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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 10/24/23 to 10/27/23, and on 10/30/23. The facility was found not to be in substantial compliance with 42 CFR §483, Subpart B. One Facility Reported Incident (FRI) and one Complaint from the Aspen Complaints/Incidents Tracking System(ACTS) were investigated, ACTS #10595 and #10490. Both were unsubstantiated. Survey Dates: 10/24/23-10/27/23 and 10/30/23 Survey Census: 78	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 observation, interview, and record review (RR), the facility failed to accommodate 1 of 3 Residents' (Resident 69) needs by not ensuring that his whiteboard (for communication), and remote for the TV, was always placed within his reach on his left side (the mobile side). As a result of this deficient practice, R69 was prevented from achieving independent functioning with regards to the TV, and he was hindered from attaining his highest practicable well-being. This deficient practice has the potential to affect all the residents at the facility	F 558		

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

Electronically Signed

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with deficits in mobility.

Findings include:

Resident (R)69 is a 53-year-old male admitted to the facility on 05/10/23 following a stroke with hemiplegia (paralysis of one side of the body) affecting his right side. Other admitting diagnoses include, but are not limited to, dysphagia (swallowing difficulties), adjustment disorder with mixed anxiety and depressed mood, deaf nonspeaking, and cognitive communication deficit (results in difficulty with thinking and how someone uses language). In addition, R69 receives all nutrition, fluids, and medication (except topical) through a gastrostomy tube (G-tube), a tube inserted through the belly that brings nutrition directly to the stomach.

On 10/24/23 at 12:22 PM, observations were made at R69's bedside. His bedside table was on his right (immobile) side, and contained a blank whiteboard with no pen in sight, and the TV remote. The TV was off, and the room was silent. R69 was non-verbal but responsive to greetings with a smile.

On 10/26/23 at 08:58 AM, observations made at R69's bedside. Bedside table was on his right side with a blank whiteboard with no pen in sight, and the TV remote. The TV was off, and the room was silent. R69 had both hands positioned on his chest. He could not move his right hand, but lifted his left hand to wave when greeted.

On 10/26/23 at 09:04 AM, an interview was done with Licensed Practical Nurse (LPN)1 outside R69's room. LPN1 confirmed that R69 cannot move his right side but can move the arm and leg

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F 558	Continued From page 2 on his left, and can activate the call light and TV remote with his left hand. LPN1 also acknowledged that R69 has a "communication problem" and stated that there is a communication board [whiteboard] at the side of the bed (currently on the bedside table on his right side). On 10/27/23 at 11:30 AM, observed Resident Care Manager (RCM)2 and LPN1 exiting R69's room after seeing him. Observations at R69's bedside confirmed that the bedside table with the whiteboard and TV remote were still placed on R69's right side. The TV was on with the volume turned very low, and no closed captioning. Followed RCM1 and LPN1 out to the nurses' station and asked about the bedside table with assistive items being placed on R69's right/paralyzed side. Both RCM1 and LPN1 agreed that the bedside table should be on his left. A review of R69's Comprehensive Care Plan (CP) noted no interventions regarding ensuring items (besides the call light) be kept within reach and on his mobile side (left).	F 558		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 580		

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mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).

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F 580	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review (RR), staff interview and facility policy review, the facility failed to notify the physician when Resident (R)70 became COVID positive and had a significant change in physical condition becoming unresponsive requiring transfer to hospital emergency room. The deficient practice has the potential to affect all residents in the facility that has a significant change in physical condition that could be life threatening. Findings include: During RR of R70's electronic health record (EHR) noted there was no documentation that R70's physician was notified of his COVID positive status on 07/24/2023 or 07/25/2023. RR of R70's EHR found Registered Nurse (RN)6's progress note which included "Resident on alert charting for COVID positive." was e-signed, dated and timed on 07/25/2023 at 00:29 AM. There was no documentation by RN6 that R70's physician was notified of his COVID positive status. RR found a progress note e-signed, dated and timed 07/25/2023 at 07:27 AM by Licensed Practical Nurse (LPN)9 that R70 was sent to the hospital emergency room at 05:46 AM via ambulance when found unresponsive that day at 05:10 AM. LPN9's progress note did not include documentation of notification of the physician for R70 after being found unresponsive. On 10/27/2023 at 11:03 AM asked facility administrator for LPN9's contact information (telephone number) for staff interview. Spoke with administrator about R70 and inquired if nurses	F 580		

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are expected to notify the doctor if there is a change with resident's status such as becoming COVID positive or becoming unresponsive and she confirmed the nurse did not notify the doctor, stated does not know why the nurse did not notify the doctor because they (facility) have doctors on call 24/7. Inquired if she knew how R70 was exposed to COVID and she stated she did not know exactly how R70 was exposed and acquired COVID, believes the facility had an outbreak at that time and stated three other residents who reside in the same corridor/wing were also COVID positive at the time.

On 10/27/2023 at 11:40 AM interviewed LPN9 regarding R70, who she found unresponsive on 07/25/2023 at 05:10 AM. Inquired if she notified the doctor that R70 was COVID positive and she stated the prior shift had done the test and is responsible to notify the doctor. Inquired if R70 presented with COVID symptoms and she stated no. Inquired if LPN9 had notified the doctor that R70 was found unresponsive and was sent to the hospital and she stated she did not notify the doctor but did notify the Director of Nursing (DON).

On 10/27/2023 at 11:50 AM interviewed Registered Nurse (RN)6, who reported R70 had complained of an itchy throat on 07/24/2023 and RN6 tested R70 for COVID and he was positive. Inquired if she notified the doctor of the test result and she could not remember if she did. RN6 notified the DON who instructed staff to move roommate out of R70's room since he was not positive for COVID.

Requested and received facility's policy on "Change in a Resident's Condition or Status"

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F 580	Continued From page 6 which states under Policy Statement "Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). Policy Interpretation and Implementation 1. The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): a. accident or incident involving the resident; b. discovery of injuries of an unknown source; c. adverse reaction to medications; d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly; f. refusal of treatment or medication three (3) or more consecutive times); g. need to transfer the resident to a hospital/treatment center;..."	F 580		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75.	F 607		

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F 607	Continued From page 7 §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interviews and facility document review, the facility failed to implement their written abuse policy and procedure for an alleged physical abuse of one of the facility residents (Resident (R) 23). This deficient practice had the potential to compromise the safety of the resident and places all residents in the facility at risk for potential physical and psychosocial harm. Findings include: Interview was conducted on 10/24/23 at 02:09 PM with R23's roommate, R66. R66 stated that she witnessed Certified Nurse's Aide (CNA) 35, "shove R23's head in the sink and attempted to rip her teeth out of her mouth." R66 stated that the incident occurred three to four months ago and that she had told everyone about the incident. R66 also added that CNA35 was also in the room when the incident occurred. R66 stated that a registered nurse supervisor had come to talk to her immediately after the incident. R66 had informed the nurse supervisor about what she had witnessed but nothing happened after that	F 607		

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F 607	Continued From page 8 conversation. A telephone interview was conducted on 10/25/23 at 01:55 PM with CNA35. CNA35 stated that she was a witness to the alleged abuse that had occurred sometime in May. CNA15 was being oriented by CNA35 during the time of the incident and were both by the sink assisting R23 with removal of her dentures. According to CNA15, CNA35 had placed one of her hands on R23's back, while the other hand was attempting to remove R23's dentures. CNA35 had placed R23's head near the sink so that she can rinse R23's mouth after removing her dentures. CNA15 did not believe that CNA35 was rough during the incident. CNA15 stated that R23 thought CNA35 had her hands around R66's neck and started yelling at them. Immediately after exiting the room, both CNA15 and CNA35 reported the incident to one of the nurses on duty. CNA15 did not recall who it was that they reported the incident to. An interview was conducted on 10/25/23 at 02:08 PM with CNA35 in the dining room. CNA35 stated that she was assisting R23 with the removal of her dentures during the incident. CNA35 held R23 on the back area for support while attempting to remove her dentures. CNA35 also positioned R23's face near the sink to rinse out her mouth. CNA35 then heard R66 yelling, "Why are you killing the old woman? If that was me, I would punch you." CNA35 did not respond to R66's comments and instead reported the incident to one of the nurses immediately after performing care to R23. The nurse that CNA35 reported the incident to no longer works at the facility.	F 607		

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F 607	Continued From page 9 An interview was conducted on 10/26/23 at 10:19 AM with Social Worker (SW) 1. SW1 stated that he was made aware about the alleged abuse on 10/25/23. He added that the alleged incident had occurred in May. SW1 indicated that the normal process for an alleged abuse would be to elevate it to the Director of Nursing (DON) or the Administrator. An interview was conducted on 10/27/23 at 07:30 AM with the Administrator. The Administrator stated that she became aware of the abuse allegation, regarding R23, on 10/26/23. A review of the facility document titled, "Comprehensive Abuse Policy and Prevention Program," dated 03/03/21 was conducted. The facility document indicated, "Upon receiving an allegation of abuse, committed against a resident, the staff member receiving the allegation must ensure the safety of the resident and immediately notify the supervisor on duty. The supervisor on duty will immediately notify the administrator or designee."	F 607		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or	F 623		

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discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email),

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and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of

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the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interview, and review of policy, the facility failed to provide written notice of discharge for one Resident (R)35 out of two residents sampled. As a result of this deficiency, there was a potential for miscommunication.

Findings include:

Review of the Electronic Health Record (EHR) indicated that R35 was discharged to the hospital on 08/31/23. Further review did not show any written notice of discharge to the resident and/or representative.

During staff interview on 10/26/23 at 02:00 PM, Administrator acknowledged that the facility did not provide written notification of discharge for R35.

Review of facility policy on Transfer or Discharge read the following: Policy Statement, when a resident/guest is transferred or discharged, details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care community or provider ... When a resident/guest is transferred or discharged from the community, the following information will be documented in the medical record ... That an appropriate notice was provided to the resident/guest and/or legal representative, the date and time of the transfer

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F 623	Continued From page 13 or discharge, the new location of the resident/guest, the mode of transportation, a summary of the resident/guest's overall medical, physical, and mental condition, disposition of medications, others as appropriate or as necessary ...	F 623		
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 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	F 625		

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F 625	Continued From page 14 by: Based on record review, staff interview, and review of policy, the facility failed to provide written notice of bed-hold policy for one Resident (R)35 out of two residents sampled. As a result of this deficiency, there was a potential for miscommunication of the bed-hold policy. Findings include: Review of the Electronic Health Record (EHR) indicated that R35 was discharged to the hospital on 08/31/23. Further review did not show any written notice of bed-hold policy to the resident and/or representative. During staff interview on 10/26/23 at 02:00 PM, Administrator acknowledged that the facility did not provide written notification of bed-hold policy for R35. Review of facility policy on Bed Holds and Returns read the following: Policy Statement, prior to transfers and therapeutic leaves, resident/guests or resident/guest representative will be informed of the bed-hold and return policy. Policy interpretation and implementation, resident/guests may return to and resume residence in the community after hospitalization or therapeutic leave as outlined in this policy, the community does not exercise a bed-hold option (unless required by contract) for any resident/guests residing in our community and return policy established by the state (if applicable) will apply to resident/guests in the community ...	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		

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F 641	Continued From page 15 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to accurately record that one Resident (R)65 of two residents sampled was receiving Hospice Services in the RAI, Minimum Data Set (MDS). As a result of this deficiency, the facility put R65 at risk for further RAI, MDS inaccuracy. Findings include: During review of R65's most recent MDS, Assessment Reference Date 07/13/23, there was no indication that R65 was receiving Hospice Services. Review of R65's progress notes showed R65 was admitted to Hospice on 03/30/23. During staff interview on 10/25/23 at 09:20 AM, MDS Coordinator (MDSC1) acknowledged that R65 was not marked as receiving Hospice Services. MDSC1 stated that they would do the necessary correction. Review of the Long-Term Care Facility RAI 3.0 User's Manual read the following: The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20(b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status ... In addition, an accurate assessment requires collecting information from multiple sources,	F 641		

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F 641	Continued From page 16 some of which are mandated by regulations ... As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		

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F 655	Continued From page 17 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop and/or implement a baseline care plan that provided effective and person-centered care for 2 of 7 residents (Residents 89 and 16) reviewed for falls. As a result of this deficient practice, the facility placed these residents at risk for avoidable declines and injuries. This deficient practice has the potential to affect all the residents at the facility. Findings include: 1) Cross-reference to F689 Accident Hazards. The facility failed to ensure the Baseline Care Plan for Falls was implemented for Resident (R)89. 2) On 10/25/2023 at 11:42 AM during record review (RR) found R16 had a fall with no injury on 10/23/2023. Reviewed R16's care plan and noted there was no care plan for risk for falls. Reviewed R16's assessment for falls and noted she had one filled out on 08/28/2023 when she was admitted, also on 09/13/2023 and on 10/24/2023	F 655		

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F 655	Continued From page 18 the day after she fell. All three fall assessments has resident rated as high risk for falls. On 10/27/2023 at 09:28 AM met with Resident Care Manager (RCM)2 to discuss R16's care plan for risk for falls. RCM2 was able to open up R16's care plan on R16's electronic health record (EHR) and noted the falls care plan was added to her care plan today (10/27/2023). Inquired if there was anything prior to 10/27/2023 and he stated no. Inquired who is responsible to start the baseline care plan for newly admitted residents and he acknowledged it was him for his section of residents. Requested and received facility policy for "Fall Prevention and Management" with an "original effective date of 05/01/21" and no revision date. Policy states "The facility will maintain a fall prevention and management program. In as much as it is in the power of the facility, the facility will prevent and/or manage the resident's risk for falls. The elderly are at increased risk for falls related to several different factors. The facility will implement a fall program for residents determined to be at risk for falls in order to better manage these factors and prevent and/or manage as much as is possible the resident from falling and/or sustaining injuries related to falling." Under "Details of Key Elements" on page 5 of the policy, it states the following "B. Dynamic Treatment Plan 1. Specific interventions based on results of fall assessments and individual resident's preference. The interdisciplinary team members must address: a. Resident, staff and family teaching b. Room modifications as needed c. Resident's daily routines d. Mental status/ behaviors e. Physical limitations 1. Activities of daily living (ADL) skills 2. Continence 6. Pain 7.	F 655		

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F 655	Continued From page 19 Medication use 8. Non-pharmaceutical interventions in place 9. Consistent appropriate and proper uses of assistive or protective devices, electronic scooter, etc., based on assessments 2. As information is updated, it needs to be communicated to the staff, resident and family. 0. Staff 1. Identify the resident's potential to fall. 2. Summarize assessments and changes needed in services. 3. Individual care plan developed, communicated with staff and implemented..."	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		

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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 observations, record review (RR) and staff interview the facility failed to develop and implement a comprehensive person-centered care plan for 4 of 19 residents sampled (Residents 8, 57, 68 and 69), to meet and maintain their needs for indwelling catheter care, dementia care, and activities of daily living (ADL). As a result of these deficient practices, these residents were placed at risk for a decline in their quality of life and were prevented from attaining their highest practicable well-being. This deficient practice has the potential to affect all the residents at the facility.

Findings include:

1) On 10/24/2023 while rounding with assigned

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residents, observed Resident (R)68 had an indwelling catheter. The indwelling catheter appeared to be draining and was covered by a privacy bag which was hanging from his bed.

Minimum Data Set (MDS) admission assessment completed on 09/14/2023 confirmed resident has an indwelling catheter. RR of R68's care plan found he did not have a care plan for indwelling catheter care. Care plan dated 09/12/2023 for bowel and bladder had short term goal date of 09/26/2023 that "Resident will maintain current level of continence. Bladder: Foley catheter". No other interventions were listed to provide indwelling catheter care to prevent and monitor for infection.

On 10/26/2023 at 01:38 PM met with Resident Care Manager (RCM)2 to discuss R68's care plan. Inquired if R68 had a care plan for indwelling catheter care. RCM2 was able to look at R68's care plan on the electronic health record (EHR) and stated he was not aware that R68's care plan was incomplete, stated resident was admitted before he started working at the facility on 09/18/2023. R68 was admitted to the facility on 09/08/2023. Asked RCM2 how he would know if his assigned resident's care plans were incomplete and he stated he would have to review the care plans and confirmed that he had not done that.

2) During RR of R8's EHR did not find a care plan for dementia care. R8 was admitted with a diagnosis of vascular dementia, unspecified severity, with other behavioral disturbance from 06/15/2016 which is listed on his diagnosis page. MDS Annual assessment dated 07/09/2023 also has R8 documented as having dementia

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F 656	Continued From page 22 (vascular dementia). This resident is also assigned to RCM2. 3) Cross Reference to F676 ADLs/Maintain Abilities. The facility failed to implement ADL (activities of daily living) interventions for R57 to maintain clean eyes to help with her activities such as watching television. 4) Cross-reference to F676 ADLs/Maintain Abilities. The facility failed to implement the interventions in Resident (R)69's Communication Care Plan to improve or maintain his ability to communicate his needs related to his diagnosis of Deaf, non-speaking. Cross-reference to F679 Activities Meet Interest/Needs. The facility failed to develop a resident-centered Activities program that fully identified and met R69's needs related to his diagnosis of Deaf, non-speaking.	F 656		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b)	F 676		

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F 676	Continued From page 23 of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide the necessary care and services to meet the activities of daily living (ADLs) needs of 2 of 3 residents (Residents 57 and 69) sampled for ADLs. Specifically, the facility did not ensure Resident (R)57's hygiene needs were met, and failed to provide the proper care and treatment to improve or maintain the communication abilities of R69. As a result of this deficient practice, these residents were not having their needs met, and were placed at risk of a decline in their physical well-being, psychosocial well-being, and quality of life. This deficient practice has the potential to affect all residents at the facility with hygiene or	F 676		

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communication needs.

Findings include:

1) Resident (R)69 is a 53-year-old male admitted to the facility on 05/10/23 following a stroke with hemiplegia (paralysis of one side of the body) affecting his right side. Other admitting diagnoses include, but are not limited to, dysphagia (swallowing difficulties), adjustment disorder with mixed anxiety and depressed mood, deaf nonspeaking, and cognitive communication deficit (results in difficulty with thinking and how someone uses language). In addition, R69 receives all nutrition, fluids, and medication (except topical) through a gastrostomy tube (G-tube), a tube inserted through the belly that brings nutrition directly to the stomach.

On 10/24/23 at 12:22 PM, observations were made at R69's bedside. His bedside table was on his right (immobile) side, and contained a blank whiteboard with no pen in sight, and the TV remote. The TV was off, and the room was silent. R69 was non-verbal but responsive to greetings with a smile.

On 10/26/23 at 08:58 AM, observations made at R69's bedside. Bedside table was on his right side with a blank whiteboard with no pen in sight, and the TV remote. The TV was off, and the room was silent. R69 had both hands positioned on his chest. He could not move his right hand, but lifted his left hand to wave when greeted.

A review of R69's Comprehensive Care Plan for Communication, initiated on 05/10/23, revealed:

"I am deaf and non-verbal but I am able to read,

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F 676	Continued From page 25 point and use limited gestures to communicate my basic needs." Interventions include "Use communication binder or dry erase board to assist with communication." On 10/26/23 at 09:04 AM, an interview was done with Licensed Practical Nurse (LPN)1 outside R69's room. Asked LPN1 how staff communicated with R69 since he was deaf. LPN1 insisted that R69 was only hard of hearing and not deaf. Was not aware of the admitting diagnosis of deafness, and could not explain it when the diagnosis was pointed out to her by the State Agency (SA) in R69's electronic health record (EHR). LPN1 confirmed that R69 cannot move his right side but can move the arm and leg on his left, and can activate the call light with his left hand. LPN1 also acknowledged that R69 can sign, using American Sign Language (ASL), and does sign at times, but reported that there is no one in the facility that can sign. LPN1 was not aware of the availability of ASL interpreter services. Although LPN1 continued to insist that R69 is not deaf, she did acknowledge that he has a communication deficit and stated that there is a communication board [whiteboard] at the side of the bed. When asked where the pen was for the communication board, LPN1 stated it was next to the whiteboard. Followed LPN1 back into the room where she could not find the whiteboard pen on the bedside table or in the bedside drawer. Asked LPN1 if they had a communication binder for R69. LPN1 dug up the communication binder from under several items on R69's wheelchair. The wheelchair was up against and facing the wall opposite R69's bed. Asked LPN1 how often R69 uses the wheelchair. LPN1 replied that R69 does not get up to the	F 676		

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F 676	Continued From page 26 wheelchair too often because he cannot tolerate sitting in it for a prolonged time without being in pain. LPN1 agreed that not having the communication binder and whiteboard pen right at the bedside makes it appear that no one is using it. On 10/27/23 at 11:30 AM, observed Resident Care Manager (RCM)2 and LPN1 exiting R69's room after seeing him. Observations at R69's bedside confirmed that the bedside table with the whiteboard and TV remote were still placed on R69's right side. The TV was on with the volume turned very low, and no closed captioning. Followed RCM1 and LPN1 out to the nurses' station and asked about the closed captioning not being activated on R69's TV, given his deafness, and about the bedside table with assistive items being placed on R69's right/paralyzed side. Regarding the closed captioning on the TV, RCM1 responded "do we even know if he can read?" Both RCM1 and LPN1 agreed that the bedside table should be on his left, but continued to disagree that R69 was deaf. LPN1 stated that when R69 wants attention, he increases the volume on his TV really loud. LPN1 continued that R69 can also hear the alarm on his tube-feeding pump go off because he always calls when the tube-feeding bag is empty. Both staff members agreed that it was possible R69 increased his TV volume for attention because he had learned that it gets a quicker response from staff than a call light, and that R69 calls when his tube-feeding bag was empty because he could see that it was empty. RCM1 agreed that whether they believed R69 was deaf or not, he should be treated as such until an audiologist evaluation was done, and his diagnosis was changed.	F 676		

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F 676	Continued From page 27 An interview with the Administrator on 10/27/23 at 12:30 PM confirmed that the facility did not have ASL interpreter services available. 2) On 10/24/2023, before noon, went into R57's room to greet and interview resident who was laying in her bed watching television. Noted R57 was barely able to open her eyes with which appeared to have clear, sticky discharge, some of which was starting to become dry and crusty. Inquired of R57 if staff had helped her wash her face that morning but resident did not respond. On 10/26/2023 at 8:40 AM observed R57 in her bed leaning to her right side near the edge of the bed and again with clear, sticky discharge on both of her eyes. Surveyor used the call light to ring for staff and facility staff responded. Inquired of Certified Nurse Assistant (CNA)27 if staff had helped R57 with her morning ADLs. CNA27 stated CNA30 was the staff assigned to work with R57 that morning. Inquired why R57's eyes were messy and CNA27 stated it was due to R57's "radiation" treatment she was receiving in her head. At this time also noted lots of hair loss on R57's pillow which is also due to the radiation treatment. CNA27 was able to help clean resident up with a warm washcloth. On 10/26/2023 at 08:56 AM met with CNA30 who was able to explain what morning ADLs entails. She stated she provides the clean washcloth to R57 to wash herself up. Inquired if she noticed resident's eyes were messy and reported face looked ok, did not notice anything about her eyes this morning, and would encourage her to clean self-up if she were dirty. CNA30 stated there are times R57 refuses to clean self-up but we do our	F 676		

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F 676	Continued From page 28 job by offering and encouraging. On 10/27/2023 at 09:12 AM met with RCM2 and inquired how often ADL assistance is being provided for R57 to assure her eyes/face are clean. He confirmed R57's care plan is "vague", does not state how often hygiene assistance will be provided to assure R57 is able to have clean eyes that do not impede her vision. Reported to RCM2 that facility staff had stated R57 has weepy messy eyes due to radiation she is receiving. RCM2 reported that R57 had completed her radiation treatment on the 10/13/23.	F 676		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure there was an ongoing resident-centered activities program that fully identified and met the resident's needs, for 1 of 3 residents sampled for activities (Resident 69). As a result of this deficient practice, Resident 69 was placed at risk of experiencing a decline in his psychosocial well-being and quality of life. This deficient practice has the potential to	F 679		

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F 679	Continued From page 29 affect all residents at the facility. Findings include: Resident (R)69 is a 53-year-old male admitted to the facility on 05/10/23 following a stroke with hemiplegia (paralysis of one side of the body) affecting his right side. Other admitting diagnoses include, but are not limited to, dysphagia (swallowing difficulties), adjustment disorder with mixed anxiety and depressed mood, deaf nonspeaking, and cognitive communication deficit (results in difficulty with thinking and how someone uses language). In addition, R69 receives all nutrition, fluids, and medication (except topical) through a gastrostomy tube (G-tube), a tube inserted through the belly that brings nutrition directly to the stomach. A review of R69's Activities Care Plan on 10/26/23 revealed the following intervention: "My activities of current/past interest----I like to watch TV and listen to music." 'General activity preferences' and 'personal history,' where the writer would normally put resident-specific information, were both blank. A review of R69's progress notes in his electronic health record (EHR) noted only the following two progress notes documented by Activities since admission: "05/16/2023 Went to do resident activity assessment this writer had a hard time understanding called ... [resident's sister] ... waiting for call back."	F 679		

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"05/24/2023 called resident emergency contact ... on 05/23/2023 and on 05/24/2023 unable to leave voice message."

On 10/26/23 at 12:30 PM, a review of R69's Activity Log from the last three months was done. For the month of August, of the 10 times that an activities' staff member had documented a 'visit': 4 of them was the resident watching TV, twice the staff member sat to watch TV with the resident, once the resident was not in the room, once the resident was asleep, and once the 'activity' was dropping off mail or a facility document (i.e., a menu or calendar).

For the month of September, of the 20 times that an activities' staff member had documented a 'visit': 5 of them was the resident watching TV with staff member not staying to watch with resident, 5 times the resident was asleep, 8 times the 'activity' was dropping off mail or a facility document, and twice the staff member was responding to R69's call light, turned the call light off, and informed a direct-care staff member.

For the month of October, of the 7 times that an activities' staff member had documented a 'visit': twice the resident was asleep, once the resident was "observed" watching TV, and 4 times the activity was dropping off mail or a facility document. In addition, the review found that the same 'visit' was often documented multiple times under different 'Sub-Categories.' For example, on 09/19/23, the same visit (which took minutes) was documented 3 times under the sub-categories of 'One-on-One,' 'Book Club/Reading,' and 'Movie.' Upon closer review of the documentation, the visit consisted of greeting the resident (who happened to be

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F 679	Continued From page 31 watching a movie on his TV), delivering a facility document, and informing a direct-care staff member that R69 needed his personal brief changed. On 10/27/23 at 10:51 AM, an interview was done with the Activities Director (AD) in the dining room. The AD stated that he was not made aware that R69 was deaf. He knew R69 could sign and so the AD had been trying to learn ASL, but did not know he was deaf. Reported that the deaf diagnosis had not been shared at any of R69's Care Conferences or Interdisciplinary Team Meetings. The AD agreed that the information impacted his ability to appropriately plan resident-centered activities. When asked how often activity staff visits a resident who is bed-bound, the AD stated that they try to go in 2-3 times a week, but after a concurrent review of the Activity Log for the past 3 months, the AD agreed that it looks like that wasn't happening. Reviewing the Activity Log closer, the AD agreed that many of the items documented as activities were closer to interactions than activities, and should not be logged multiple times for the same visit.	F 679		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		

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F 689	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 1 of 10 residents (Resident 89) sampled for accidents was free from accident hazards. Specifically, after identifying a newly admitted resident as a Falls Risk, the facility failed to ensure his bed was kept in the lowest position, in alignment with his Baseline Care Plan. As a result of this deficient practice, Resident (R)89 was placed at an increased risk of an avoidable injury, should he suffer a fall out of bed. Findings include: Resident (R)89 is a 73-year-old male admitted to the facility on 10/25/23. His admitting diagnoses include, but are not limited to, a wedge compression fracture (a fracture which usually occurs in the front of the vertebra, collapsing the bone in the front of the spine and leaving the back of the same bone unchanged, which results in the vertebra taking on a wedge shape) of the first lumbar (lower back) vertebra, following a fall on 10/09/23. On 10/26/23 at 08:43 AM, observations were done of R89 as Licensed Practical Nurse (LPN)1 prepared to give him medications. As LPN1 and the Surveyor entered the room, R89 was observed laying in the bed closest to the door with his bed in what appeared to be the highest position. In order to give R89 his oral medication, LPN1 asked him to sit up in bed. R89 sat up to the side of the bed with his legs dangling over, with at least five inches between the bottom of his feet and the floor. After giving him his medication, LPN1 asked R89 if he could get up	F 689		

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out of bed, R89 responded that although he could walk, "I'm on shaky ground." LPN1 reminded him to call for help before getting out of bed, and prepared to leave the room.

At 08:49 AM, asked LPN1 if R89 was at risk for falls. LPN1 responded that R89 had just been admitted the previous day and this was the first time she had him in her assignment. LPN1 continued on to say that she didn't know if he was a falls risk and that is why she reminded him to call for help before getting out of bed. Asked why his bed was left in the high position if she did not know whether he was at risk for falls. LPN1 responded "I can put it down," and returned to the room. LPN1 asked R89 "do you want your bed to be lower?" R89 stated "no, I'm the one that put it like this." It was unclear by the exchange if R89 had been referring to the height of the bed as opposed to the level of the head of the bed, as it had been positioned up at approximately a 75 degree angle. LPN1 left the room a second time with R89's bed left in the high position.

On 10/26/23 at 02:37 PM, while reviewing R89's electronic health record (EHR), the following was noted in his Baseline Care Plan (BCP):

"Problem Start Date: 10/26/23 ... [R89] is at risk for falls related to previous hx [history] of fall on 10/9/23 and overall weakness," with one of the planned interventions being, "Low bed in place, wheels locked."

A review of his progress notes noted 2 Nursing Progress Notes written, with Registered Nurse (RN)7 documenting "Fall prevention and safety education provided ... Bed low locked position," and LPN5 documenting "Fall education given to

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F 689	Continued From page 34 Resident ... Bed in low position."	F 689		
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 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758		

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F 758	Continued From page 35 §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 interviews and record review, the facility failed to provide Gradual Dose Reduction (GDR) to one out of five sampled residents (Resident (R) 27) who is currently on a psychotropic medication. This failed practice has the potential to negatively affect all residents on psychotropic medications which may be clinically contraindicated at a higher dose. Findings include: R27 was admitted to the facility on 11/29/22. R27 has the diagnosis of but not limited to neurocognitive disorder, Parkinson's disease, dementia, and anxiety disorder. A review of R27's Electronic Health Record (EHR) indicated that R27 has been prescribed Lexapro tablet 10mg/once a day for anxiety disorder since being admitted to the facility on 11/29/22. Further review of the R27's EHR showed no indication that a GDR was attempted since 11/29/22. Interview was conducted with Resident Care Manager (RCM) 1 on10/27/23 at 12:35 PM in her office. RCM1 stated that there was no GDR	F 758		

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F 758	Continued From page 36 attempt for R27's Lexapro prescription and he has had the same dose since admission. RCM1 also added that there was no pharmacist recommendation for GDR regarding R27's Lexapro prescription. A review of the facility document titled, "Psychotropic medication, use of," dated 05/01/21 was conducted. The facility document indicated, "Resident who use psychotropic drugs shall receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs."	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 812		

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review, the facility failed to store and label food in accordance with professional standards for food service safety as evidenced by the following observed practices: the facility failed to maintain a clean standing fan in the kitchen, correctly test the temperatures on the tray line, correctly test the sanitizer level of their three-compartment sink in the kitchen, failed to maintain a clean refrigerator in 1 of 2 resident nourishment rooms, and failed to maintain the proper temperature for food safety in the refrigerator of the other resident nourishment room. Residents (R) risk serious complications from foodborne illness as a result of their compromised health status. Unsafe and/or unsanitary food handling practices represent a potential source of pathogen exposure for all residents at the facility able to consume food orally.

Findings include:

1) On 10/24/2023 at 10:23 AM while doing the initial tour of the kitchen noted the standing fan facing the three-compartment sink area was heavily soiled with a thick layer of dust. Inquired about the standing fan with the Food Service Manager (FSM) who stated it is scheduled for a cleaning on Monday (10/30/2023). Inquired if the facility is having a vendor clean the fan and the FSM stated he is the one who will be cleaning it with a pressure washer once it is available for his use.

2) On 10/24/2023 at 11:10 AM observed tray line. Dietary cook (DC)1 started taking temperatures of the food that was on the tray line and noted the time exceeded fifteen seconds. Inquired of DC1 how long she is to test the temperature of the food on the trayline and she stated "one minute?"

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LEGACY HILO REHABILITATION & NURSING CENTER	563 KAUMANA DRIVE HILO, HI 96720

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F 812	Continued From page 38	F 812		

Looked at FSM who stated this was how the kitchen staff have been taking it. Notified kitchen staff the tray line food temperature checks are done with a fifteen second hold.

3) On 10/25/2023 at 08:51 AM went to the kitchen to observe testing of the sanitizer of the three compartment sink. Encountered a dietary cook (DC)1 who was at the sink and asked her to check the sanitizer. DC1 left the area to get her supervisor, FSM. Once both staff were present requested the DC1 perform the test on the sanitizer to assess the level of chemicals present. Test strip container was passed to DC1. She stood in front of the sink and looked at FSM who nodded at her. She tore off a piece of test strip and dipped it into the water. During this interaction it did not appear that DC1 knew how to do the sanitizer level checks. A poster with instructions on how to test the sanitizer is posted at the sink that gives step by step instructions on how to do the testing per the manufactures instructions with the safe range that staff compare the dipped strip to. Surveyor checked the expiration date on the sanitizer test strips and noted it was expired with the expiration date of "Sep 1, 2020". Inquired with the FSM when he received these test strips and he was not able to answer, stated he did not know the test strips had an expiration date. Inquired if testing the sanitizer is annual training for kitchen staff and FSM stated staff get trained when they first start but he did not believe this was included with annual training. Review of the kitchen logs for sanitizer testing showed three or more different staff initials which the FSM confirmed are staff who do the testing on a regular basis.

4) On 10/25/23 at 09:40 AM, inspected the

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resident refrigerator (fridge) in 1 of 2 nourishment rooms. Observed a bag with 4 unlabeled frozen dinners/snacks in an unlabeled bag in the freezer. Also observed an unlabeled frozen dinner in the freezer door compartment. Both the freezer and the fridge were dirty. The fridge had dried orange liquid droppings, the sandwich bins had crumbs and debris, and underneath the bottom drawers, more debris was visible. The freezer also had dried orange liquid drops. Validated with Certified Nurse Aide (CNA)27 that the fridge and freezer were for residents only, and that all items in the fridge should be labeled. CNA27 also validated the dirty state of the fridge and freezer. Stated that kitchen staff are responsible to check the fridge, restock (with juice and snacks), and wipe it down daily. On the side of the fridge as one enters the nourishment room, observed the following on a Nourishment Schedule Check log (separate from the temperature check logs):

"1. Every shift to check all opened juices and food is dated. Any opened juice and not dated need to be tossed.

[bullet point] See attached for food storage by the family or visitor policy [no attached policy]."

The log had space below that for date, shift, zone, name of person checking. Only 4 checks were documented: 08/23/23, 08/24/23, 08/31/23, 09/03/23.

A review of the policy Foods Brought by Family/Visitors, last revised July 2017, noted the following:

"Perishable foods ... in the refrigerator ... will be labeled with the resident's/guest's name, the item

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F 812	Continued From page 40 and used within 3 days." 5) Observation was conducted on 10/25/23 at 10:50 AM in the nourishment room. The thermometer reading in the refrigerator was 48 degrees Fahrenheit. The thermometer was observed on the refrigerator door. Observation was conducted on 10/25/23 at 02:53 PM in the nourishment room. The thermometer reading in the refrigerator was 46 degrees Fahrenheit. The thermometer was observed on the refrigerator door. Observation and interview were conducted on10/25/23 at 02:59 PM in the nourishment room. Food Service Manager (FSM) was queried about the normal temperature for food storage in the refrigerator. FSM replied that the temperature should be around 38-40 Fahrenheit. When the thermometer on the refrigerator door was checked, the reading indicated 45 degrees Fahrenheit. FSM stated that the temperature in the refrigerator was not within the normal range and should be colder.	F 812		
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.	F 880		

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F 880	Continued From page 41 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 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	F 880		

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F 880	Continued From page 42 (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 policy review, the facility failed to ensure proper glove use procedures were followed by a staff member. This deficient practice places the residents at risk for the development and transmission of communicable diseases and infections. Findings include: Observation was conducted on 10/24/23 at 02:32 PM. Registered Nurse (RN) 8 was observed walking in the hallway from his medication cart parked outside room 124 to room 134 with gloves on. RN8 then knocked and entered room 134 and closed the door. Concurrent observation and interview were conducted on 10/24/23 at 02:51 PM. RN8 was observed leaving room 134 with gloves on, walked down the hallway, and removed the gloves at the nurse's station. When asked if he was supposed to have gloves on in the hallway,	F 880		

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F 880	Continued From page 43 RN8 answered, "no." A review of the facility document titled, "Glove Use," dated 10/01/22 was conducted. The document indicated, "Used gloves should be discarded into the waste receptacle inside the room."	F 880		