STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125057	A. BUILDING _____ B. WING _____	06/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) from June 3, 2024 to June 6, 2024. The facility was found not to be in substantial compliance with 42 CFR §483, Subpart B. On 06/06/24 the SA found F689 and F760 Past Non-Compliance on 06/05/24 through record review and staff interview conducted on 06/06/24. The facility was notified during the exit conference. Survey Dates: 06/03/24 - 06/06/24 Survey Census: 30	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		

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

Electronically Signed

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 observation, interview and record review, the facility failed to enhance one Resident (R)6 of 12 residents in the sample's quality of life while in her room in bed. Music, television, or other auditory stimulating activities were not provided to the resident. The deficient practice dishonored the residents right to a dignified existence. Findings include: Random observations of Resident (R)6 on the following dates and times: 06/03/24 at 08:35 AM and 3:00 PM; 06/04/24 at 09:35 AM and 2:35 PM; and 06/05/24 at 08:35 AM. Observed R6 in bed awake with eyes closed or sleeping. The room was quiet without television or music playing.	F 550		

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F 550	Continued From page 2 On 06/04/24 at 11:26 AM a telephone interview was conducted with R6 family member (FM). During the interview, the FM said, it really bothers me that her room is so quiet, they need to put the television on with cartoons or something. I have spoken to them several times about it and half the time they turn the television on. On 06/05/24 at 2:46 PM, interviewed the Recreation Coordinator (RC). When asked when the residents are in their room in bed why some rooms have a television on or music playing, and others don't. The RC replied, it depends on the resident's level, the more active ones might have an IPAD or a cell phone, toys, or a hanging mobile. For the others who aren't, and they are dependent, they should have a television unless it's time to go to sleep. Electronic medical record reviewed. Minimum data set annual dated 03/24/2024. R6 is Comatose and in a persistent vegetative state. Care plan dated 09/20/22 reviewed. Activities interventions: Sensory stimulation activities auditory, visual, tactile. TV/Movies. On 06/06/24 at 08:20 AM, observation in R6's room. Noted the room was quiet without any television or music playing. The Registered Nurse (RN)25 was repositioning R6's bed. The surveyor asked RN25 why the room doesn't have any television or music playing. RN25 stated, well it is dayshift, so activities will be coming in and later. RN25 turned on the television to a channel with sporting activities. Activity programs policy MED-PASS, Inc. revised June 2018 reviewed. ...4. "Activities" are	F 550		

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F 550	Continued From page 3 considered any endeavor, other than routine ADLs, in which the resident participates, that is intended to enhance his or her sense of well-being and to promote or enhance physical, cognitive, or emotional health...	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting	F 584		

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F 584	Continued From page 4 levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure a clean environment for one resident ((R)12) sampled. The mesh netting on the inside of R12's crib became soiled during care and staff did not change or clean the mesh. R12 regularly puts her legs vertically on the mesh which increases the resident's likelihood of encountering the soiled mesh. As a result of this deficient practice, residents with mesh on the inside of the crib have an increased potential for exposure to an unsanitary environment. Findings include: On 06/03/24 at 08:45 AM, conducted an observation of Certified Nurse Aide (CNA)25 and Registered Nurse (RN)99 providing peri-care for Resident R12. The resident had a large bowel movement (liquid consistency). Staff lowered the right bedrail and the mesh netting on the inside of the crib was in direct contact with the soiled bedsheet, which then soiled the mesh. Observations of R12 lying horizontally on the bed with her legs up against the mesh on 06/03/24 at 08:45 AM and 02:23 PM, 06/04/24 at 03:12 PM, 06/05/24 at 09:43 AM and 01:50 PM. On 06/06/24 at 11:25 AM, conducted a	F 584		

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F 584	Continued From page 5 concurrent interview and record review with RN25. RN25 reviewed the resident's bowel movement log located in the resident's room and confirmed on 06/03/24, R12 had a large watery bowel movement. RN25 visually inspected the mesh netting and confirmed the mesh on the inside of R12's crib was soiled and needed to be changed. Staff changed the mesh and cleaned R12's mattress/bedding.	F 584		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up	F 661		

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F 661	Continued From page 6 care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the following at the time of the resident's discharge for one resident (R) 32 of four in the sample: Communication of necessary information to one resident and the residents care giver; document a concise summary from the physician of the residents stay and course of treatment in the facility; and reconciliation of medications. Findings include: On 06/04/24 at 2:36 PM, Electronic Medical Record (EMR) reviewed. R32 is a 23-year-old male admitted to the facility on 11/11/23 and discharged on 04/29/24. Diagnosis includes spastic diplegic cerebral palsy, localization related (focal partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, acute respiratory failure with hypoxia, and tracheostomy. Physicians discharge summary dated 04/29/24 reviewed. The Physician hand wrote a note that stated "Had stable course." On 06/04/24 at 3:03 PM, confirmed with the Social Services Director (SSD) that R32 was a voluntary discharge. The surveyor requested the discharge summary, post discharge plan of care and the last care conference meeting notes. Received and reviewed the discharge summary for R32. Summary: "had stable course" signed by Primary physician, and dated 05/02/24.	F 661		

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F 661	Continued From page 7 Admission care conference summary dated 01/11/24 reviewed. Social work report. ...The family anticipates that he will reside at the facility for three to four months. Care conference summary discharge dated 04/12/24 reviewed. Social work follow up. No follow-up needed. Patient discharging on Monday 04/29/24. Care plan for R32 reviewed. Anticipated discharge to be within the next three to four months. The decision makers overall goal established in initial assessment is to have R32 return to the community once in home, nursing can be provided once again. Requested a copy of the discharge orders from the physician and the discharge instructions form from the Administrator on 06/06/24 at 10:45AM. At 11:25AM, the Administrator and the Registered Nurse (RN)23, who was assigned charge nurse on the day of discharge, discussed the discharge with the surveyor. RN23 verified with the surveyor that she verbally went over the checklist with R32's caregiver at the time of the discharge, and did not complete a discharge instruction form or document the discussion in the EMR. Orders reviewed. No discharge orders from the physician were found and the surveyor verified with the Administrator on 06/06/24 at 11:45 AM. Transfer of resident policy 10/2018 reviewed. Discharge of resident (nursing). Procedure: 1. All discharges require a physician order... 6. If the resident is being discharged to home, the assigned nurse must complete the discharge instructions form and review the following with the resident and responsible party: a. Medication...c.	F 661		

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F 661	Continued From page 8 Equipment if any... e. Follow up physician visits... A copy of the discharge instructions is given to the resident/responsible party. The original is left in the chart.	F 661		
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. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure a resident's environment remains free of accident hazards for one resident (R27) sampled. Past non-compliance was determined for an incident on 03/01/24, R27 had an unwitnessed fall from the crib. The facility was not in compliance for accident hazard at the time the fall occurred, the noncompliance happened after the last survey date and prior to this survey, and there was sufficient evidence that the facility corrected the noncompliance and was in substantial compliance at the time of the current survey related to falls. However, in response to the fall, the facility installed a crib canopy, but did not conduct a safety assessment or assess for potential accident hazards for R27 after the canopy was implemented. As a result of this deficient practice, residents with newly implemented equipment are at a potential risk of harm resulting from an accident hazard.	F 689		

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F 689	Continued From page 9 Findings include: 1) Past non-compliance was determined for an unwitnessed fall R27 sustained on 03/01/24. Review of the facility's investigation documented at approximately 03:30 PM- 03:40 PM, staff suctioned the resident's tracheotomy (an opening surgically created through the neck into the trachea (windpipe) to allow air to fill into the lungs, a tube is inserted through it to provide an airway and to remove secretions from the lungs) and brought the railing up and left the room. At approximately 04:00 PM, staff went into R27's room and found the resident on the ground. The resident's gastro-jejunal (GJ) tube balloon was dislodged, and the stoma was open and completely exposed. A ST button (a low-profile tube) was inserted into the stoma and notified the physician. Post fall, the facility completed a root cause analysis of the fall, staff training (Fall Prevention and Safety, Locking Crib Rails, and Raising Side Rails), completed a physical therapy assessment of R27 functional abilities, revised the care plan with interventions which included implementing a canopy for the crib. 2) R27 is a 2-year-old female who was admitted to the facility on 11/01/22 with diagnosis which include George's syndrome, paralysis of vocal cords and larynx, chronic respiratory failure, tracheostomy, gastrostomy, dysphagia, pulmonary hypertension, dependence of respirator (ventilator), hypoxic ischemic encephalopathy (a type of brain injury that occurs when the brain experiences a decrease in oxygen or blood flow before, during, or after birth). R27 has a Preadmission Screening and Resident Review (PASRR) Level 2 condition of mental	F 689		

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F 689	Continued From page 10	F 689		

retardation and is totally dependent on staff for all care and needs.

As a result of the fall on 03/01/24, the facility implemented the use of a canopy for R27's crib. On 06/03/24 at 09:50 AM, conducted an observation of R27 in the crib with a canopy over the top of the crib. The canopy was observed to be a heavy-duty plastic covering which covered the top of the crib. R27 was able to reach up and touch the canopy. R27 was observed watching a television through the canopy which distorted the images on the television (located above the front of the crib).

Conducted a review of R27's Electronic Health Record (EHR) on 06/06/24 at 10:12 AM. Review of the care plan documented a safety intervention for the crib rails/side rails/padding: a. Raise side-rails and close canopy of crib to prevent falls secondary to motor disabilities, immature/impaired cognitive development/ abilities. Review of the progress notes documented a note physical therapy which documented an assessment of R27's functional ability and the potential need for R27 to be reassessed if implementation of the canopy was delayed for several months but did not include an assessment of R27 after the canopy was implemented. This surveyor was unable to find a safety assessment after the canopy was implemented or evaluation of the use of the canopy for R27.

On 06/06/24 at 10:46 AM, conducted an interview and concurrent record review of R27's EHR with Registered Nurse (RN)33. Inquired if the facility completed a safety assessment of the implementation of the canopy after it was

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F 689	Continued From page 11 installed on R27's crib. RN33 confirmed a safety assessment or evaluation of the canopy was not done after the canopy was installed. RN33 also confirmed the facility did not identify that the canopy distorts the images on the television and did not consider how that would/could influence R27's development. On 06/06/24 at 09:10 AM, during an interview with the Administrator confirmed the facility did not conduct a safety assessment or an evaluation for the use of the canopy after the equipment was installed.	F 689		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to assure Resident (R) 15's insulin was held when his blood glucose level was less than 80 as ordered by the physician. The facility was not in compliance for significant medication error at the time the significant medication error occurred, the noncompliance happened after the last survey and prior to this survey. There was sufficient evidence that the facility corrected the noncompliance and was in substantial compliance at the time of the current survey related to significant medication errors. Findings Include: On 06/06/24 at 09:30 AM during record review of R15's Electronic Health Record (EHR) found R15	F 760	Past noncompliance: no plan of correction required.	

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F 760	Continued From page 12 was given Lantus Solostar Solution Peninjector 100 unit/ml (insulin Glargine) 55 units subcutaneously on 01/04/24 which is ordered to be given two times a day for R15's Type 2 Diabetes Mellitus with an order to hold (do not give the medication) for blood glucose (BG) less than 80. R15 had his blood glucose checked on 01/04/24 at 0730 (07:30 AM) and was documented at 79 mg/dl. Registered Nurse (RN) 25 gave R15 his 0900 (09:00 AM) dose of Lanstus Solostar 55 units of insulin instead of holding this medication as ordered by the physician with the hold parameter for blood glucose (BG) less than 80. On 06/06/24 at 09:51 AM interviewed Assistant Director of Nursing (ADON) and Administrator who were able to provide a copy of the incident event report for this medication error. Medication error was found after the fact by facility staff who reported the error to the charge nurse on the same day this incident occurred, 01/04/24. R15's doctor was notified of medication error on 01/04/24 at 1455 (02:55 PM) with no orders given at that time. R15's son was also notified of the medication error on 01/04/24 at 15:44 (03:44 PM). On 01/04/24 R15's blood glucose was rechecked at 02:45 PM and documented at 81 mg/dl. Later that same day at 1930 (07:30 PM) R15's blood glucose was documented at 69 mg/dl, which is a critical level requiring staff intervention. R15 was given glucose tablets as ordered for BG less than 70 mg/dl. R15's 2100 (9:00 PM) dose of Lanstus Solostar 55 units of insulin was held per physician ordered parameters. R15's physician was notified of critical BG level of 69 mg/dl and order given to decrease R15's Lantus Solostar insulin from 55 unit to 50 units twice a day with the same hold	F 760		

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F 760	Continued From page 13 parameters. Review of incident report found Director of Nursing (DON) re-educated staff to read instructions/parameters carefully and cosign with another staff to double check. Root cause analysis was completed for the medication error on 01/04/24 at 0900 which resulted in the critical BG level later that evening at 1930. Facility is found to be in past non-compliance for this citation, facility found the medication error the day it occurred on 01/04/24, reported it to the charge nurse, DON, physician and R15's son and corrected it that day which included monitoring of R15, administration and holding of medication, staff interviews were conducted and staff were reeducated to review medication carefully before administering, to use the 5Rs. No POC is required for this citation.	F 760		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident-	F 791		

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F 791	Continued From page 14 (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents had routine dental care for two residents (R10 and R5) sampled. R10's most recent dental consult was conducted on 11/27/20. R5's most recent dental consult was conducted on 11/11/21. Findings include: 1) On 06/06/24 at 11:17 AM during record review of R10's Electronic Health Record (EHR) found resident had a dental consult filled out from 2020. Record review found R10 has a care plan in	F 791		

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F 791	Continued From page 15	F 791		

place for facility staff to arrange for dental consult yearly and PRN which was initiated on 01/10/2020. At this time inquired of Assistant Director of Nursing (ADON) if R10 was seen by the dentist within the past year. ADON stated she would check on this.

On 06/06/24 at 11:59 AM during interview with Administrator she stated she had Director of Nursing schedule upcoming dental appointments for all residents in the facility for June and July 2024. Administrator stated dentists were not coming to facilities during the pandemic and just returned in 2023. ADON was unable to find any documentation at this time that R10 was seen in 2023.

2) On 06/03/24 at 03:50 PM, conducted an observation of R5 lying in bed. R5's mouth was open and saw that the resident's teeth were yellow, appeared dirty, and had white reside on the inside of the resident's mouth to include his tongue.

Conducted a record review of R5's Electronic Health Record (EHR). Review of the physician orders documented an order for, "... f. May be seen by facility Dentist for examination, treatment, medications twice a year and as needed...". Review of the resident's care plan documented R5 has self-care deficits for all personal needs related to cognitive impairment, contractures, immobility, and inability to make purposeful movements and has spastic quadriparesis with an intervention to "...Provide oral hygiene BID (twice daily) and PRN (as needed) ..." Review of the task list, oral hygiene had been provided once on 06/02/24 (at 07:19 PM) and once on 06/03/24 (at 09:48 PM).

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F 791	Continued From page 16 On 06/05/24 at 10:32 AM, conducted a concurrent record review and interview with Unit Clerk (UC) and Administrator. UC stated the dentist comes to the facility once a year and reviewed a binder with the dental appointment summaries. Reviewed R5's dental summaries and it documented the resident's last dental check-up was on 11/11/21 (dental consults were documented as completed in 2016, 2017, and 2018). A review of R5's EHR did not contain documentation under the miscellaneous tab, assessments, physician orders, and progress notes of any other dental exam conducted after 11/11/21. UC stated R5 had been seen in 2023 and would get the dental consult summary from the dentist's office. UC reported the dentist's office was closed on 06/05/24 and 06/06/24 but would continue to follow-up for the requested dental consult summary. Administrator was unable to provide additional documentation of any other dental consult conducted after 11/11/21.	F 791		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility	F 842		

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F 842	Continued From page 17 must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.	F 842		

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F 842	Continued From page 18 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review, the facility failed to accurately document a medication order in the narcotic medication record for one resident (R)20, of 28 medication administration observations in the sample. The dosage was documented to give Lacosamide oral solution 10 milligram (mg) per milliliters (ml); give eight ml via Jejunostomy tube (J-Tube) two times a day. The Registered Nurse (RN) 23 verified the order should read give 12 ml via J-Tube two times a day. Findings include: On 06/05/24 at 09:00 AM a concurrent interview and observation during a medication administration for R20 revealed that the narcotic medication record for Lacosamide Oral Solution 10 MG/ML give 8 ml via J-Tube two times a day was handwritten with the incorrect dosage. The surveyor questioned RN23 about the dosage, and she verified with the electronic medical record, medication administration record (MAR) states give 12 ml. The bottle of the medication had small labels that stated the dosage has been	F 842		

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F 842	Continued From page 19 changed in the medical record. The RN said, the narcotic form should have been updated, and removed it from the binder. A Medication Administration General Guidelines 2007 PharMerica Corp reviewed. Page 4, 9. Verify medication is correct three times before administering the medication ...c. before dose is administered.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		

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F 880	Continued From page 20 (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 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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F 880	Continued From page 21 Based on observation and interviews, the facility failed to ensure staff implemented infection control practices for infection prevention and and prevention of communicable diseases. Observed Registered Nurse (RN) 26 take off dirty gloves and put on clean gloves without performing hand hygiene. Observed Direct Care Staff (DCS)1 provide suctioning to a resident then enter another resident's room all while the staff's face mask was pulled under his/her chin, exposing the staff's mouth and nose. Findings include: 1) On 06/05/24 at 09:37 AM observed RN 26 prepare and administer Resident (R) 16's medications via their gastromy tube. After the task was completed RN26 took off her gloves, threw away the dirty gloves and put on a new pair of clean gloves. RN26 then suctioned R16's mouth and cleaned their mouth with a swab and prescribed medication. Afterwards interviewed RN26 and asked if she is to do anything after taking off her dirty gloves before putting on new clean gloves and she stated "no my hands weren't dirty." On 06/05/24 at 11:10 AM interviewed Assistant Director of Nursing who confirmed staff are to do hand hygiene between glove use. Requested a copy of facility policy on hand hygiene. On 06/05/24 at 15:00 PM Administrator provided a copy of facility policy titled Handwashing/Hand Hygiene which states Indications for Hand Hygiene 1. Hand Hygiene is indicated g. immediately after glove removal. 2) On 06/03/24 at approximately 03:05 PM,	F 880		

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F 880	Continued From page 22 observed DCS1 providing suctioning to a resident, then entered the adjacent room. While in the adjacent room, DCS1 was at another resident's bedside observing the resident with his/her mask still down under the chin, which exposed DCS1's mouth and nose. On 06/05/24 at 12:40 PM, conducted an interview with the Infection Control Physician (ICP). During the interview, inquired as to what type of personal protective equipment (PPEs) staff should wear while in the resident's room and while providing care. ICP confirmed during suctioning and while in the resident's room, staff should have a face mask on and it should be properly worn to cover staff's mouth and nose.	F 880		