RA12 explained that there is usually a list of residents that request to attend bingo. RA12 indicated that R22 was not on the list. RA12 also explained that one of her tasks is to go around and let the residents know bingo was an activity for the day. RA12 stated she did not go into R22's room on 07/26/23 to invite her to bingo. RA12 also added that any resident that wants to come to bingo are accommodated and are not denied participation. Interview with Registered Nurse (RN) 53 was conducted on 07/27/23 at 08:47 AM. RN53 stated that RA12 usually does the inviting of the residents for facility activities. She also added that there is no limit to the number of resident participants because everyone should be accommodated. RN53 stated that R22 should have been able to attend bingo on 07/26/23,	F 656	INTERDISCIPLINARY TEAM (IDT) WILL IMPLEMENT CORRECTIVE ACTIONS FOR R30 FOUND TO BE AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: 1) HN/SRN met with all nursing staff working to review R30□s care plan regarding upper and lower range of motion (ROM) and to re-educate on completing documentation of task in PCC regarding PROM/AROM, to be documented accurately and in a timely manner. Re-education to all staff is being done during shift endorsements-on going. Complete 08.11.23 2) RAI / IDT to review / re-assess and discuss residents ADL and participation with Passive Range of Motion (PROM)/Active Range of Motion (AROM). R30□s care plan was clarified and rewritten to Provide and encourage participation of passive and active ROM exercised during care as tolerated. Completed 08.03.23 HEAD NURSE (HN), NURSING SUPERVISOR (SRN), AND DIRECTOR OF NURSING (DON) WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: 1) Residents who are newly admitted and/or on long term care stay with inability to move independently will be identified by HNs. Completed 08.09.23 2) DON/SRN will check documentation of these identified residents in PCC POC if	

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F 656	Continued From page 10 especially since it's on R22's care plan. A review of R22's Electronic Health Record (EHR) indicated, "I [R22] make daily decision, just invite and escort me when I am available to any group activities for meeting my emotional, intellectual, physical, and social r/t CVA with right sided weakness. These activities are my favorite and very important to me i.e. bingo, Catholic mass/service, keeping up with the news, music, and being with group of people."	F 656	nursing staff is accurately documenting PROM/AROM. Completed 08.10.23 HEAD NURSE (HN), Nursing Supervisor (SRN), MDS COORDINATOR (RAI), INTERDISCIPLINARY TEAM (IDT) AND QUALITY ASSUSRANCE NURSE (QA) WILL IMPLEMENT MEASURES OR SYSTEMIC CHANGES TO ENSURE THAT THIS DEFICIENT PRACTICE DOES NOT RECUR, INCLUDING: 1) HN/SRN will continue to provide re-education to CNAs regarding POC PROM / AROM documentation. Completed 08.11.23 2) QA will conduct weekly random checks of CNA□s POC task for accurate and timely documentation of PROM and AROM task and provide report to HNs. Start 08.17.23□Ongoing 3) HN will ensure that RAI/IDT will review / update ADL care plans upon admission, quarterly, annual and significant change regarding PROM/AROM, review POC task based on the residents□ current status. Start 08.16.23□ Ongoing QUALITY ASSURANCE NURSE (QA) AND QUALITY ASSURANCE PERFORMANCE IMPROVEMENT COMMITTEE (QAPI) WILL MONITOR CORRECTIVE ACTIONS TO ENSURE THAT THIS DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR, INCLUDING: 1) QA to summarize findings to report quarterly at QAPI committee. Audit plan to	

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F 656	Continued From page 11	F 656	be discussed at next QAPI committee meeting on 08/22/23. Start 11.28.23- Ongoing	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to communicate necessary	F 661	DIRECTOR OF NURSING (DON), SOCIAL WORKER (SW) OAHU REGION	8/30/23

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F 661	Continued From page 12 discharge information to the resident, resident representative and/or family member (FM), and provider(s) for one resident (R), R74, out of a sample of two residents. Inadequate information was documented by R74's physician detailing R74's course of stay at the facility and incomplete information was noted in the nursing discharge instructions and discharge care plan. Finding includes: Record review of R74's electronic health record (EHR) revealed a "Social History And Assessment" document that stated that R74 was a 95-year-old resident. R74 did not want to prolong her life and a discussion was made with the FM regarding hospice care. R74 has lived in a foster home for one and a half years and wants to return there. "Transfer/Discharge Report" noted that she was admitted on 04/22/23 and discharged on 05/18/23 to a foster home. Read "Skilled Charting - V2" document dated 05/18/23. R74 needed total care with her activities of daily living (ADL) and had impaired balance and was weak. R74 was not eating well due to difficulty swallowing, was incontinent of bowel and bladder, and used oxygen delivered through tubing to her nose. R74 was referred to hospice care. Reviewed "Discharge Summary Report," written by R74's physician. A handwritten word next to "Diagnoses," three handwritten lines after "Physician Summary, " and a handwritten date of documentation were all difficult to decipher. "Discharge Instructions" had no notation under "Treatments," "Last Meal," "Last BM [bowel movement]," "Follow-up Visits," "Physician Name, Phone Number, Appointment Date/Needed," "Ambulation Status, " "Transfers," "Other," and entries listed under "Social Services"	F 661	MEDICAL DIRECTOR (ORMD) WILL IMPLEMENT CORRECTIVE ACTION FOR R74 FOUND TO BE AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: R74 was discharged as planned on 05/18/23 to the foster home where she had been living for the past 18 months. SW clarified with the hospice provider R74 hospice status at the time of discharge. Bristol hospice reported R74 was not officially enrolled in hospice at the time of discharge. Consent forms had been signed and needed DME were in place, but R74 was not enrolled until she returned to her foster home. 1) SW met with DON/ORMD to discuss R74 discharge process. Completed 08.02.23 2) R74 progress notes updated to reflect non-enrollment to Bristol Hospice and a summary of R74 disposition at the time of discharge. Completed 08.02.23 SOCIAL WORKERS (SW) HOW WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: 1) SW will review all residents with anticipated discharge care plans. Completed 08.28.23 2) SW will update discharge care plans as changing needs may arise. Start 08.28.23-Ongoing SOCIAL WORKERS (SW) QUALITY ASSURANCE NURSE (QA) AND INTERDISCIPLINARY TEAM (IDT) WILL IMPLEMENT MEASURES OR	

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F 661	Continued From page 13 ("Community referrals," "Social/Emotional/Behavior Status," and "Coping Mechanisms/Reaction to Discharge." There were only the discharge medications noted on the document and not the medication regimen R74 was admitted with, indicating changes made in R74's medication during her course of stay at the facility. The discharge care plan did not state that R74 was referred to hospice services and did not describe the care to be received at her foster home. On 07/27/23 at 10:23 AM, a concurrent review of R74's EHR and interview were done with Registered Nurse (RN)19 at the unit's nursing station. RN19 stated that the physician describes the resident's course of stay at the facility in their discharge summary. Reviewed "Discharge Summary Report" with RN19 and she could not decipher the physician's handwriting and confirmed that it was also incomplete because it did not summarize R74's course of care received at the facility. During the concurrent review of the nursing "Discharge Instructions," RN19 stated that residents are discharged with instructions reviewed with the resident and/or resident representative containing any follow-up appointment(s) with the provider(s), therapy to be received and with instructions on how to perform them (as appropriate) and the resident's current medications with instructions. RN19 stated that the document was not complete because all blank spaces pertinent to R74 should have been completed and they were not. As a result of both incomplete documents, the foster home care operator, R74 and FM, will not know the regression of R19's health in the facility and the needed care that R74 is to receive.	F 661	SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, INCLUDING: 1) SW will create a new discharge checklist tool to be utilized by all social workers to ensure completion of discharge documentation in a timely manner. Start 09.01.23-Ongoing 2) SW will consult weekly with the IDT to ensure all necessary resident needs are identified and addressed in the discharge care plan. Needs such as caregiver training, oxygen, tube feeding supplies, home PT/OT assessment, etc. will be listed on the discharge care plan. Start 08.28.23-Ongoing 3) QA will conduct monthly audits of discharge checklist to ensure that care plans and discharge documentation is completed. Start 09.01.23-Ongoing SOCIAL WORKER (SW), QUALITY ASSURANCE NURSE (QA), QUALITY ASSURANCE PERFORMANCE IMPROVEMENT COMMITTEE (QAPI) WILL MONITOR CORRECTIVE ACTION TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR, INCLUDING: 1) SW and QA will submit audits at quarterly QAPI meetings for review. Start 11.28.23-Ongoing MEDICAL DIRECTOR (MD) DIRECTOR OF NURSING (DON) AND HEALTH INFORMATION MANAGEMENT (HIM) WILL IMPLEMENT CORRECTIVE	

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F 661	Continued From page 14 On 07/27/23 at 11:14 AM, interviewed Social Worker (SW)2 via phone. SW2 confirmed that R74's discharge care plan was incomplete because it did not state that R74 was referred to hospice care and any needed treatments or care. Record review of "Transfer/Discharge Requirements and Documentation" policy and procedure with effective date 01/07/18. It stated, " ... IV. Procedure ... C. A comprehensive discharge care plan must be developed by the social worker as appropriate based on the resident and/or resident representative preferences, goals, and needs ... H. Staff will provide sufficient preparation and orientation to the resident to ensure a safe and orderly transfer or discharge from the facility including providing discharge instructions that outline post-discharge care (prescribed and over the counter medications and treatments) and summary of arrangements made for follow up and post discharge services as applicable and agreeable by resident and/or representative."	F 661	ACTIONS FOR R74 FOUND TO BE AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: 1) MD sent email letter to R74□s physician advising him of importance of legibility and to provide a narrative summarizing the overall course for the reason of admission and any other major diagnoses/complications when completing the Discharge Summary and asking for his cooperation in this matter. Completed 08.28.23 MEDICAL DIRECTOR (MD), ADMINISTRATION (ADMIN), DIRECTOR OF NURSING (DON), HEALTH INFORMATION MANAGEMENT (HIM), AND HEALTH UNIT CLERK (HUC) WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: 1) Admin created a soft copy Discharge Summary form for physicians to complete by typing. Completed 07.28.23 2) MD sent soft copy Discharge Summary form to involved physician to complete and not to complete in his handwriting. HIM/HUCs will not accept handwritten form. Completed 08.28.23 3) DON will send soft copy of Discharge Summary form to Maluhia physicians if not already submitting typed discharge summary. Completed 08.29.23 HEALTH INFORMATION MANAGEMENT (HIM) AND HEALTH UNIT CLERK (HUC),	

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F 661	Continued From page 15	F 661	MEDICAL DIRECTOR (MD), ADMINISTRATION (ADMIN) AND DIRECTOR OF NURSING WILL IMPLEMENT MEASURES OR SYSTEMIC CHANGES TO ENSURE THAT THIS DEFICIENT PRACTICE WILL NOT RECUR, INCLUDING: 1) HIM will accept only printed soft copy of discharge summaries and will follow up with physician(s) if handwritten discharge summaries are submitted. Start 09.07.23-Ongoing 2) ORMD will randomly audit involved physicians completed discharge summaries to include a summary of course of care received at facility. Start 09.01.23 Ongoing 3) Soft copy of discharge summary form will be set up on each unit with the HUC for use by involved physician and any other provider, if needed. They will be asked to type their discharge summary, print, sign and fax back to facility. Start 09.01.23-Ongoing QUALITY ASSURANCE RN (QA), HEALTH INFORMATION MANAGEMENT (HIM) AND QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT COMMITTEE (QAPI) WILL MONITOR CORRECTIVE ACTIONS TO ENSURE THAT THIS DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR, INCLUDING: 1) QA/HIM will do monthly discharge chart audits of involved physician□s (and any other providers identified) discharge summaries to ensure compliance. Start 09.07.23-Ongoing	

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F 661	Continued From page 16	F 661	2) QA to report deficiencies quarterly at QAPI meetings who will refer findings to MD/ADMIN for further corrective interventions. Start 09.07.23-Ongoing HEAD NURSE (HN), DIRECTOR OF NURSING (DON), NURSING SUPERVISOR (SRN), SOCIAL WORKER (SW) WILL IMPLEMENT CORRECTIVE ACTIONS FOR R74 FOUND TO BE AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: 1) DON reviewed R74□s Discharge Instruction form and confirmed that the document had blank spaces and not complete. Although resident was being readmitted to the foster home she was previously discharged prior to hospitalization, nurse should have completed blanks and noted that resident was being referred to hospice services due to her decline in condition (severe dysphagia, recurrent aspirations), name of hospice services, and date of referral. Completed 08.21.23 2) DON reviewed findings and corrections with nurse involved with R74□s discharge and HNs/SRNs. Completed 08.29.23 HEAD NURSE (HN), DIRECTOR OF NURSING (DON), NURSING SUPERVISOR (SRN), AND LICENSED NURSES (LN) WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS PRACTICE, INCLUDING: 1) DON checked residents discharged to community since survey. There was one	

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F 661	Continued From page 17	F 661	resident who was discharged home after receiving short term therapy. Discharge Instructions form was properly completed by Nursing and Rehab Services. Completed 08.21.23 2) SRN/HN/LN will ensure that Discharge Instruction form will be completed for all residents with planned discharge to the community. Start 08.21.23-Ongoing HEAD NURSE (HN), DIRECTOR OF NURSING (DON), NURSING SUPERVISOR (SRN), LICENSED NURSES (LN), REHABILITATION SERVICES (REHAB), REGISTERED DIETITIAN (RD), AND SOCIAL SERVICES (SW) WILL IMPLEMENT MEASURES OR SYSTEMIC CHANGES TO ENSURE THAT THIS DEFICIENT PRACTICE DOES NOT RECUR, INCLUDING: 1) HN/LN will complete the Discharge Instruction form with input from the appropriate discipline (Rehab, SW, and RD) for all residents with planned discharge to the community. Start 08.28.23-Ongoing 2) SRN/HN will review Discharge Instruction form is complete prior to resident□s discharge to the community. Start 08.21.23-Ongoing DIRECTOR OF NURSING (DON), NURSING SUPERVISOR (SRN), QUALITY ASSURANCE RN (QA), AND QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) WILL MONITOR CORRECTIVE ACTIONS TO ENSURE	

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F 661	Continued From page 18	F 661	THIS DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR, INCLUDING: 1) QA/SRN/DON will conduct monthly audits for all planned discharges to the community to ensure Discharge Instructions are completed. Start 08.21.23- Ongoing 2) DON summarized deficiency to QAPI committee and discussed plan to submit audit findings to the quarterly QAPI committee. Completed 08.22.23 3) DON will report audit results to the quarterly QAPI committee. Start 11.28.23- Ongoing	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 757		8/28/23

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F 757	Continued From page 19 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff member the facility failed to ensure each resident's drug regimen must be free from unnecessary drugs for two of five residents sampled (Resident (R) 27 and R32). The facility failed to monitor R32's and R27's behaviors and use the appropriate diagnoses related to psychotropic medications. Findings include: 1) Review of the facility's policy and procedure "Psychotropic Drug Use" effective 09/01/18, documented a "...physician's order must be obtained for use of any psychotropic medication" and the order must include "Indication and clinical need on measurable diagnosis or condition for the medication" and "specific...behavior targeted." The policy and procedure further documented "There must be documented monitoring of episodes of symptoms or behaviors..." 2) During review of R32's Electronic Health Record (EHR) on 07/26/23 at 09:12 AM, R32's physician's orders include an antipsychotic medication, Seroquel, 6.25 milligrams (mg) once a day effective 06/09/23, and an antidepressant medication, Sertraline, 50 mg in the evening effective 02/11/22. Both for Dementia with Behavioral Disturbance. Documentation of the monitoring of the behaviors related to the use of the psychotropic medications were not found.	F 757	3 MAKAI HEAD NURSE (HN) and Licensed Nurses (LN) WILL IMPLEMENT CORRECTIVE ACTIONS FOR R32 FOUND TO BE AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: 1) HN will reactivate behavior monitoring tools in PointClickCare (PCC) for the duration of psychotropic medications.Completed 07.28.23 2) LNs will monitor R32 behaviors and document in PCC. Start 07.28.23-Ongoing NURSING SUPERVISOR (SRN), HEAD NURSES (HN) AND LICENSED NURSES (LN) WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE, INCLUDING: 1) SRN/HN reviewed 3 Makai residents PointClickCare medical records to identify residents receiving psychotropic medications and ensure behavior monitoring tools are in place and not discontinued while resident remains on psychotropic medication.Completed 07.31.23 2) SRN/HNs/LNs to monitor and document behaviors for residents that are currently on psychoactive medications and ensure that behavior monitoring tools are in place and completed.Start	

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F 757	Continued From page 20 Review of R32's nursing notes documented on 07/05/22 "Resident's behavior such as asking for enema at all times, fixated on going to the ER [Emergency Room] and fixated on not having a bowel movement has not been observed for the past 5 months of her behavior monitoring review. We will reactivate behavior monitoring as we observed such behavior." On 12/19/23, "Verbalizing wanting to die behavior has not been observed for the past several months of her behavior monitoring review. We will reactivate behavior monitoring as we observed such behaviors." R32 continued to be administered the psychotropic medications after behavior monitoring was discontinued. Further review of R32's nursing notes documented on 06/09/23, "Resident was seen by...[the physician]...on 6/8/23 for follow up via telehealth. Received telehealth notes today. APRN...[Advanced Nurse Practitioner], covering for MD...[Medical Director]...and was updated of the recommendation. Signed consent for the use of psychoactive medication. We will continue to monitor resident's behavior." On 07/26/23 at 02:23 PM interview and concurrent record review with Registered Nurse (RN) 53 was done. RN53 confirmed R32 was prescribed Seroquel, an antipsychotic, and Sertraline, an antidepressant. RN53 reported the behaviors that were monitored for Seroquel were not having a bowel movement and accusing daughters of bulling her. RN53 confirmed behavior monitoring was discontinued because she no longer exhibited the behaviors for several months. RN53 reported due to R32 not exhibiting behaviors related to the Seroquel the dose had gradually decreased from 50 mg to currently 6.25 mg. RN53 further reported for Sertraline, R32	F 757	07.28.23 Ongoing DIRECTOR OF NURSING (DON), NURSING SUPERVISOR (SRN), HEAD NURSES (HN), QUALITY ASSURANCE RN (QA) AND SOCIAL WORKER (SW) WILL IMPLEMENT MEASURES OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, INCLUDING: 1) LN receiving new orders of psychoactive medications will create a behavior monitoring tool specific for the targeted behavior in PointClickCare.Start 08.01.23 Ongoing 2) QA to audit all new orders of psychoactive medications that behavior monitoring tools was created and being completed.Start 09.01.23 Ongoing 3) DON/SRN will conduct monthly audits to ensure that behavior monitoring are completed and documented by the LNs and HNs for all residents receiving psychotropic medications.Start 08.28.23-Ongoing DIRECTOR OF NURSING (DON) AND QUALITY ASSURANCE RN (QA) WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR, INCLUDING: 1) DON will summarize monthly audit findings and report to the quarterly QAPI committee.Start 09.01.23 Ongoing 2) QA monthly audit findings will be reported and reviewed at the Nurse Managers meeting.Start 09.01.23 Ongoing 3) QA will report monthly audit findings to	

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F 757	Continued From page 21 was admitted with a dose of 25 mg but was increased to 50 mg on 02/11/22 due to expressing she is better off dead and did not want to be a burden to her family. RN53 reported R32 has not expressed negative statements of wanting to die since the dose change and the behavior monitoring was discontinued. 2) On 07/24/23 at 11:33 AM, interviewed R27 in his room. R27 laid in bed and responded appropriately to inquiries. R27 stated that he takes an antidepressant and would like to see a psychiatrist because he stated, "This is not the best living situation." Record review of R27's electronic health record (EHR) revealed under "Orders," directives for Escitalopram (medication to treat depression) 20 mg (milligrams) one tablet daily, Mirtazapine (medication to treat depression) 7.5 mg one tablet at bedtime, and Trazodone (medication to treat depression) 50 mg one tablet at bedtime for insomnia. There were no behavior monitoring documentation by the licensed nurses found in R27's EHR which indicated if R27's depression improved or if his depression continued or became worse with the use of the three antidepressant medications. There was also no documentation noting any follow up on the effectiveness to treat R27's insomnia with the administration of Trazadone. There also was no consent signed by the resident for the use of Trazodone. Care Plan stated an intervention under R27's depression, "... Administer Lexapro, Trazodone, Mirtazapine ... as ordered. Monitor for ... effectiveness..." On 07/27/23 at 11:33 AM, concurrent review of R27's EHR and interview were done with	F 757	quarterly QAPI committee. Start 11.28.23-Ongoing 2MAKAI HEAD NURSE (HN), LICENSED NURSES (LN), AND SOCIAL WORKER (SW) WILL IMPLEMENT CORRECTIVE ACTIONS FOR R27 FOUND TO BE AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: 1) R27 was a lateral admission on 01/28/23 from another Honolulu Nursing Home with two anti-depressants for depressive mood and insomnia. He was seen by a psychiatrist on 01/15/23 where the PASSR Psychiatric Evaluation was completed. Both antidepressants were ordered and consent forms were signed by Head Nurse and resident, dated 01/29/23. Another psych consult was completed on 06/08/23 at this facility noting the two antidepressants and another antidepressant was ordered for R27 poor appetite and mood. HN will reactivate R27 behavior monitoring tools in PointClickCare (PCC) for the duration of psychotropic medications.Start 07.31.23□Completed 08.16.23 2) LNs will monitor R27s behaviors and document in PCC.Start 07.31.23□Ongoing 3) SW met with resident to discuss his depression, insomnia and appetite. R27 did confirm that the Trazodone does help him sleep. SW will schedule another	

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F 757	Continued From page 22 Registered Nurse (RN)19 at the unit's nursing station. RN19 confirmed that there was no behavior monitoring notation done by the licensed nurses to indicate the effectiveness of the antidepressants for R27's depression and insomnia (Trazodone). RN19 also stated that the diagnosis of insomnia for Trazadone was unacceptable and that the diagnosis should be for the usage of Trazadone as an antidepressant. RN19 searched in R27's EHR and paper chart for the consent to use Trazodone and none was found.	F 757	psych consult for 08/28/2023 as he had requested. Completed 08.23.23 NURSING SUPERVISOR (SRN), HEAD NURSES (HN), LICENSED NURSES (LN) AND SOCIAL WORKER (SW) WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE, INCLUDING: 1) HN/SRN/DON, and SW will review all residents with any psychotropic medications to ensure behavior monitoring are in place and not discontinued while resident remains on psychotropic medication. HN reviewed all residents with psychotropic medications and added Behavior monitoring as indicated.Start 07.31.23□Completed 8-28-23 2) SRN/HNs/LNs to monitor and document behaviors for residents that are currently on psychoactive medications and ensure that behavior monitoring tools are in place and completed.Start 07.31.23□Ongoing DIRECTOR OF NURSING (DON), NURSING SUPERVISOR (SRN), HEAD NURSES (HN), QUALITY ASSURANCE RN (QA) AND SOCIAL WORKER (SW) WILL IMPLEMENT MEASURES OR SYSTEMIC CHANGES TO ENSURE THAT THIS DEFICIENT PRACTICE WILL NOT RECUR, INCLUDING: 1) Nursing will consult with SW on residents with psychotropic medications and their behaviors. SW to do social history	

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F 757	Continued From page 23	F 757	with the residents and/or their families, during admission assessment and as indicated, to gain knowledge of the resident□s behaviors along with appropriate and effective non-pharmacological interventions.Start 08.28.23-Ongoing 2) LN/HN/SRN to input behavior monitoring into PointClickCare.Start 07.31.23-Ongoing 3) SW will arrange as needed for psychiatric consults to determine if psychotropic medications are appropriate and necessary. Start 08.28.23-Ongoing 4) QA to audit all new orders of psychoactive medications that behavior monitoring tools was created and being completed.Start 09.01.23□Ongoing DIRECTOR OF NURSING (DON), QUALITY ASSURANCE RN (QA), AND NURSING SUPERVISOR (SRN) WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THIS DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR, INCLUDING: 1) DON/SRN will conduct monthly audits of residents on psychotropic medications requiring psychiatric consultations. Start 08.31.23□Ongoing 2) DON will report audit findings to the quarterly QAPI committee for further discussion and appropriate interventions.Start 11.28.23-Ongoing 3) QA monthly audit findings will be reported and reviewed at the Nurse Managers meeting.Start 09.01.23□Ongoing	

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F 757	Continued From page 24	F 757	4) QA nurse will report monthly audit findings to quarterly QAPI committee. Start 11.28.23-Ongoing	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		8/28/23

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F 758	Continued From page 25 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff member the facility failed to evaluate one of five residents sampled (Resident (R) 32) for gradual dose reduction (GDR) for a psychotropic medication prescribed to treat behaviors that are no longer monitored and exhibited. Findings include: Cross Reference to F757, the facility failed to ensure each R32's drug regimen was free from unnecessary drugs due to not monitoring R32's behaviors related to psychotropic medications. On 07/26/23 at 09:12 AM review of R32's Electronic Health Record (EHR) was done. R32 was admitted to the facility on 11/05/21 with a physician's order of Sertraline 25 milligrams (mg), one tablet in the evening. On 02/11/22, R32's Sertraline dose was increased to 50 mg, one tablet in the evening. Behaviors that were monitored related to the antidepressant but discontinued were fixated on not having a bowel	F 758	DIRECTOR OF NURSING (DON), 3 MAKAI HEAD NURSE (HN), SOCIAL WORKER (SW) and LICENSED NURSES (LN) WILL IMPLEMENT CORRECTIVE ACTIONS FOR R32 FOUND TO BE AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: 1) DON reviewed R32□s psychotropic medication regimen history with Pharmacy Consultant. Res was admitted on 11/05/21 with Sertraline 25mg for Depression and Seroquel 50mg for Dementia with Behavioral Disturbances. HN/SW have been consulting with our board certified Gero-psychiatrist numerous times for R32. On 02/17/22 Gero-psychiatrist consult was done since resident stated she was a burden to family and had thoughts of being dead. Sertraline was increased to	

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F 758	Continued From page 26 movement, asking for enema, and fixated on going to the emergency room were discontinued on 07/05/22. Making up stories/accusatory, crying, feeling unhappy and getting mad/throws tantrums were discontinued on 09/05/22. Verbalizing wanting to die was discontinued on 12/19/22. Review of a consent form for the antidepressant dated 02/11/23 documented "increase Zoloft [Sertraline] to 50 mg in the evening for target behavior feeling unhappy verbalizing wanting to die." Review of a nursing note on 12/19/23 documented "Verbalizing wanting to die behavior has not been observed for the past several months of her behavior monitoring review. We will reactivate behavior monitoring as we observed such behaviors." On 07/26/23 at 02:23 PM interview and concurrent record review with Registered Nurse (RN) 53 was done. RN53 confirmed R32 is currently prescribed Sertraline 50 mg in the evening. RN53 reported R32 was admitted with a dose of 25 mg but was increased to 50 mg on 02/11/22 due to expressing she is better off dead and did not want to be a burden to her family. RN53 reported R32 has not expressed negative statements of wanting to die since the dose change and the behavior monitoring was discontinued. RN53 confirmed it has been more than 6 months since the facility discontinued the behavior monitoring and the facility has not attempted or evaluated for a GDR for the antidepressant during R32's stay in the facility and after increasing the dose more than a year ago.	F 758	50mg. On 03/17/22, Gero-psychiatrist evaluated resident and noted mood is much improved on higher dose of Sertraline. Recommended to continue Sertraline at higher dose and dose reduction of Seroquel to 37.5mg. R32□s MD agreed with recommendation and ordered the above. On 10/19/22 Pharmacist Consultant sent recommendation memo to resident□s MD to evaluate current dose and consider a dose reduction. MD responded that resident with good response, maintain the current dose. On 11/10/22 Gero-psychiatrist consult visit, stated mood is much improved on higher dose of Sertraline. No recent problems. Suggested dose reduction of Seroquel to 12.5mg at HS. Resident□s MD agreed with recommendation and ordered the above. On 06/08/23 Gero-psychiatrist consult visit noted resident is stable, no serious behavioral issues, recommend dose reduction of Seroquel to 6.25mg at HS. Resident□s MD agreed with recommendation and ordered the above. In response to surveyor□s concern regarding GDR of Sertraline, Gero-psychiatrist was immediately consulted on 07/27/23 and psych consult was performed. Gero-psychiatrist wrote the	

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F 758	Continued From page 27 Review of the facility's policy and procedure "Psychotropic Drug Use" effective 09/01/18 documented "Within the first year in which a resident is admitted on a psychotropic medication...or after the facility initiated an psychotropic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinical contraindicated."	F 758	following: 1) Discontinue Seroquel - Seroquel is being discontinued first due to higher risk (e.g. metabolic syndrome) compared with Sertraline. 2) Continue with current dose of Sertraline for now, further dose reduction as tolerated. Generally in psychopharmacology, better to change one medication at a time rather than two dose reduction/discontinuations at once. Seroquel being discontinued first due to higher risk, further dose reduction of Sertraline as tolerated in the future. Resident□s MD agreed with recommendation and ordered the above. Completed 08.23.23 2) DON consulted with Medical Director and she agreed with Gero-psychiatrist□s priority to reduce and discontinue antipsychotic medication first since poses higher risk for side effects for elderly; to gradually reduce psychotropic medication one at a time to prevent decline in mood and behavior; and to monitor for a period of time and then consider to attempt to decrease Sertraline in the future. As suggested by Pharmacist Consultant, Medical Director agrees if resident does well without Seroquel to consider GDR of Sertraline in October 2023. Completed 08.24.23 3) LN will monitor R32 behaviors and document in PCC.Start 07.31.23-Ongoing. 4) HN/SW will review behavior/mood documentation and upon receipt in October of the pharmacy consultant□s	

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F 758	Continued From page 28	F 758	recommendation memo, inform resident□s physician of current status and suggest GDR, if appropriate. To Be Completed 10.31.23 NURSING SUPERVISOR (SRN), HEAD NURSES (HN) LICENSED NURSES (LN) AND SOCIAL WORKER (SW) WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: 1) HN/SRN/LN to identify residents receiving psychotropic medications. Completed 07.31.23 2) HN/SW will ensure that GDR/evaluation to continue or discontinue psychotropic medication is completed, as appropriate, based on facility□s Psychotropic Medication Policy and Procedure.Start 08.28.23-Ongoing DIRECTOR OF NURSING (DON), NURSING SUPERVISOR (SRN), HEAD NURSES (HN), QUALITY ASSURANCE RN (QA) AND SOCIAL WORKER (SW) WILL IMPLEMENT MEASURES OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, INCLUDING: 1) HN/SW will collaborate and schedule Geriatric psychiatrist referral for possible gradual dose reduction every 12 months or sooner based on resident□s mood and behavior stability. If resident is hospice status, HN/SW will consult with hospice services.Start 08.28.23-Onging	

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F 758	Continued From page 29	F 758	2) QA Nurse to audit all newly admitted/readmitted and current residents on psychotropic medications that GDR is completed on a timely basis.Start 08.28.23 Ongoing 3) DON/SRN will conduct monthly random audits of residents on psychotropic medications to ensure that GDRs and psychiatric consults are completed, as appropriate. DON will consult with Pharmacy Consultant and Medical Director for input.Start 08.24.23-Ongoing DIRECTOR OF NURSING (DON) AND QUALITY ASSURANCE RN (QA) WILL MONITOR CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR, INCLUDING: 1) QA audit findings will be reported and reviewed at the Nurse Managers meeting and submitted to the quarterly QAPI committee.Start 11.28.23-Ongoing 2) DON summarized deficiency to QAPI Committee and plan to submit audit findings summary to the quarterly QAPI committee. Completed 08.22.23	
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	F 761		8/29/23

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F 761	Continued From page 30 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and facility policy review, the facility failed to properly store medications in a manner that facilitates considerations of precautions and safe administration in one out of two medication carts sampled. This deficient practice has the potential to promote medication administration error to one resident in the facility. Findings Include: Observation and interview were conducted on the third-floor hallway near the nurse's station on 07/25/23 at 01:52 PM. A medication cart contained a resident's medication blister pack labeled, "Senna 8.6 mg tablets." On the blister pack was a handwritten note indicating, "Discard after 5/23." Registered Nurse (RN) 6 was	F 761	HEAD NURSE (HN) WILL IMPLEMENT CORRECTIVE ACTIONS FOR 3MAKAI RESIDENTS FOUND TO BE AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: 1) HN removed expired PRN medication from the medication cart. Completed 07.28.23 HEAD NURSE (HN) AND LICENSED NURSES (LN)) WILL IDENTIFY OTHER RESIDENTS HAVING HE POTENTIAL TO BE AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: 1) HNs/LNs inspected medication and treatment carts on both units for expired medications. Completed 07.28.23 HEAD NURSE (HN), LICENSED NURSES (LN) AND QUALITY	

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F 761	Continued From page 31 questioned about the medication blister pack. RN6 confirmed that the medication should not have been in the cart and should have been discarded. Record review was conducted on the facility's document titled, "Medication Storage," dated 01/23. The document indicated, "Outdated, contaminated, discontinued, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal ..."	F 761	ASSURANCE NURSE (QA) WILL IMPLEMENT MEASURES TO ENSURE THAT THIS PRACTICE DOES NOT RECUR, INCLUDING: 1) HNs/LNs will be checking daily by assigned every shift ALL PRN MEDICATIONS in the medication carts, treatment carts, and medication refrigerator to ensure there are no expired medications. Start 09.01.23-Ongoing 2) HN and LNs will review PRN medications not used and ask MD to discontinue order due to non-use. Start 08.01.23-Ongoing 3) QA will conduct monthly audits for expired medications in the medication carts, treatment carts, and refrigerators. Start 09.01.23-Ongoing DIRECTOR OF NURSING (DON), QUALITY ASSURANCE NURSE (QA) AND QUALITY ASSURANCE PERFORMANCE IMPROVEMENT COMMITTEE (QAPI) WILL MONITOR CORRECTIVE ACTIONS TO ENSURE THE EFFECTIVENESS OF THESE ACTIONS, INCLUDING: 1) QA will summarize findings of the monthly audits on a quarterly basis. DON will report findings to the quarterly QAPI committee. Start at next QAPI meeting on 11.28.23--Ongoing	
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must-	F 803		8/28/23

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F 803	Continued From page 32 §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews the facility failed to ensure a resident's (Resident (R) 55) menu met her preferences. Findings include: R55 was admitted to the facility on 08/20/22. R55's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/24/23 documented R55 scored a 15 (cognitively intact) during the Brief Interview for Mental Status (BIMS).	F 803	REGISTERED DIETITIAN (RD) AND DIETITIAN ASSISTANT (DA) WILL IMPLEMENT CORRECTIVE ACTIONS FOR R55 FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE, INCLUDING: 1) RD visited R55 for current/updated food preferences on 07/26/23. R55 requested large tossed salads be added to lunch and dinner. R55 further requested only chicken for lunch and dinner meals no beef, no pork, no fish and no turkey. RD recommended R55	

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	125009	A. BUILDING _____ B. WING _____	07/27/2023

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F 803	Continued From page 33 On 07/24/23 at 09:18 AM interview with R55 was done. R55 stated she prefers to have lots of fresh vegetables with her meals. R55 reported she likes to have a bite of fresh vegetable after eating a piece of meat because she does not feel good when she eats too much meat. R55 reported she did not get any vegetables with her breakfast and during lunch and dinner her salad is very small. On 07/24/23 at 01:32 PM observed a small salad with R55's lunch. Observed R55 to eat all her salad. R55 stated she got lettuce, but it was not enough, and she wanted more lettuce. R55 further reported during her dinners she receives only a little bit of fresh vegetables. On 07/25/23 at 08:11 AM observed no vegetables with R55's breakfast. R55 stated she did not get any vegetables with her breakfast. On 07/25/23 at 12:07 PM observed R55 eat all her small salad but did not touch her chicken or cooked carrots and ate a small portion of her rice. Inquired why R55 did not eat the other food, R55 stated she does not really like the food and reported she ate all her salad. On 07/26/23 at 12:05 PM observed R55 eat all her small salad, fruit, a portion of her rice and soup but did not touch her chicken with gravy and cooked vegetables. Observed Staff Member (SM) 3 ask R55 if she is done with her meal and inform R55 she will take her back to her room. Inquired with SM3 if she is usually in the dining room providing supervision, SM3 stated she rotates with other staff members. Inquired if R55 does not eat much of her meals, SM3 stated she usually does not. Further inquired if SM3 knew the reason why, SM3 stated she was not sure.	F 803	use Language Line interpreter services several times and verbalized preference to speak in English but declined. Completed 07.28.23 2) RD assistant visited resident to clarify which chicken dishes were acceptable and resident□s Geri menu file was updated. Completed 07.28.23 3) RD 07/28/23 contacted family to confirm/clarify resident□s food preferences due to responses by R55. Per son□s report 08/03/23, R55 had not expressed a change in food preferences or complaints or requested no meats except chicken to him when he calls her daily, but he will clarify further with her and inform RD of any further changes. Completed 08.03.23 4) R55 care plan updated on 07/28/23, 07/31/23, 08/16/23 and 08/24/23 with additional interventions: Alert nurse/dietitian if my meal intake decreases consistently, Offer me substitutes if I□m not able to eat or if I don□t like what I receive, notify the nurse/dietitian if I express a change in my food preferences, Review/update my food preferences semi-annually and as needed. Completed 08.24.23. 5) DA reviewed daily menu with R55 to ensure preferences are met and updated Gerimenu for 3 weeks due to R55 ending interview process. Completed 08.04.13 6) RD reviewed resident□s medical	

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F 803	Continued From page 34 On 07/26/23 at 12:27 interview and concurrent record review with Registered Dietician (RD) 1 was done. RD1 explained the admission process to ensure the facility gathers information on residents' preferences. RD1 reported during admission and annually her assistant will use the worksheet "Assistant to Dietitian New Admission/Annual Worksheet" to help determine preferences. Inquired if a form was done with R55, RD1 stated it was not done with R55 and it was not documented that her assistant attempted to meet with R55 and if R55 refused. RD1 reported she spoke with her son about the resident's preference because R55 may speak another language which may have been challenging for her assistant. Inquired if the facility uses interpretor services, RD1 confirmed they do, and it was not documented interpreter services was attempted to be used with R55 to ensure her preferences were considered.	F 803	history 08/04/23 and determined that 2gm Na diet restriction probably not indicated, discussed with HN to liberalize diet to Diabetic, No Added Salt, Low cholesterol diet for better meal satisfaction since family brings regular food weekly; order obtained from PCP to liberalize sodium restriction in diet. Completed 08.04.23. REGISTERED DIETITIAN (RD), DIETITIAN ASSISTANT (DA), CERTFIED NURSES AIDE (CNA) AND LICENSED NURSE (LN) WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE, INCLUDING: 1) DA interview worksheet for admissions/annual and/or as needed food preference reviews updated to include documentation of resident interviews and/or why resident was unable to be interviewed. Completed 07.28.23 2) All residents with care plans with meal/food intake will have interventions added: Notify the nurse/dietitian if I express a change in my food preferences and Review/update my food preferences semi-annually and as needed if/when notified by staff. Completed 08.28.23 3) BIMS score will be added to Admission/annual nutrition assessment forms for residents on PO (per oral) diets so that if BIMS score increases to 13 to 15, resident will be interviewed for food	

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F 803	Continued From page 35	F 803	preferences if they haven□t been already template changed. Completed 08.02.23-Ongoing REGISTERED DIETITIAN (RD), DIETITIAN ASSISTANT (DA) AND QUALITY ASSURANCE ASURANCE NURSE (QA) WILL IMPLEMENT MEASURES OR SYSTEMIC CHANGES TO ENSURE THAT THID DEFICIENT PRACTICE WILL NOT RECUR, INCLUDING: 1) RD/DA will keep a record of all new assessments, annuals, semi-annuals completed of whether resident was interviewed for food preferences. Start 07.28.23-Ongoing 2) RD to review updated interview worksheet to confirm resident participation or non-participation, document all findings in residents□ nutrition assessment and food preferences will be documented in the Geri menu.Start 07.28.23□ Ongoing 3) RD/QA will conduct quarterly reviews of residents□ charts with BIMS 13 to 15 to determine if they were interviewed to verbalize food preferences. Start 07.28.23-Ongoing REGISTERED DIETITIAN (RD) AND QUALITY ASSURANCE NURSE (QA) AND QUALITY ASSURANCE PERFORMANCE IMPROVEMENT COMMITTEE (QAPI) WILL MONITOR CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR, INCLUDING:	

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F 803	Continued From page 36	F 803	1) RD will submit a report of all findings from chart reviews at quarterly QAPI meetings.Start 11.28.23-Ongoing	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §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	F 880		8/29/23

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F 880	Continued From page 37 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to follow proper infection control during lunch service on a nursing unit and did not do hand hygiene after removing used gloves and putting on clean gloves during one resident's (R)43 care. This deficient practice	F 880	NURSING SUPERVISIORS (SRN) WILL IMPLEMENT CORRECTIIVE ACTIONS FOR RESIDENTS R43, R45 AND R46 FOUND TO BE AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: 1) CNA was immediately counseled and	

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F 880	Continued From page 38 encourages the development and transmission of communicable diseases and infections and has the potential to affect all residents in the facility. Findings include: 1) On 07/24/23 at 11:50 AM, observed the delivery of lunch trays on a nursing unit. Certified Nurse Aide (CNA) 49 went into a room labeled with an "Enhanced Barrier Precaution" poster. CNA49 raised the head of bed for resident (R)46 by pressing a button located on the panel at the foot of R46's bed. CNA49 did not perform hand hygiene upon exiting from the room. CNA49 retrieved a paper place mat at the nursing station, walked to the dining cart located in the hallway between R46's and the next room, opened the dining cart, and obtained R46's lunch tray. CNA49 entered R46's room, placed the paper place mat on his table, took the dining items off the tray, and placed it on the paper place mat. CNA49 performed hand hygiene upon exiting the room. On 07/24/23 at 12:10 PM, observed CNA39 enter R45's room. CNA39 assisted R45 to sit up for lunch. CNA39 did not hand hygiene upon exiting from the room. On 07/26/23 at 09:48 AM, interviewed CNA48 in the hallway of the nursing unit. CNA48 stated that hand hygiene should be performed before serving the resident's dining tray. On 07/26/23 at 12:31 PM, interviewed the Infection Preventionist (IP) in the unit's large dining room. IP stated that staff should perform hand hygiene after touching the resident or resident's environment.	F 880	re in-serviced on hand hygiene after removing of gloves and before putting on new gloves while providing peri-care. Completed 07.27.23 2) CNA was counseled regarding hand hygiene after touched resident environment and when leaving room. Completed 08.29.23 DIRECTOR OF NURSING (DON), HEAD NURSE (HN), LICENSED NURSES (LN), NURSING SUPERVISOR (SRN), EDUCATION NURSE (EN), & INFECTION PREVENTIONIST (IP) WILL IDENTIFY OTHER RESIDENTS WITH THE POTENTIAL TO BE AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: 1) All residents who eat their meal inside their room and residents who require staff assistance in incontinence care. Completed 07.28.23 2) CNA on all units and shifts were in-serviced to perform hand hygiene after removal of gloves and before putting on gloves while providing peri-care and after exiting resident room. Start 07.27.23-Ongoing DIRECTOR OF NURSING (DON), HEAD NURSE (HN), LICENSED NURSES (LN), NURSING SUPERVISOR (SRN), EDUCATION NURSE (EN), & INFECTION PREVENTIONIST (IP) WILL IMPLEMENT MEASURES OR SYSTEMIC CHANGES TO ENSURE THAT THIS DEFICIENT PRACTICE WILL NOT RECUR INCLUDING: 1) IP will conduct in-services on hand hygiene for all personnel who touch	

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F 880	Continued From page 39 2) On 07/26/23 at 09:48 AM, observed CNA48 perform R43's perineal care. CNA48 wore gloves and wiped R43's perineal area clean of stool. CNA48 removed her used gloves and did not perform hand hygiene before putting on clean gloves. CNA48 confirmed she did not perform hand hygiene after removing her gloves because it was inaccessible (alcohol hand-rub stations are located outside of the resident's rooms). On 07/26/23 at 12:31 PM, interviewed IP in the unit's dining room. IP stated that hand hygiene should be performed after the removal of used gloves and before putting on clean gloves. Record review of "Hand Hygiene" policy and procedure with effective date of 02/03/23. It stated, "II. POLICY: ... 2. Indications for Antiseptic Hand Rubbing or Antiseptic Handwashing ... 4. Before preparing or serving food ... 6. Before and after touching a resident ... 7. Before putting on and after removing gloves (wearing gloves is not a substitute for hand hygiene) ... 13. Upon entry to a resident's room ... 14. Before exiting a resident's room ..."	F 880	resident environment, enter and leave resident room and wear gloves while performing tasks. Start 08.01.23-complete 09.08.23 2) EN and IP will conduct in-services on hand hygiene upon hire and at the annual education fair. Start 09.01.23- Ongoing 3) IP is exploring ways to place hand sanitizers in the resident rooms so accessible to direct care staff during care. Start 08.08.23-Ongoing DIRECTOR OF NURSING (DON), QUALITY ASSURANCE RN (QA), HEAD NURSE (HN), LICENSED NURSES (LN), NURSING SUPERVISOR (SRN), EDUCATION NURSE (EN), & INFECTION PREVENTIONIST (IP) WILL MONITOR CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR, INCLUDING: 1) Audit tool created for HNs/QA/SRNs/EN/DON, and IP to monitor and provide feedback to staff to correct deficient practice. Completed 08.01.23 2) HNs/QA/SRN/EN/IP will conduct random hand hygiene and gloving audit during care and meal tray service immediate feedback correction will be provided as needed. Start 09.01.23 - Ongoing 3) IP will submit audit reports to the DON to report at the quarterly QAPI Committee meeting. Start 11.28.23(next QAPI meeting)-Ongoing	