POC NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125032	A. BUILDING ______ B. WING ______	12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE HO'OLA HAMAKUA	45-547 PLUMERIA STREET HONOKAA, HI 96727

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on December 8, 2023. The facility was found not to be in substantial compliance with 42 CFR 483, Subpart B. A facility reported incident from Aspen Complaints/Incidents Tracking System (ACTS # 10661) was also investigated and was not substantiated. Survey Dates: 12/05/23 to 12/08/23 Survey Census: 51 Sample Size: 17 Supplemental residents: 1	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		1/22/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 12/29/2023

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

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interview with a resident and record review, the facility failed to provide treatment and care in a manner that promoted his or her quality of life for one of 17 residents (Resident (R) 25) in the active case sample. This deficient practice has the potential to affect the resident's psychosocial well-being. Findings include: Record review noted R25 was admitted to the facility on 06/05/19. A review of her quarterly Minimum Data Set with an assessment reference date of 10/13/23 documents R25 is cognitively intact. R25 also requires substantial assistance to roll from left and right and is dependent on helper to transfer to and from a bed to a chair (or	F 550	Corrective action of residents found to be affected by the deficient practice: Resident 25 was interviewed by the Director of Nursing on December 27, 2023, regarding these issues and a formal grievance was filed. Resident was not able to name specific staff members that were rough during incontinent care and mechanical lift transfer. She stated that they were not intentionally being rough, but that because she has chronic pain, they don□t realize they may be rough, and that if they tell her what they are going to do, that would be helpful. Resident 25 agreed that staff education ensuring staff explain what they will be doing, and also	

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F 550 (Summary Statement of Deficiencies)

Continued From page 2
wheelchair).

On 12/06/23 at approximately 11:30 AM an interview was conducted with R25. R25 reported sometimes staff members are rough during care, specifically while providing incontinence care and during transfer via mechanical lift. R25 explained staff members push or pull her side to side while cleaning her. She also explained during transfer, staff will put her back on the bed or lift her without warning, stating this action could "snap my neck." R25 clarified if staff would explain to her what they will be doing, she can brace herself or be prepared for the movement.

R25 also shared that she had to wait 45 minutes for call light response, and she gets frustrated when nobody responds. R25 reported she usually calls for assistance at night as she wants to have her personal brief changed before going to sleep. R25 further reported that it would be "fine" if staff respond and let her know that they are currently helping another resident and will be back.

R25 expressed concern that the facility seems to have only one sling for the mechanical lift. R25 explained that if her sling becomes soiled and sent to the laundry, she stays in bed and can't go out to activities. She also questioned why some staff can find an extra sling and there are times when she is told there is no sling available.

F 550 (Provider's Plan of Correction)

being more aware when caring for residents with chronic pain would be an acceptable resolution.

The resident was also not able to name staff members, or dates or times that the staff took a long time to answer call lights. She stated that one time, it took 45 minutes for a staff member to answer her call light, but it was a long time ago, maybe even a year. Resident 25 stated that staff education on the importance of answering call lights in a timely manner would be an acceptable resolution.
Additional slings were ordered on December 27, 2023.

IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED:

All residents have the potential to be affected by this deficiency.
A facility wide audit was completed to identify residents with chronic pain issues. The care plans for these residents were updated and a list of residents were added in the nursing report room to inform staff of those that may be more sensitive during care.

Facility wide audit was completed to ensure an adequate number of slings available for residents and order for additional slings was placed on December 27, 2023.

MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE

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F 550	Continued From page 3	F 550	Education will be provided to all nursing staff on AIDET and how to care for residents with chronic pain. Leadership rounds will be conducted weekly to evaluate the resident experience. The question, Has anyone treated you roughly? has been added to these rounds. In addition, weekly leadership observations will be completed with staff to ensure proper use of AIDET. No Pass Zone will be implemented in the facility and the staff will be educated on this new process. All staff members should answer call lights when they are activated. If the staff member is unable to assist the resident because the request is outside of their scope, they will let the resident know that they will notify the appropriate staff. If a staff member is unable to help the resident at that particular time, they will let the resident know when they can return to complete the task. Focus Rounds for call light observation will be developed. Extra slings will be kept in the supply room. Staff will be educated on the location. Focus Rounds will be developed and weekly checks will be completed to ensure an adequate supply of slings are available. The Director of Nursing or designee will be responsible for ongoing compliance. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS	

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F 550	Continued From page 4	F 550	Focus Rounds on call light observations and monitoring of slings will be reviewed weekly x 90 days or until 100% compliance is met. The results of the leadership rounds and observations will be reviewed weekly x 90 days or until 100% compliance is met. The results of these rounds will be reported in QAPI to monitor the effectiveness of these changes and to ensure correction is achieved and maintained.	
F 572 SS=D	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is not met as evidenced by: Based on interview with the resident council, the	F 572	Corrective action of resident identified:	1/22/24

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F 572	Continued From page 5 facility failed to ensure residents were provided ongoing communication regarding where to find the State Agency (SA) report with survey results and the facility's plans of correction, and information on how to file a complaint with the SA and Long-Term Care Ombudsman (LTCO) should they want to exercise these rights. Findings include: On 12/06/23 at 11:00 AM an interview was conducted with four resident council representatives. Asked the residents if the State inspection was available to read. The representatives were not aware of the location of the survey results, and that the report was available for them to review. Upon query, the representatives were not aware of where the LTCO's contact information was posted. Also, the representatives could not recall being provided with information on how to formally file a complaint with the SA. A review of the facility's hospitality book does not include information for reviewing the survey results, LTCO information, and how to file a complaint with the SA.	F 572	Social services reviewed the list of residents present at the resident council meeting held with the state agency surveyor on 12/6/2023. Residents 16, 25, 33 and 39 were educated by the social worker on the location of the survey results and how to file a complaint with the Office of Healthcare Assurance and the LTC Ombudsman on 12/27/2023 and 12/28/2023. IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED: All residents have the potential to be affected by this deficiency. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE Written communication on the location of the survey results and how to contact the Office of Healthcare Assurance and the LTC Ombudsman was provided to current residents and their family members on 12/28/23. The location of the survey binder and also the Nursing Home Compare website link was added to the facility�s Hospitality book on 12/28/23, which is included in the admission packet. Information on how to file a complaint with the Office of Healthcare Assurance and LTC Ombudsman, along with addresses and phone numbers, were added to the facility�s Hospitality book on 12/28/23,	

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F 572	Continued From page 6	F 572	which is included in the admission packet. Social services will meet with new admissions to review the location of the survey results and how to contact the Office of Healthcare Assurance and LTC Ombudsman. Information on the location of the facility□s survey results and how to contact the Office of Healthcare Assurance and the LTC Ombudsman has been added as a standing agenda item at every resident council meeting. The Social Worker or designee will be responsible for ongoing compliance. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS The social services department will audit all admissions for 90 days, or until 100% compliance is met, to ensure that information on the location of the facility□s survey results and how to contact the Office of Healthcare Assurance and the LTC Ombudsman is documented. The resident council minutes will be audited monthly x 3 months to ensure that the information on the location of the facility□s survey results and how to contact the Office of Healthcare Assurance and the LTC Ombudsman is provided at each resident council meeting. The results of these audits will be reported in QAPI to monitor the effectiveness of these changes and to ensure correction is achieved and	

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F 572	Continued From page 7	F 572	maintained.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced	F 583		1/22/24

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F 583	Continued From page 8 by: Based on observation and interview with staff, the facility did not assure a resident was provided with personal privacy during incontinence care. Findings include: On 12/06/23 at 08:56 AM observed the curtain was drawn to block view into the residents' room. Knocked at the door, peered around the curtain, and observed R48 lying on his right side with his left lower extremity exposed from the waist down. Further observed the curtain between the roommates was not fully drawn, R36 was sitting up in bed and could view his exposed roommate. Interview with Certified Nurse Aide (CNA)5 was done. CNA5 reported that she closed the curtain between the residents, however, R36 opened it. CNA5 reportedly told the resident not to open the curtain. Inquired whether R36 does this all the time, initially CNA5 responded yes. CNA5 then clarified, this was the first time she observed this behavior. Upon further query, CNA5 stated she would speak to the nurse. Subsequent observations on 12/06/23 at 10:08 AM and 01:02 PM found the curtain between the residents was fully closed.	F 583	Corrective action of residents found to be affected by the deficient practice: CNA 5 was educated on privacy curtains and room dividers on 12/28/2023. Resident 48s care plan was updated on 12/28/23 to include the intervention, My roommate will sometimes open up the privacy curtain between our beds while staff are providing care. Use a clip to secure the privacy curtain when providing care and as needed. Resident 36s care plan was updated to include the intervention, Remind me not to open the privacy curtain between my bed and my roommates bed. IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED: Staff were interviewed to determine if they had encountered similar instances with other residents. No other individuals were identified as having this behavior. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE Education on privacy curtains and room dividers will be provided for all nursing staff. Focus rounds for observations on resident care and the provision of privacy will be developed. The Director of Nursing or designee will	

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F 583	Continued From page 9	F 583	be responsible for ongoing compliance. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS The focus rounds will be completed and reviewed x 90 days or until 100% compliance is met. The results of these focus rounds will be reported in QAPI to monitor the effectiveness of the changes and to ensure correction is achieved and maintained.	
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 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.	F 623		1/22/24

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F 623	Continued From page 10	F 623		

Continued From page 10

(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), 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

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F 623	Continued From page 11 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 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 and interview with staff member, the facility did not ensure the notice of transfer/discharge contained the required contents; a copy of the notice is sent to the Long-Term Care Ombudsman (LTCO); and a resident transferred from the facility's long-term care/nursing to the critical access hospital was	F 623	Corrective action of residents found to be affected by the deficient practice: Resident 54 was discharged on 09/07/2023. Resident 55 was discharged on 10/12/2023. The forms for these residents were not able to be updated.	

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F 623	Continued From page 12 not provided written notice of transfer for 2 (Residents 54 and 55) of 2 residents in the sample. Findings include: 1) Resident (R)54 was admitted to the facility on 08/03/23 and discharged to an acute hospital on 08/13/23. R54 was readmitted on 08/22/23 and discharged on 09/07/23 to an acute hospital. On 12/07/23 at 01:29 PM the facility provided fax confirmation of notification to the LTCO of R54's discharges. The facility sent notice of the discharge log to the LTCO. Review of the discharge log documented the resident's admission date, discharge date, name of resident, and discharge disposition (discharge location) At approximately 02:15 PM, the facility provided copies of the transfer/discharge notices that were provided to R54. The "LTC Transfer/Discharge Notice" forms were reviewed. The content of the form did not include the following, a statement of the resident's appeal rights (including contact information and information on how to appeal); contact information for the LTCO; and for residents with intellectual and developmental disabilities and residents with a mental disorder the contact information of the state's protection and advocacy authorities. Also review of the notice dated 08/12/23 noted the form was incomplete. The effective date of transfer/discharge and transfer/discharge location were left blank. On 12/07/23 at 02:15 PM interviewed the	F 623	The Discharge/Transfer notice was updated on 12/28/2023 to include verbiage on the resident□s right to appeal. The Discharge/Transfer Notice form provided by the Hawaii LTC Ombudsman Program was completed for all residents that were discharged or transferred in the last 30 days and submitted to the Hawaii State Long Term Care Ombudsman office. IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED: All residents that are being transferred to another facility or discharged from the facility have the potential to be affected by this deficiency. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE The Discharge/Transfer Notice policy was updated on 12/28/2023 to include a revised LTC Transfer/Discharge Notice form and the Discharge/Transfer Notice from the Hawaii LTC Ombudsman Program. A copy of the LTC Transfer/Discharge Notice form was added to the facility□s transfer packet. Education on the updated Discharge/Transfer Notice policy and the	

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	125032	A. BUILDING ______ B. WING ______	12/08/2023

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F 623	Continued From page 13 Administrator. The Administrator reported notice is sent to the LTCO. Inquired whether the LTC Transfer/Discharge Notice with the required content is sent to the LTCO. Administrator was not sure whether the form was sent to the LTCO. Administrator deferred to the Social Worker (SW). On the morning of 12/08/23 SW was not available for interview. Left a message with the SW Assistant requesting to meet with the SW regarding transfer/discharge. Prior to exit, the SW was not available for interview. 2) R55 was admitted to the facility on 10/11/23. R55 was transferred to the facility's critical access hospital for wound care. On 12/07/23 at 02:15 PM, the Administrator reported a written notification was not provided as the facility did not recognize the transfer from their long-term care facility to the critical access hospital as a transfer. A review of the facility's policy for "Discharge/Transfer Notice" does not include the required contents of the notice, specifically appeal rights, and contact information for both the LTCO and advocacy authorities for persons with developmental disabilities and/or mental disorder.	F 623	revised LTC Transfer/Discharge Notice form will be provided to all licensed nurses. Education on the updated Discharge/Transfer policy and the Discharge/Transfer Notice from the Hawaii LTC Ombudsman Program will be provided to the social services department. The Director of Nursing or designee will be responsible for ongoing compliance. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS All transfers and discharges will be audited for the next 90 days or until 100% compliance to ensure that the residents and the state ombudsman□s office were given the appropriate transfer/discharge forms. The results of this audit will be reported in QAPI to monitor the effectiveness of the changes and to ensure correction is achieved and maintained.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		1/22/24

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F 690	Continued From page 14 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to provide appropriate services to prevent urinary tract infections for one of the two residents (Resident (R) 34) in the sample. The deficient practice exposed the resident to contaminants that may cause preventable urinary tract infections. This has the potential to affect all residents with a urinary catheter.	F 690	Corrective action of residents found to be affected by the deficient practice: RN 8 was educated on catheter care and proper placement of collection bag and tubing for residents on a wheelchair. In addition, the CNAs that were assigned to that unit were also educated. Resident 34s care plan was updated to	

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F 690

Continued From page 15

Findings include:

On 12/05/23 at 02:38 PM, observed R34 sitting up in a wheelchair in his room. R34 had a urinary catheter tubing connected to a collection bag placed in a dignity cover that was hung under the wheelchair seat. Both the urinary catheter tubing and collection bag were touching the floor.

On 12/06/23 at 11:19 AM, review of Electronic Health Record (EHR) for R34 conducted. R34 is a 69-year-old resident admitted to the facility on 09/17/21. Diagnoses include hemiplegia and hemiparesis (paralysis and weakness on one side of the body), benign prostatic hyperplasia (noncancerous enlargement of the prostate gland), and neuromuscular dysfunction of bladder (lack of bladder control due to brain, spinal cord, or nerve problem). R34 was also taking Ciprofloxacin (oral antibiotic) for a urinary tract infection.

On 12/07/23 at 09:43 AM, observed R34 sitting in a wheelchair in the Pau Hana room watching television. Urinary catheter tubing and collection bag were touching the floor. At 09:52 AM, Registered Nurse (RN) 8 pushed R34 closer to the medication cart that was in the hallway outside of the Pau Hana room to administer oral medications. As RN8 transported R34, both the urinary catheter tubing and the collection bag were dragging on the floor.

On12/07/23 at 01:50 PM, interview with the Infection Preventionist (IP) was conducted in her office. IP confirmed that both the urinary catheter tubing and collection bag are not supposed to be touching the floor for infection control.

F 690

include the intervention, Ensure that catheter tubing and collection bag are not touching the ground/floor.

IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED:

Facility wide audit was completed to identify residents with indwelling catheter use. The care plans for these residents were updated.

MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE

Education will be provided for all nursing staff on catheter care and proper placement of collection bag and tubing for residents on a wheelchair.

Focus rounds will be developed to include observations of residents with urinary catheters and proper placement of collection bags and tubing.

The Director of Nursing or designee will be responsible for ongoing compliance.

MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS

The focus rounds will be completed and reviewed x 90 days or until 100% compliance is met. The results of the focus rounds will be reported in QAPI to monitor the effectiveness of the changes and to ensure correction is achieved and maintained.

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F 755 SS=D	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 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 observation, interview with staff, and review of the policy and procedures, the facility did not assure drug records for controlled drugs were maintained. This deficient practice has the	F 755	Corrective action of residents found to be affected by the deficient practice: The narcotic log was reviewed and	1/22/24

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F 755	Continued From page 17 potential for possible drug diversion. Findings include: On 12/07/23 at 02:02 PM concurrent observation was done with Licensed Practical Nurse (LPN)8 and LPN9. A review of the "Narcotic Count Medication Room/Lock Cabinet" form found missing nurse signatures. Concurrent review of the log with LPN8 noted there were no nurse signatures for the off duty and on duty nurse for 12/06/23 at 11PM and no off duty signature for 12/07/23 at 7AM (the on duty nurse for this shift signed the log). Further review found missing signatures for 11/20/23 (off duty at 7AM); 11/10/23 (off duty at 3PM); 11/06/23 (on duty at 7AM and off duty 3PM); 10/28/23 (off duty at 7AM); 10/23/23 (off duty at 7AM); 10/22/23 (on duty at 11 PM); and 10/08/23 (off duty at 7AM). Inquired why is it important for the licensed nurses to sign the log for narcotic counts/reconciliation. LPN8 responded to show that the medications were counted. LPN9 responded to ensure there is no diversion of the medications. The facility provided policy and procedure, titled, "Medication Storage - Controlled Medication Storage" with the following procedure: "At each shift change or when keys are surrendered, a physical inventory of Schedule II, including refrigerated items, is conducted by two licensed nurses or per state regulation and is documented on the controlled substances accountability record or verification of controlled substances count report. The nursing care center may elect to count all controlled medication at shift change." Procedure also includes, "Current controlled	F 755	missing signatures were obtained by 12/28/23. The staff members that were identified as not appropriately signing the narcotic logs were educated by 12/28/23. IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED: All residents that are ordered controlled substances have the potential to be affected by this deficiency. A review of all narcotic logs for the last three months was completed and signatures obtained. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE All licensed nurses will be educated on Pharmerica�s Controlled Substances policy. The controlled substance log will be reviewed weekly to verify that it is complete with all necessary signatures. The Director of Nursing or designee will be responsible or ongoing compliance. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS An audit of the controlled substance log will be completed and reviewed x 90 days or until 100% compliance is met. The	

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F 755	Continued From page 18 medication accountability records are kept in MAR or narcotic book. When completed, accountability records are submitted to the director of nursing and maintained on file at the nursing care center." On 12/08/23 AM at 09:37 AM interview with the Director of Nursing (DON) confirmed there are some missing signatures on the log. DON stated she attributes some of the missing signatures to nurses working doubles and only signing it once.	F 755	results of the audit will be reported in QAPI to monitor the effectiveness of the changes and to ensure correction is achieved and maintained.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		1/22/24

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F 880	Continued From page 19 procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its	F 880		

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F 880	Continued From page 20 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement the facility's infection prevention and control measures. Facility did not ensure that staff were wearing applicable personal protective equipment (PPE) when providing care to two residents (Resident (R) 41 and 12) on Transmission Based Precautions (TBP). This deficient practice placed the residents at risk for the potential spread of infections and communicable diseases. Findings include: 1) On 12/06/23 at 08:56 AM, observed signage next to R41's door indicating she was on "Droplet Plus Precautions". R41 was sitting in a wheelchair with her breakfast tray on a table in front of her. R41 was not wearing a mask and was telling the staff that she wanted to come out of her room. Certified Nurse Aide (CNA) 3 entered the room to check on R41 without any PPE other than a surgical mask. CNA3 explained to R41 that she needed to stay in her room for now and asked her if she was done with her meal. R41 said she was done eating and CNA3 brought the tray to the cart that was out in the hallway. As CNA3 was walking out of the room, R41 tried to follow her out the room. As R41 approached the door, another CNA asked her to, "Please stay in the room for now, we'll be right with you." At that time, Registered Nurse (RN) 3 was passing by the room and approached R41 by the door. RN3 was only wearing a surgical mask and was touching R41's shoulder to comfort her. Surveyor pointed out the sign by the door to RN3 and asked her if R41 was on TBP. RN3 replied,	F 880	Corrective action of residents found to be affected by the deficient practice: Resident 12 and Resident 41 were both removed from transmission-based precautions on 12/8/2023. CNA 3, RN 3 and RNA 1 were educated on transmission-based precautions on 12/28/2023. IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED: All residents have the potential to be affected by this deficiency. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE CNA 3, RN 3 and RNA 1 were interviewed to determine how to better alert the staff to residents on transmission-based precautions. Systemic changes were made based on the results of these interviews. In order to easily distinguish between enhanced barrier precautions and transmission-based precautions, residents on enhanced barrier precautions will have their PPE stored in isolation hangers placed on the doors and residents on transmission-based precautions will have their PPE stored in a cart in the hallway. Isolation hangers	

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F 880	Continued From page 21 "Yes." and started putting on gown, gloves, N95 mask and face shield. 2) On 12/07/23 at 12:52 AM, observed a "Droplet Plus Precautions" signage posted by R12's room. Restorative Nursing Assistant (RNA) 1 was helping distribute the lunch trays at the Maile Wing. RNA1 entered R12's room to bring her meal tray wearing only a surgical mask. RNA1 was in the room with R12 for approxiamtely three minutes as she set up her lunch on the bedside table. Review conducted of facility's infection prevention and control program last reviewed in June 2023. Stated under "10. Droplet Plus", ". . . f. Perform Hand Hygiene and wear a N95 mask, face shield and gown upon entry into the resident room and when working within three feet of the resident. . . " On 12/07/23 at 01:52 PM, interview with the Infection Preventionist (IP) was conducted in her office. IP confirmed that the staff entering any room where the resident is on TBP should be wearing N95 mask, gown, face shield and gloves.	F 880	were ordered on 12/28/2023. The charge nurse will use the Patient Touch phone system to notify staff when a resident is placed on transmission-based precautions. All nursing staff will be educated on Transmission-Based precautions. Focus rounds will be developed to monitor for proper donning of PPE when entering a room of a resident on transmission-based precautions. The Infection Preventionist or designee will be responsible for ongoing compliance. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS The focus rounds will be completed and reviewed x 90 days or until 100% compliance is met. The results of the focus rounds will be reported in QAPI to monitor the effectiveness of the changes and to ensure correction is achieved and maintained.	