STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125041	A. BUILDING _____ B. WING _____	01/26/2024

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LILIHA HEALTHCARE CENTER	1814 LILIHA STREET HONOLULU, HI 96817

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 01/23/24-01/26/24. The facility was not in compliance with 42 CFR 483 Subpart B. Facility Reported Incident (ACTS 10695) was also investigated and not substantiated. Survey Census: 87 Sample Size: 25	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 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	F 550		3/1/24

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

Electronically Signed | 02/16/2024

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F 550	Continued From page 1 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 resident interviews and policy review, the facility failed to treat two Residents (R) 9 and R139, 68 of eight residents sampled, with respect and dignity. Findings include: Resident interview on 01/23/24 at 01:30 PM, R68 said that Staff would respond to the call bell and say they would be back but not return until several hours later. R68 said that this made him/her feel ignored. Resident interview on 01/24/24 at 08:45 AM, R9 revealed the following: Staff would respond to the call bell and say they would be back but it would take several hours for them to return, Staff would ignore and not pass on a request to speak to the doctor or other person, Staff would speak to each other in a language other than English and it felt as if they were talking about him/her. Review of policy on Resident Rights read Policy;	F 550	F550=D Resident Rights/Exercise of Rights Dignity: Resident stated staff would respond to call bell and say they would be back but not return until several hours and staff would speak to each other in a language other than English and it felt as if they were talking about him/her. -Corrective actions: Facility filed a grievance for R68, R9, and R 139. Concerns were addressed on 2/12/24 -Identification of others: Residents residing in the facility are at risk. -Systemic change: Administrator/designee have initiated education for staff on 1/31/24 regarding resident's right to be treated with respect and dignity to enhance the resident's quality of life and access to persons and services. -Monitoring: Administrator/designee will conduct interviews of 4 residents every week x4 weeks, then 4 residents monthly x 2 months to validate if the staff are	

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F 550	Continued From page 2 The facility will 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 ... Resident rights; The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility ... R139 stated during an interview on 01/23/2024 that often he would press call bell, staff would acknowledge the call bell and state to R139 they would be back soon. R139 went onto to say staff would return after a long time, one time 40 minutes. Minimum Data Set (MDS) for R139 displayed under Section GG, that R139 required substantial assistance for movement. R139 due to extensive edema of both lower and upper extremities was unable to move by themselves without staff assistance. R139 stated during interview on 01/29/2023, that they would call for assistance to move when in pain, and waiting lengthy time periods increased the pain. R139 was tearful during the interview while relying this information. R139's reliance on staff assistance, and their lack of timely assistance did not provide care for these residents in a dignified manner.	F 550	responding to their request timely and staff are not speaking in a language other than English. Findings will be reported to facility QAPI Committee monthly x 3 months or until a lesser frequency is deemed appropriate. Compliance Date: March 1, 2024	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical	F 578		3/1/24

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F 578	Continued From page 3 services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 of 6 residents sampled (Residents 33 and 55) were informed of their right to develop an advance health care directive, aided in doing so, and/or was periodically reassessed in his/her decision-making capacity to	F 578	F578=D Formulate Advance Directive: Facility failed to ensure residents were informed of their right to develop an advance healthcare directive. -Corrective actions: Education/information	

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F 578	Continued From page 4 do such. As a result of this deficient practice, the residents were placed at risk of not having their wishes honored for future health care decisions, should they become incapacitated. This deficient practice has the potential to affect all the residents at the facility. Findings include: 1) On 01/24/24 at 11:23 AM, during a review of Resident (R)33's electronic health record (EHR), an advance health care directive (AHCD) was not found. A review of the social services progress notes revealed no mention of an AHCD. The documentation was requested from the facility. On 01/25/24 at 02:22 PM, an interview with the Social Services Director (SSD) was done in his office. The SSD confirmed that R33 was admitted to the facility in August of 2023, and that there was no documentation available indicating that R33 had an AHCD, or was offered assistance in creating one. 2) An AHCD was not found during a review of R55's EHR on 01/24/2024. A request to the SSD was made on 01/24/2024 for the AHCD for a list of residents including R55. No AHCD was found by the SSD for R55. A request to the SSD was made on the afternoon of 01/25/2024 for any documentation to show that R55 had been offered information on the option of formulating an AHCD on admission and was further offered on other occasions during the resident's admission. No documentation was provided. The same request was made to the administrator on the morning of 01/26/2024. No documentation was received.	F 578	related to the right to formulate AHCD was provided to R33 and R55 on 2/1/24 and 2/15/24. Documentation in the medical record reflects that education/information was provided. -Identification of others: Residents residing in the facility are at risk. -Systemic changes: Administrator/designee re-educated the Social Services staff on 1/31/24 related to educating the resident/representative regarding the right to formulate an AHCD and documenting the education in the medical record. -Monitoring: Administrator/designee will audit new admission medical records for documentation related to education. Findings will be reported to facility QAPI Committee monthly x 3 months or until a lesser frequency is deemed appropriate. Compliance Date: March 1, 2024	

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F 656	Continued From page 5	F 656		
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 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	F 656		3/1/24

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F 656	Continued From page 6 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, and interview with staff members, the facility did not ensure that the development and implementation of comprehensive person-centered care plans were done for 3 of 25 residents (Residents 33, 60 and 139) in the sample. As a result of this deficient practice, these residents were placed at risk for a decline in their quality of life, and were prevented from attaining their highest practicable physical, mental, and psychosocial well-being. This deficient practice has the potential to affect all the residents at the facility. Findings include: 1) Cross-reference to F688 Increase/Prevent Decrease in ROM/Mobility. Despite identifying positioning/mobility needs for Resident (R)33, the facility failed to develop a care plan to effectively address those needs. 2) During interview with R60 on 01/23/2024, R60 expressed a desire to mobilize more with the Hemi-Walker available to R60. R60 feels confident this could be achieved if staff walked him daily. R60 had a care plan in place for altered ADL function, with an approach/intervention stating "uses Hemi-walker	F 656	F656=E Develop/Implement Comprehensive Care Plan -Corrective action: R33 comprehensive care plan was updated to include positioning/mobility needs, R60 comprehensive care plan was updated to include the assistance and guidance, and frequency of occurrence in using the Hemi-Walker. R139 comprehensive care plan was updated to include interventions that state the required amount of assistance to move in bed, sit from lying, and lie down from sitting. -Identification of others: Residents residing in the facility are at risk. -Systemic change: DON/designee reeducated nursing administration and LN staff on 1/31/24 regarding importance of developing and implementing a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's needs in the comprehensive assessment. -Monitoring: DON/designee will complete an audit for 4 random residents needs with ADL decline to validate that	

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F 656	Continued From page 7 and Wheelchair for mobility" stating CNAs and nursing are the responisble disciplines to carry out this approach/intervention. Record review conducted on 01/24/2024, showed that R60 particpated in a restorative nursing program, which provided R60 assistance and guidance in using the Hemi-Walker. The care plan was missing the frequency of occurance for this intervention for R60. Interview with MDS staff, confirmed there was no frequency included in the care plan, as the care plans "are generalized" and not indivalized. 3) Minimum Data Set (MDS) for R139, displayed under Section GG, that R139 required substantial assistance for movement, including moving from lying to sitting, sitting to lying and moving from left to right sides and vice versa. Progress notes have documented on several occasions that R139 requires 3-4 person assist. Due to extensive edema to both lower and upper extremities, R139 is dependent on staff for all movement. Care plans are in place for R139 for altered self care and decrease in Activities of Daily Living (ADL) performance. These careplans have interventions in place to encourage resident to use enablers and to be independent. There are no interventions that state the required amount of assistance that R139 requires to move in bed, sit from lying and lie down from sitting. Interview with MDS staff member verified there are no specific interventions on the amount of assistance that is required by R139, stating their careplans "are generalized" an individualized.	F 656	comprehensive care plans are updated weekly x4 weeks, then monthly x2 months. Findings will be reported to facility QAPI Committee monthly x 3 months or until a lesser frequency is deemed appropriate. Compliance Date: March 1, 2024	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility.	F 688		3/1/24

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F 688	Continued From page 8 §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure Resident (R)33 received the appropriate treatment, equipment, and/or services to increase or prevent further decrease in range of motion (ROM) of her neck/head. As a result of this deficient practice, R33 was hindered from reaching her highest practicable well-being. This deficient practice has the potential to affect all the residents at the facility with ROM deficits. Findings include: Resident (R)33 is a 75-year-old female admitted to the facility on 05/07/19 for long-term care. R33's diagnoses include but are not limited to left-sided hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness) following a stroke, anarthria (complete loss of speech), and gastrostomy status (a surgical	F 688	F688=D Increase/Prevent Decrease in ROM/Mobility -Corrective action: R33 was referred to rehab on 1/25/24 for PT/OT contracture management and positioning device related to neck tilting to right side. -Identification of others: Residents residing in the facility are at risk. -Systemic change: DON/designee reeducated nursing administration and LN staff on 1/31/24 regarding assessment of residents with contractures who would benefit from therapy evaluation and treatment. Implementation of restorative nursing program to ensure residents appropriate services, equipment, and assistance to maintain mobility. -Monitoring: DON/designee will complete an audit for 4 random residents to validate	

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F 688	Continued From page 9 opening into the stomach made for a feeding tube). A review of R33's most recent Occupational Therapy (OT) Discharge Summary on 04/19/23 notes a "discharge impairment of 100%... This score indicates that she [R33] requires 27 hours of 1:1 (one to one) care to complete her basic ADLs [activities of daily living] per week." In addition, R33's Functional Skills Assessment indicated she was completely "Dependent (100% assist, or 2 or more helpers) ..." in all categories [eating, hygiene, transfers, bathing, and dressing] with a "Self Care Function Score (score 0-12; 12 being the highest function) = 0." The discharge summary also included documentation of caregiver training of " ... Positioning maneuvers, Proper body mechanics ... PROM [passive range of motion] ... with 100% return demonstration provided during session." A review of R33's Comprehensive Care Plan noted the following intervention under the "Category: Med [medication] Management ... Maintain body in functional alignment when at rest." Despite being completely dependent on staff for positioning, there were neither interventions addressing positioning/proper body mechanics under the category of "ADLs Functional Status," nor was there a separate category/care plan addressing positioning. Multiple observations were made of R33 in bed on 01/23/24 at 09:21 AM, 09:30 AM, 11:11 AM, and 02:24 PM, on 01/24/24 at 11:14 AM, 11:59 AM, and 02:14 PM, and on 01/25/24 at 08:45 AM, with her head bent heavily and uncomfortably to the right, with her right ear less than two inches from her right shoulder. No pillows, neck rolls, or	F 688	that resident with contractures receives appropriate services and treatments to prevent further decrease in range of motion weekly x4 weeks then monthly x2 months. Findings will be reported to facility QAPI Committee monthly x 3 months or until a lesser frequency is deemed appropriate. Compliance Date: March 1, 2024	

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F 688	Continued From page 10 braces were observed to assist in positioning her head in functional alignment with her shoulders or body. On 01/25/24 at 08:45 AM in particular, R33 was observed with a wedge pillow under her right shoulder, propping her right shoulder up, causing her head to be positioned back and heavily bent to the right. R33 was noted to be moaning in her sleep, which was not observed on previous days. On 01/25/24 at 11:36 AM, an interview was done with Unit Manager (UM)3 at R33's bedside. UM3 agreed that R33 appeared uncomfortable with her head in misalignment with her shoulders and body, bent heavily towards her right shoulder. When asked if R33 was able to straighten her neck anymore, as all observations up until then had her with her head in the same position, UM3 stated she did not know. UM3 also reported that she was unaware of any neck braces, or orthotic devices ordered to assist in positioning R33's head.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §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, interview, and record review, the facility failed to ensure 1 of 4 residents in the sample (Resident 52) was free from accidents hazards. Resident (R)52 was observed	F 689	F689=D Free of Accident Hazards/Supervision/Devices -Corrective actions: R52 oversized	3/1/24

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F 689	Continued From page 11 ambulating with slippers oversized for her feet, placing her at increased risk for an avoidable fall. Despite previously being identified as a high risk for falls, the facility failed to recognize R52's oversized footwear as a potential hazard until pointed out by the State Agency (SA). This deficient practice has the potential to affect all ambulating residents at the facility. Findings include: Resident (R)52 is a 78-year-old female admitted to the facility on 07/12/21 for long-term care. Her current diagnoses include but are not limited to dementia, difficulty in walking, history of syncope (fainting) and collapse, and restlessness and agitation. On 01/23/24 at 10:53 AM, observed R52 sitting in the second-floor dining room at activities. Noted a bright yellow Falls Risk identification bracelet around her right ankle, an oversized pair of slippers on her feet, no socks, and a front-wheeled walker next to her. A review of R52's electronic health record (EHR) noted no documentation that a risks versus benefits discussion had taken place regarding R52's use of oversized slippers for ambulation. On 01/23/24 at 01:51 PM, an interview was done with Unit Manager (UM)3 in the second-floor dining room. During a concurrent observation of R52 ambulating back to her room with stand-by assistance, UM3 confirmed that the slippers were too large for her feet, and combined with her high falls risk status, were safety hazards. UM3 reported that the oversized slippers were provided by R52's family and were the only	F 689	slippers were replaced on 1/25/24. -Identification of others: Residents residing in the facility are at risk. -Systemic change: DON/designee reeducated nursing staff regarding identification of potential hazard for ambulatory residents. All new admissions that are ambulatory will be assessed for proper fitting footwear. -Monitoring: DON/designee will complete an audit of 4 ambulatory residents weekly x3 months to validate that proper fitted footwear are in place. DON/designee will present findings at the facility's Quality Assurance and Performance Improvement meeting monthly until the QAPI team recommends a lesser frequency. Findings will be reported to facility QAPI Committee monthly x 3 months or until a lesser frequency is deemed appropriate. Compliance Date: March 1, 2024	

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F 689	Continued From page 12 footwear R52 had. UM3 noted that R52 loved her slippers, refused to wear non-slip socks, and always put her slippers on when she wanted to walk anywhere. On 01/24/24 at 08:35 AM, an interview was done with UM3 in her office. UM3 confirmed that the oversized slippers were not previously identified as a safety hazard contributing to an increased risk of falls, and so had not been care planned for. Concurrent review of R52's Comprehensive Care Plan (CP) noted an intervention for "proper well-maintained footwear" under the category of Falls, but it did not define what proper footwear would be. UM3 agreed that "proper footwear" is too vague, and that for R52, proper footwear should include proper fit, which no one had assessed before.	F 689		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident	F 726		3/1/24

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F 726	Continued From page 13 assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review (RR), the facility failed to ensure nurse competency in pain assessment for 1 of 1 resident (Resident 64) sampled for pain management. As a result of this deficient practice, Resident (R)64 remained on a narcotic with a high risk of addiction and dependence for pain that could potentially have been managed with non-narcotic medication. This deficient practice placed R64 at risk for avoidable addiction and dependence in addition to other adverse effects of taking Fentanyl, and has the potential to affect all the residents at the facility receiving narcotic pain medication. Findings include: Resident (R)64 is a 93-year-old female admitted to the facility on 08/11/22. Her current diagnoses include but are not limited to Alzheimer's disease, muscle weakness, an almost healed sacral pressure ulcer (pressure sore on the lower back), and severe protein-calorie malnutrition. A review of her electronic health record (EHR) noted that	F 726	F726=D Competent Nursing Staff -Corrective action: R64 pain regimen was reviewed by attending MD on 1/25/24. MD ordered to hold Fentanyl patch on 1/30/24 until 2/29/24 then reevaluate. -Identification of others: Residents residing in the facility are at risk. -Systemic change: DON/designee will educate nursing staff on pain identification, assessment, and management upon admission, on-going assessment, change of condition/status, and as needed on 2/16/24. House-wide audit will be completed on 2/16/24 for residents on narcotic pain regimen and discuss any findings with attending MDs. -Monitoring: DON/designee will complete an audit for 4 random residents weekly x 4 weeks then, 5 random residents monthly x2 months recommends a lesser frequency. Findings will be reported to facility QAPI Committee monthly x 3 months or until a lesser frequency is	

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F 726	Continued From page 14 R64's primary language is Cantonese, and that she was discharged off of Hospice care in November 2023. On 01/24/24 at 08:20 AM while doing morning rounds, asked R64 how she was doing. R64 did not respond. Asked R64 "are you OK?" R64 answered "no." Due to the language barrier, asked R64 "how come no?" To which it sounded as if R64 responded, "sore feet." Repeated "sore feet" back to her, and R64 answered "yes," and pointed towards her right foot. Asked to see her feet, to which she nodded yes, but while trying to unwrap her feet which were tightly tucked into her blanket, R64 repeated "sore, sore." Refrained from attempting to unwrap feet any further so as not to cause additional pain. Grabbed the Cantonese picture cards at the bedside and pointed to the pictures/writing for pain and medicine. R64 nodded yes. Informed Registered Nurse (RN)9 that R64 was complaining of pain. RN9 responded quickly, stating she would give R64 some acetaminophen. At 11:50 AM, checked back with R64, who reported that her pain was a "little bit better." A review of R64's medication administration record (MAR) noted that RN9 had given R64 her routine acetaminophen 650 milligrams (mg), due at 09:00 AM, earlier that morning when she had complained of pain, and had not given any as needed analgesics. Further review of R64's MAR revealed routine orders for acetaminophen 650mg three times a day for pain, and fentanyl patch 25 micrograms (mcg)/hour, one patch applied every three days for pain management, with the last patch documented as applied on 01/21/24 at 08:00 PM. Also noted were the following as needed orders for pain: acetaminophen 650mg every four hours, and	F 726	deemed appropriate. Compliance Date: March 1, 2024	

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F 726	Continued From page 15	F 726		

tramadol 50mg three times a day "for severe pain if routine ... [acetaminophen] is ineffective." Neither as needed medication had been documented as given at any time during the month of January.

On 01/24/24 at 12:00 PM, an interview was done with RN9 in the hallway outside of R64's room. When asked where R64 usually had pain, RN9 reported that she was uncertain, stating that it could be R64's feet or that "there might be contractures" (a tightening of muscle, tendons, ligaments, or skin which prevents normal movement of the associated body part) in her lower legs that were causing pain. RN9 did a concurrent review of R64's EHR to confirm where her pain usually was. After a brief review, RN9 reported that she was unsure what was the location, source, or character of R64's pain. When asked if she had assessed R64's feet or legs earlier that morning when she had complained of pain, RN9 stated that she did not assess the source of pain "this morning," but stated that she had before. After further review of R64's EHR, RN9 could find no documentation in the progress notes, physician orders, or MAR to indicate the location or characteristics of R64's pain, or why she continued to have a routine fentanyl order, a medication known to be a powerful narcotic. At 12:08 PM, as Unit Manager (UM)3 walked by, RN9 stopped her to ask if she knew why R64 had the routine fentanyl order. UM3 stated her belief that it was "a carryover" order from when R64 was on Hospice for pain associated with her pressure ulcer, however RN9 reported that the pressure ulcer was almost healed with no openings remaining to the surface of the skin.

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F 726	Continued From page 16 On 01/25/24 at 11:15 AM, an interview was done with UM3 in her office. UM3 reported that following her own review of R64's EHR, she could find no clear documentation of the location and character of R64's pain. UM3 agreed that a more thorough pain assessment should be done to identify where R64 was feeling pain, what her level of pain was, and if the routine pain medications could be reduced. On 01/26/24 at 09:56 AM, an interview was done with the Director of Nursing (DON) in the conference room. The DON confirmed that his expectation is for nurses to conduct a thorough pain assessment when administering any pain medication, whether routine or as needed.	F 726		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of	F 790		3/1/24

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F 790	Continued From page 17 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; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide or obtain from their dental consultant, routine dental services to meet the resident's needs. This deficient practice has the potential to affect all residents currently residing in the facility. Findings include: Resident (R)27 is an 80-year-old female admitted to the facility on 12/05/22. During an interview with her family representative (FR)5 on 01/23/24 at 01:34 PM at her bedside, FR5 reported that R27 had not received any routine dental visits since her admission. On 01/25/24 at 10:20 AM, a review of R27's electronic health record (EHR) found no	F 790	F790=D Routine/Emergency Dental Services -Corrective action: R27 has an appointment scheduled for 2/18/24. -Identification of others: Residents residing in the facility are at risk. -Systemic change: Facility contracted a dentist to provide evaluation at the facility every month effective 2/18/24. There are 25 residents on the initial list to be seen and evaluated. -Monitoring: DON/designee will complete an audit of 4 random residents in each unit weekly x4 weeks, then 5 random residents in each unit monthly x2 months. Findings will be reported to facility QAPI Committee monthly x 3 months or until a	

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F 790	Continued From page 18 documentation of any dental visits or exams since admission. On 01/25/24 at 11:15 AM, an interview was done with Unit Manager (UM)3 in her office. When asked, UM3 reported that the facility dentist had not been in for routine or emergency dental services since COVID began in 2020. UM3 confirmed that for dental emergencies, residents were sent out to his office, but that routine dental services had not been done since he (the facility dentist) stopped coming in. A review of the facility's Dental Services policy, last revised 06/2023 revealed the following: "It is the policy of this facility to assist residents in obtaining routine ... and emergency dental care ..." and; "Routine dental services means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor partial or full denture adjustments, smoothing of broken teeth, and limited prosthodontic procedures ..."	F 790	lesser frequency is deemed appropriate. Compliance Date: March 1, 2024	
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations the facility failed to provide a comfortable environment for residents,	F 921	F921=E Safe/Functional/Sanitary/Comfortable	3/1/24

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F 921	Continued From page 19 staff and the public by not maintaining the environment in good repair. Findings include: Observations on 01/23/2024 - 01/26/2024, showed wallpaper on upper half of walls in the hallway of 1st floor, is lifting off in several areas and curling over. Outside of room 108 there is patch of wallpaper missing, approximately 12" x 18". It appears this patch has been torn off. On the opposite wall a picture has been removed with the area underneath significantly lighter in color than the rest of the wallpaper, providing an appearance of unkept cleaning of walls. The disrepair of the state of the wallpaper, is unkept and not conducive to a homelike environment. Watermarks are apparent on several areas of the wallpapered area of the hallway on the 1st floor unit.	F 921	Environment -Corrective action: Outside of room 108 missing patch of wallpaper was repaired on 1/29/24. -Identification of others: Wallpapered areas in the facility are potentially affected. -Systemic change: Removal of wallpaper in the hallway of 1st floor unit has been initiated. Walls will be cleaned, repaired, and primed for painting. Administrator/designee will do a monthly walk through the units and other care areas to validate that facility is maintaining the environment in good repair. -Monitoring: Findings will be reported to facility QAPI Committee monthly x 3 months or until a lesser frequency is deemed appropriate. Compliance Date: March 1, 2024	