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	125043	A. BUILDING _____ B. WING _____	R 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A desk review was completed on 07/24/23 by the State Agency (SA), the Office of Health Care Assurance (OHCA). The facility was not in compliance which resulted in recitation of deficient practices.	{F 000}		
{F 550} SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	{F 550}		

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

Electronically Signed

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{F 550}	Continued From page 1	{F 550}		

resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure all staff were provided education for a previously cited deficiency of staff speaking in the English language while providing care for and in resident areas and assisting residents with meals at eye level as indicated in the facility's Plan of Correction (POC).

Findings include:

The State Agency (SA) conducted a desk review of support documentation provided by the facility in a binder (Supporting Documents, 06/09/23) and additional documents received via fax (on 07/20/23). The facility's Plan of Correction (POC) accepted by the SA documented the Director of Nursing (DON)/designee provided education to all staff regarding staff speaking in English language only in the resident care areas and assisting residents with meals at eye level on 5/12/2023. Review of all documents submitted by the facility did not provide evidence that the facility had educated most of the staff as accepted in the POC.

Conducted telephone interviews with the Administrator and Director of Nursing (DON) on

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{F 550}	Continued From page 2 07/19/23, regarding the lack of documentation of staff training. Requested for the facility to provide sign-in sheets for the education provided and inquired as to how the facility was keeping track of which staff completed training and staff that needed to complete training to support the facility was making a reasonable attempt to train staff to ensure the residents would continue to experience the deficient practice. Requested the facility fax the additional documents to the SA by 07/20/23. On 07/20/23 at 09:06 AM, the SA received additional documentation via fax. Review of the additional documents confirmed the facility did not provide education to an adequate number of staff to ensure the resident's exposure to the deficient practice would be reduced. Review of the signatures on the sign-in sheet documented the following staff were educated: - 1 duplicate sign-in sheet used in F604-restraints - 7 duplicated signatures - 19 of 39 Registered Nurses (RN)/ Licensed Practical Nurse (LPN), sign-in sheet did not have the date or time the education was provided - 31 of 60 Certified Nurse Aide (CNA)/ Nurse Aide (NA), sign-in sheet did not have the date or time the education was provided - 11 of 20 Food Service staff - 9 of 9 Activity staff - 6 Rehab staff In addition, the sign-in sheets contained duplicated names on the sign-in sheet. Also, no master list of staff that completed training, did not complete training, reason training was not completed, and/or how the facility would ensure	{F 550}		

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{F 550}	Continued From page 3 the untrained staff would receive the training.	{F 550}		
{F 604} SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to provide staff education for use the	{F 604}		

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{F 604}	Continued From page 4	{F 604}		

least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for mitten restraints for all licensed staff as indicated in the facility's Plan of Correction (POC). As a result of this deficient practice, residents are at risk of experiencing physical and psychosocial harm.

Findings include:

The State Agency (SA) conducted a desk review of support documentation provided by the facility in a binder (Supporting Documents, 06/09/23) and additional documents received via fax (on 07/20/23). The facility's Plan of Correction (POC) accepted by the SA documented the Director of Nursing (DON)/designee provided education to all staff on the resident's rights to be free from physical restraint, released form restraint as ordered, restraint assessment if medically necessary, and least restrictive restraint use.

Conducted telephone interviews with the Administrator and Director of Nursing (DON) on 07/19/23 at 11:08 AM, regarding the lack of documentation of staff training. Requested for the facility to provide sign-in sheets for the education provided and inquired as to how the facility was keeping track of which staff completed training and staff that needed to complete training to support the facility was making a reasonable attempt to train staff to ensure the residents would continue to experience the deficient practice. Requested the facility fax the additional documents to the SA by 07/20/23.

On 07/20/23 at 09:06 AM, the SA received additional documentation via fax. Review of the

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{F 604}	Continued From page 5 additional documents confirmed the facility did not provide education to all staff at documented in the POC. The sign-in sheets contained duplicated names on the sign-in sheet. Also, no master list of staff that completed training, did not complete training, reason training was not completed (sick leave, vacation leave, or any other reason), and how the facility would ensure the untrained staff would receive the training. Review of the signatures on the sign-in sheet documented the following staff were educated: - 1 duplicate sign-in sheet used in F550 Resident Rights, The facility just changed the title of the training. - 6 duplicated signatures - 19 of 39 Registered Nurses (RN)/ Licensed Practical Nurse (LPN), sign-in sheet did not have the date or time the education was provided - 44 of 60 Certified Nurse Aide (CNA)/ Nurse Aide (NA), sign-in sheet did not have the date or time the education was provided - 3 other disciplines (social work and admission)	{F 604}		
{F 625} SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing	{F 625}		

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facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure all licensed nurses were educated on the bed hold policy. As a result of this deficiency, residents could potentially experience harm.

Findings include:

The State Agency (SA) conducted a desk review of support documentation provided by the facility in a binder (Supporting Documents, 06/09/23) and additional documents received via fax (on 07/20/23). The facility's Plan of Correction (POC) accepted by the SA documented Social Work (SW)/designee provided education to all licensed staff on the bed hold policy.

Review of all documents submitted to the SA documented there were no sign-in sheet for the education of all licensed nurses on the bed hold

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{F 625}	Continued From page 7 policy. The facility's POC documented all licensed nurses would be educated, and the lack of documentation confirmed the facility did not. One sign-in sheet titled Bed Hold Notification and Dental Consult F/Up (follow-up), it was observed that "Dental Consult F/Up" had been handwritten and the document did not have a date or time on the sign-in sheet. Review of the sign-in sheet documented there was a total of 14 signatures. - 9 of 39 licensed nurses - 5 other staff Conducted telephone interviews with the Administrator and DON on 07/19/23 at 11:08 AM, regarding the lack of documentation of staff training. Requested for the facility to provide sign-in sheets for the education provided and inquired as to how the facility was keeping track of which staff completed training and staff that needed to complete training to support the facility was making a reasonable attempt to train staff to ensure the residents would continue to experience the deficient practice. Requested the facility fax the additional documents to the SA by 07/20/23. No additional documentation was received related to this deficient practice.	{F 625}		
{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	{F 656}		

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needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for 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 record review and interview, the facility

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{F 656}	Continued From page 9	{F 656}		

failed to ensure all licensed staff was trained on the comprehensive care plan to ensure care plans are developed and implemented for resident centered care plans. As a result of this deficiency, residents could potentially experience harm due to unaddressed resident centered areas.

Findings include:

The State Agency (SA) conducted a desk review of support documentation provided by the facility in a binder (Supporting Documents, 06/09/23) and additional documents received via fax (on 07/20/23). The facility's Plan of Correction (POC) accepted by the SA documented the Director of Nursing (DON)/designee provided education to all licensed staff for resident centered comprehensive care plan.

Conducted telephone interviews with the Administrator and Director of Nursing (DON) on 07/19/23, regarding the lack of documentation of staff training. Requested for the facility to provide sign-in sheets for the education provided and inquired as to how the facility was keeping track of which staff completed training and staff that needed to complete training to support the facility was making a reasonable attempt to train staff to ensure the residents would continue to experience the deficient practice. Requested the facility fax the additional documents to the SA by 07/20/23.

On 07/20/23 at 09:06 AM, the SA received additional documentation via fax. Review of the additional documents confirmed the facility did not provide education to an adequate number of staff to ensure the resident's exposure to the

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{F 656}	Continued From page 10 deficient practice would be reduced. The facility did not educate at least half of all direct care staff. In addition, the sign-in sheets contained duplicated names on the sign-in sheet. Also, no master list of staff that completed training, did not complete training, reason training was not, and how the facility would ensure the untrained staff would receive the training. Review of the sign-in sheets documented only 18 of 39 licensed staff recieved education and the sign-in sheet included 1 duplicate signature and an entire sign-in sheet was a duplicate of training provided for F657. The facility just changed the title of the training.	{F 656}		
{F 657} SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	{F 657}		

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or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure all licensed staff were trained on the revising the resident's comprehensive care plan. As a result of this deficiency, residents could potentially experience harm.

Findings include:

The State Agency (SA) conducted a desk review of support documentation provided by the facility in a binder (Supporting Documents, 06/09/23) and additional documents received via fax (on 07/20/23). The facility's Plan of Correction (POC) accepted by the SA documented the Director of Nursing (DON)/designee provided education to all licensed staff for revising resident centered comprehensive care plan.

Review of all documents submitted by the facility did not provide evidence that the facility had educated most of the staff as accepted in the POC.

Conducted telephone interviews with the Administrator and Director of Nursing (DON) on 07/19/23, regarding the lack of documentation of staff training. Requested for the facility to provide sign-in sheets for the education provided and inquired as to how the facility was keeping track of which staff completed training and staff that needed to complete training to support the facility was making a reasonable attempt to train staff to

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{F 657}	Continued From page 12 ensure the residents would continue to experience the deficient practice. Requested the facility fax the additional documents to the SA by 07/20/23. On 07/20/23 at 09:06 AM, the SA received additional documentation via fax. Review of the additional documents confirmed the facility did not provide education to an adequate number of staff to ensure the resident's exposure to the deficient practice would be reduced. The facility did not educate at least half of all direct care staff. In addition, the sign-in sheets contained duplicated names on the sign-in sheet. Also, no master list of staff that completed training, did not complete training, reason training was not, and how the facility would ensure the untrained staff would receive the training. Review of the sign-in sheets documented only 17 of 39 staff received education, 1 signature was duplicated on the sign in sheet, and 1 sign in sheet was duplicated in it's entirety for education completed in F656. The facility just changed the title of the training.	{F 657}		
{F 677} SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure all staff were trained on grooming, hygiene, and shower documentation via Point Click Care to ensure residents activities for daily living are addressed. As a result of this deficiency, residents could potentially experience	{F 677}		

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{F 677}	Continued From page 13	{F 677}		

harm.

Findings include:

The State Agency (SA) conducted a desk review of support documentation provided by the facility in a binder (Supporting Documents, 06/09/23) and additional documents received via fax (on 07/20/23). The facility's Plan of Correction (POC) accepted by the SA documented the Director of Nursing (DON)/designee provided education to all staff on grooming, hygiene, and shower documentation via Point Click Care to ensure residents activities for daily living are addressed.

Conducted telephone interviews with the Administrator and Director of Nursing (DON) on 07/19/23, regarding the lack of documentation of staff training. Requested for the facility to provide sign-in sheets for the education provided and inquired as to how the facility was keeping track of which staff completed training and staff that needed to complete training to support the facility was making a reasonable attempt to train staff to ensure the residents would continue to experience the deficient practice. Requested the facility fax the additional documents to the SA by 07/20/23.

On 07/20/23 at 09:06 AM, the SA received additional documentation via fax. Review of the additional documents confirmed the facility did not provide education to all staff to ensure the resident's exposure to the deficient practice not reoccur. Review of the sign-in sheets documented 15 of 39 licensed nursing staff and 36 of 54 aide staff received education. Closer review of the sign-in sheets documented 14 duplicate signatures.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 688} SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure all staff were educated on Range of Motion (ROM) and splinting procedures. As a result of this deficiency, residents could potentially experience harm. Findings include: The State Agency (SA) conducted a desk review of documentation provided by the facility in a binder (Supporting Documents, 06/09/23) and additional documents received via fax (on 07/20/23). The facility's Plan of Correction (POC) accepted by the SA documented the Director of Nursing (DON)/designee provided education to all staff on ROM and splinting procedures. Review of sign-in sheets of education provided for Splint	{F 688}		

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{F 688}	Continued From page 15 schedules, referrals to rehab, proper documentation, and contractures/ROM confirmed the facility did not educate staff. Conducted telephone interviews with the Administrator and Director of Nursing (DON) on 07/19/23 at 11:08 AM, regarding the lack of documentation of staff training. Requested for the facility to provide sign-in sheets for the education provided and inquired as to how the facility was keeping track of which staff completed training and staff that needed to complete training to support the facility was making a reasonable attempt to train staff to ensure the residents would continue to experience the deficient practice. Requested the facility fax the additional documents to the SA by 07/20/23. On 07/20/23 at 09:06 AM, the SA received additional documentation via fax. Review of the additional documents confirmed the facility did not provide education to all staff as stated in the POC. Closer review of the sign-in sheets documented only 17 of 39 licensed nursing staff and 36 of 54 aide staff were educated and there were 17 duplicate signatures. Also, no master list of staff that completed training, did not complete training, reason training was not, and how the facility would ensure the untrained staff would receive the training.	{F 688}		
{F 689} SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	{F 689}		

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{F 689}	Continued From page 16 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure all licensed staff were educated on the proper destruction of Fentanyl patches via RX destroyer. As a result of this deficiency, residents could potentially experience harm due to accidental exposure. Findings include: The State Agency (SA) conducted a desk review of support documentation provided by the facility in a binder (Supporting Documents, 06/09/23) and additional documents received via fax (on 07/20/23). The facility's Plan of Correction (POC) accepted by the SA documented the Director of Nursing (DON)/designee provided education to all licensed staff on the destruction of Fentanyl patches via RX destroyer. Review of all documents submitted to the SA documented the educational sign-in sheet had a total of 31 signatures, 5 of the staff had signed the sign-in sheet twice. The sign-in sheets only contained the topic of the training, it did not contain the date or time the education was conducted or who conducted the educational training. The facility's POC documented all licensed nurses would be educated, and the documentation confirmed the facility did not. Conducted telephone interviews with the Administrator and Director of Nursing (DON) on 07/19/23, regarding the lack of documentation of	{F 689}		

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{F 689}	Continued From page 17 staff training. Requested for the facility to provide sign-in sheets for the education provided and inquired as to how the facility was keeping track of which staff completed training and staff that needed to complete training to support the facility was making a reasonable attempt to train staff to ensure the residents would continue to experience the deficient practice. Requested the facility fax the additional documents to the SA by 07/20/23. On 07/20/23 at 09:06 AM, the SA received additional documentation via fax. Review of the additional documents confirmed the facility did not provide additional documentation to support the facility had met the 100% compliance of training the licensed nurses. Also, no master list of staff that completed training, did not complete training, reason training was not, and how the facility would ensure the untrained staff would receive the training. In addition, the sign-in sheet was a duplicate of the sign-in sheet for Medication Regime Review and Medication Cart Locked at All Times. The facility just changed the title of the training.	{F 689}		
{F 693} SS=E	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	{F 693}		

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{F 693}	Continued From page 18 enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §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 record review and interview, the facility failed to ensure all licensed staff were educated on the enteral feeding policy update and instruction for licensed nurses to change tube feeding formula and flush bag when formula is consumed or after 48 hours whichever time comes first. As a result of this deficiency, residents could potentially experience harm due to accidental exposure. Findings include: The State Agency (SA) conducted a desk review of support documentation provided by the facility in a binder (Supporting Documents, 06/09/23) and additional documents received via fax (on 07/20/23). The facility's Plan of Correction (POC) accepted by the SA documented the Director of Nursing (DON)/designee provided education to all licensed staff were educated on the enteral feeding policy update and instruction for licensed nurses to change tube feeding formula and flush bag when formula is consumed or after 48 hours whichever time comes first.	{F 693}		

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{F 693}	Continued From page 19 Conducted telephone interviews with the Administrator and Director of Nursing (DON) on 07/19/23, regarding the lack of documentation of staff training. Requested for the facility to provide sign-in sheets for the education provided and inquired as to how the facility was keeping track of which staff completed training and staff that needed to complete training to support the facility was making a reasonable attempt to train staff to ensure the residents would continue to experience the deficient practice. Requested the facility fax the additional documents to the SA by 07/20/23. On 07/20/23 at 09:06 AM, the SA received additional documentation via fax. Review of the additional documents confirmed the facility did not educate all staff as indicated in the POC that was accepted by the SA. In addition, the sign-in sheets contained duplicated names on the sign-in sheet. Also, no master list of staff that completed training, did not complete training, reason training was not, and how the facility would ensure the untrained staff would receive the training.	{F 693}		
{F 755} SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures	{F 755}		

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{F 755}	Continued From page 20	{F 755}		

that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure all licensed staff were educated on the proper destruction of Fentanyl patches via RX destroyer. As a result of this deficiency, residents could potentially experience harm due to accidental exposure.

Findings include:

The State Agency (SA) conducted a desk review of support documentation provided by the facility in a binder (Supporting Documents, 06/09/23) and additional documents received via fax (on 07/20/23). The facility's Plan of Correction (POC) accepted by the SA documented the Director of Nursing (DON)/designee provided education to all licensed staff on the destruction of Fentanyl

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{F 755}	Continued From page 21 patches via RX destroyer. Review of all documents submitted to the SA documented the educational sign-in sheet had a total of 31 signatures, 5 of the staff had signed the sign-in sheet twice. The sign-in sheets only contained the topic of the training, it did not contain the date or time the education was conducted or who conducted the educational training. The facility's POC documented all licensed nurses would be educated, and the documentation confirmed the facility did not. Conducted telephone interview with the Administrator and Director of Nursing (DON) on 07/19/23 at 11:08 AM, regarding the lack of documentation of staff training. Requested for the facility to provide sign-in sheets for the education provided and inquired as to how the facility was keeping track of which staff completed training and staff that needed to complete training to support the facility was making a reasonable attempt to train staff to ensure the residents would continue to experience the deficient practice. Requested the facility fax the additional documents to the SA by 07/20/23. On 07/20/23 at 09:06 AM, the SA received additional documentation via fax. Review of the additional documents confirmed the facility did not provide additional documentation to support the facility had met the 100% compliance of training the licensed nurses. Also, no master list of staff that completed training, did not complete training, reason training was not, and how the facility would ensure the untrained staff would receive the training. In addition, a the sign-in sheet was a duplicate of the Medication Regime	{F 755}		

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{F 755}	Continued From page 22 Review and Medication Cart Lock at all times training. The facility just changed the title of the training.	{F 755}		
{F 756} SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly	{F 756}		

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{F 756}	Continued From page 23	{F 756}		

drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure all licensed nurses were educated on the Medication Record Review (MRR) procedure by 05/12/23. As a result of this deficiency, residents could potentially experience harm.

Findings include:

The State Agency (SA) conducted a desk review of support documentation provided by the facility in a binder (Supporting Documents, 06/09/23) and additional documents received via fax (on 07/20/23). The facility's Plan of Correction (POC) accepted by the SA documented the Director of Nursing (DON)/designee provided education to all licensed staff on the Medication Record Review (MRR) procedure.

Review of all documents submitted to the SA documented there were no sign-is sheet for the education of all licensed nurses on the MRR procedure. The facility's POC documented all licensed nurses would be educated, and the lack of documentation confirmed the facility did not.

Conducted telephone interviews with the Administrator and Director of Nursing (DON) on 07/19/23 at 11:08 AM, regarding the lack of documentation of staff training. Requested for the facility to provide sign-in sheets for the education provided and inquired as to how the

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{F 756}	Continued From page 24 facility was keeping track of which staff completed training and staff that needed to complete training to support the facility was making a reasonable attempt to train staff to ensure the residents would continue to experience the deficient practice. Requested the facility fax the additional documents to the SA by 07/20/23. On 07/20/23 at 09:06 AM, the SA received additional documentation via fax that did not confirm all licensed nurses were educated. There were two sign-in sheets titled, MRR procedure & Medication Cart Lock at All Times provided as documentation of the education of licensed nurses. Review of the two sign-in sheet documented the sign-in sheets were duplicate sheets of other training topic, the only difference was the topic/title of the document and there was no date or time of when the training occurred, and contained only 11 of 30 licensed nurses. In addtion, the sign-in sheet was a duplicate of the sign-in sheet for Medication Destruction- Fentanyl Patch Destruction through RX Destroyer. The facility just changed the title of the training.	{F 756}		
{F 791} SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet	{F 791}		

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{F 791}	Continued From page 25 the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure all licensed nurses were educated on dental consult review of recommendation and proper follow up. As a result of this deficiency, residents could potentially experience harm.	{F 791}		

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{F 791}	Continued From page 26 Findings include: The State Agency (SA) conducted a desk review of support documentation provided by the facility in a binder (Supporting Documents, 06/09/23) and additional documents received via fax (on 07/20/23). The facility's Plan of Correction (POC) accepted by the SA documented the Director of Nursing (DON)/designee provided education to all licensed staff on the dental consult review of recommendation and proper follow up. Review of all documents submitted to the SA documented there were no sign-is sheet for the education of all licensed nurses on the dental consult review of recommendation and proper follow up. The facility's POC documented all licensed nurses would be educated, and the lack of documentation confirmed the facility did not. One sign-in sheet titled Bed Hold Notification and Dental Consult F/Up (follow-up), it was observed that "Dental Consult F/Up" had been handwritten and the document did not have a date or time on the sign-in sheet. Review of the sign-in sheet documented there was a total of 14 signatures, only 8 of the signatures were licensed nurses, out of 30 licensed nurses on the facility roster. Conducted telephone interview with the Administrator and DON on 07/19/23 at 11:08 AM, regarding the lack of documentation of staff training. Requested for the facility to provide sign-in sheets for the education provided and inquired as to how the facility was keeping track of which staff completed training and staff that needed to complete training to support the facility was making a reasonable attempt to train staff to ensure the residents would continue to	{F 791}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 791}	Continued From page 27 experience the deficient practice. Requested the facility fax the additional documents to the SA by 07/20/23. No additional documentation was received related to this deficient practice.	{F 791}		
{F 825} SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure all licensed nurses, Certified Nurse Aides (CNA), and supervisors were educated on Range of Motion (ROM) exercise and referral to rehabilitation for any decline in mobility for further evaluation and management. As a result of this deficiency, residents could potentially experience harm.	{F 825}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING _____ B. WING _____	R 07/19/2023

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{F 825}	Continued From page 28 Findings include: The State Agency (SA) conducted a desk review of support documentation provided by the facility in a binder (Supporting Documents, 06/09/23) and additional documents received via fax (on 07/20/23). The facility's Plan of Correction (POC) accepted by the SA documented the Director of Nursing (DON)/designee provided education to all staff on ROM and splinting procedures. Review of sign-in sheets of education provided for Splint schedules, referrals to rehab, proper documentation, and contractures/ROM confirmed the facility did not educate staff as documented in the POC Conducted telephone interviews with the DON on 07/19/23 at 11:08 AM, regarding the lack of documentation of staff training. Requested for the facility to provide sign-in sheets for the education provided and inquired as to how the facility was keeping track of which staff completed training and staff that needed to complete the training. Requested the facility fax the additional documents to the SA by 07/20/23. On 07/20/23 at 09:06 AM, the SA received additional documentation via fax. Review of the additional documents confirmed the facility did not provide education to all staff as stated in the POC. Closer review of the sign-in sheets documented only 17 of 39 licensed nursing staff and 36 of 54 aide staff were educated and there were 17 duplicate signatures. Also, no master list of staff that completed training, did not complete training, reason training was not, and how the facility would ensure the untrained staff would receive the training.	{F 825}		

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{F 838}	Continued From page 29	{F 838}		
{F 838} SS=C	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including	{F 838}		

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{F 838}	Continued From page 30 but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the staff needs of its resident population accounted for the acuity of the residents as a factor when determining the number of staff needed to meet the unique needs of its residents. Findings include: The State Agency (SA) conducted a desk review of support documentation provided by the facility in a binder (Supporting Documents, 06/09/23) and additional documents received via fax (on	{F 838}		

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{F 838}	Continued From page 31 07/20/23). The facility's Plan of Correction (POC) documented updates to the facility assessment are made as needed. However, review of the submitted facility assessment documented the facility has the option to staff the facility without considering the acuity of the residents, "Examples of two different ways to look at your staffing plan are provided in the tables below. Choose a methodology that works best for your organization...", to which one of the methodologies does not utilize the acuity of the residents. In addition, the documentation of the facility assessment provided did not include the entire section 3.2 Staffing Plan and sections 3.3 & 3.4. There were no audits or documentation indicating the facility reviewed the resident's acuity and determined if the facility is adequately staffed according to the acuity. On 11/19/23 at 11:08 AM, conducted a telephone interview with the Administrator. The Administrator was verbally informed of the missing information and the option to staff the facility without considering the acuity of the resident would not ensure this deficient practice would be corrected. The facility faxed additional documentation to the SA which did not include a complete or updated facility assessment to ensure the resident's acuity is addressed when staffing the facility.	{F 838}		