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ISLANDS SKILLED NURSING & REHABILITATION	1205 ALEXANDER STREET HONOLULU, HI 96826

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance on 05/16/24. The facility was found not to be in substantial compliance with 42 CFR 483, Subpart B. Two facility reported incidents (FRI) and one complaint were investigated (ACTS #10922, 10957, 10360) There were deficient practices related to the complaint investigation and no deficient practices cited related to the FRI investigations. Survey Census: 34 residents Sample Size: 16 residents	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

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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 observations, record review, and interviews, the facility failed to ensure residents were provided privacy and dignity while receiving care in the facility for three of 16 residents (Resident (R) 4, R7 and R26). R4 and R7 had urinary catheter bags that were uncovered and visible to people in the hall. R26 was exposed staff and visitors in the room during personal care. This deficient practice disregarded the resident's right to dignity and respect.

Findings include:

1) On 05/14/24 at 2:55 PM, observation in R26's room. R26 is a dependent male resident on a mechanical ventilator who's bed is next to the open door and in a room with three other

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residents. The privacy curtain was half closed and revealed R26 laying in his bed naked, while receiving personal care from Certified Nurse's Aide (CNA) 12 and CNA68. The surveyor pulled the curtain closed saying "I'll close the curtain to give...[R26]...privacy," and noted the curtain was too short, leaving a large gap at the head of the bed. The CNAs said to the surveyor, it's too short. The privacy curtain was not large enough to drape around the ventilator and respiratory equipment to provide privacy.

2) On 05/13/24 at 2:49 PM, observation in the hallway facing R7's room. R7 is a dependent female resident on a mechanical ventilator with her bed next to the door. The urinary catheter bag was seen hanging from the lower rail of her bed without a cover. Visitors were observed walking in the hall outside of the resident's room.

On 05/14/2024 at 9:15 AM, observation in the hall outside of R7's room noted the urinary catheter bag was covered with a dark blue bag. The surveyor spoke with Respiratory Therapy Supervisor (RTS) about the covered bag and confirmed that the bag was covered by the certified nurse aides (CNAs) who are going room to room to place the covers on the urinary catheter bags on the unit.

Review of the facility's policy and procedure, "Quality of Life-Dignity" with no effective, revision, or review date, documented "Staff shall promote, maintain and protect resident privacy including bodily privacy during assistance with personal care and during treatment procedures."

3) On 05/13/24 at 09:52 AM, observed from outside of R4's room, his urinary catheter bag

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F 550	Continued From page 3 hanging from the bottom of his bed, uncovered. On 05/13/24 at 09:53 AM, an interview with CNA17 was done. Inquired if the facility uses dignity bags for residents with urinary catheters, CNA17 reported they normally use dignity bags when the residents is going out of the facility, but it also depends on whether they have the supply. Review of the facility's policy and procedure, "Quality of Life-Dignity" with no effective, revision, or review date, documented "Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist resident as needed by: a. Helping the resident to keep urinary catheter bags covered."	F 550		
F 551 SS=D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions	F 551		

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of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.

§483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.

§483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law.

§483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.
(i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority.
(ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative.
(iii) To the extent practicable, the resident must be provided with opportunities to participate in the

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care planning process.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure the rights of a resident's representative in a medical treatment decision to insert a tracheostomy cap (T-cap) was exercised. The deficient practice dishonored the resident representative's right to make important decisions in the care and treatment for Resident (R) 27.

Findings include:

Electronic Health Record (EHR) reviewed. R27 is an 18-year-old female resident, admitted on 09/26/23 with a diagnosis that included respiratory failure with a tracheostomy (an artificial airway in the throat). R27 is dependent on staff for her care and Family Member (FM) 3 is her legal guardian and makes R27's healthcare and treatment decisions.

05/14/24 at 10:54 AM, observation and interview with FM3 who reported that two months ago a Speech Therapist (SLP) who no longer works here did something that really upset her. The SLP had the respiratory therapist (RT) apply a T-cap to R27's trach. FM3 stated that she was very upset because placing the cap was against medical advice, and afterward, R27 was visibly upset and started crying. She was very fearful after that. After the incident occurred, FM3 spoke to Director of Rehabilitation (DOR) about her concerns and was told the therapist will be no longer be assigned to R27 and will be leaving the facility once they find a replacement.

On 05/15/24 at 11:55 AM, interview with DOR.

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DOR said an incident happened around March 11 between the SLP and FM3. It was handled, and we discharged the SLP from her assignment with R27. FM3 reported to DOR that she wasn't comfortable with how the SLP was performing her duties. FM3 said she told the SLP that she didn't want to have them place a T-cap on R27's trachea, and in spite of the FM3's disagreement to the treatment, the SLP went ahead and requested an order from the doctor and the RT placed the T-cap. FM3 found out what happened and was upset because she didn't consent to it. DOR stated that FM3 should have given consent to place the T-cap. DOR informed the Administrator and nursing, and disciplinary action was taken. The SLP is no longer here. Another speech therapist was reassigned to work with R27.

Received and reviewed the investigation documentation (email threads) dated 03/12/24, at 04:42 PM from DOR to the Administrator regarding the incident of the T-cap trial for R27. The email documentation summarized the complaint from FM3 to DOR. The employee status change notification for the SLP was changed from part-time to as needed (PRN) dated and signed 03/22/24.

On 05/16/24 at 01:46 PM, interview with RT52 about the cap trial. "It was communicated to everybody to do the cap trial for R27. I told R27 that I was going to put on the cap. When I put it on, she seemed okay and her oxygen saturations were ok, so I left her to go and check on another resident. Right away she turned on the call light and when I went back, ...[R27]... was crying, and she was very upset. I asked her if she wanted me to take it off and she nodded her head yes

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F 551	Continued From page 7 and was crying. I think she thought it was a Passy Muir valve (PMV), (a cap that is placed onto the trach which allows voice and speaking) because every morning we put the PMV on and she didn't know it was different. The cap feels very different than the PMR because the breathing is very different. The next day mom called, and I told her what happened, she was very upset, for her it was traumatic, because her mom didn't want her to have it."	F 551		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items	F 582		

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and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure written copy of the Notice of Medicare Non-Coverage (NOMNC) form was provided and acknowledged by the beneficiary (resident) or the beneficiary's representative according to the NOMNC instructions for three of three residents sampled (Resident (R) 190, R191, and R192).

Findings include:

Review of R190's Electronic Health Record

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(EHR) found R190 was admitted to the facility on 02/12/24 and discharged home on 03/16/24. R190's Minimum Data Set (MDS) at discharge with an Assessment Reference Date (ARD) of 03/16/24 documented R190's Brief Interview for Mental Status (BIMS) a 14 out of 15 (cognitively intact).

Review of R191's EHR found R191 was admitted to the facility on 02/22/24 and discharged home on 03/23/24. R191's MDS at discharge with an ARD of 03/23/24 documented R191's Brief Interview for Mental Status (BIMS) a 15 out of 15 (cognitively intact).

Review of R192's EHR found R192 was admitted to the facility on 09/28/23 and discharged to a care home on 01/04/24. R192's MDS at discharge with an ARD of 01/04/24 documented R192's Brief Interview for Mental Status (BIMS) a 5 out of 15 (severe cognitive impairment).

On 05/14/24 at 01:58 PM, during review of beneficiary notification for residents who received Medicare Part A services, the facility documented R190, R191, and R192 was provided a copy of the NOMNC form. Inquired with Administrator documentation the form was provided to the residents or the residents' representatives, the provided NOMNC forms documented "COPY LEFT AT BEDSIDE ..." for R190 and R191 and "SENT VIA SECURE EMAIL ..." for R192. Further inquired documentation an email was sent to R192's representative and the facility's policy regarding providing residents the NOMNC form to residents and their representative.

On 05/14/24 at 02:54 PM, an interview with Administrator was done. Administrator reported

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the facility does not have a policy regarding the NOMNC form but follows the "Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123." Administrator further reported an email with the NOMNC form was not sent to R192's representative.

On 05/14/24 at 03:13 PM, an interview with Social Services Director (SSD) confirmed she did not email R192's representative the NOMNC form. Inquired with SSD why she left R190 and R191's NOMNC form at bedside table but not obtain their signature or their representative's signature if they will pick up the form from the facility, SSD stated from her understanding she did not need to give the residents' a written notification but just needed to verbally tell them.

Review of the instructions for the NOMNC form provided by the Administrator documented "The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understand that the termination decision can be disputed. Used of assistive devices may be used to obtain a signature." The instructions further document for "Notice Deliver to Representatives" that "Providers are required to develop procedures to use when the beneficiary/enrollee is incapable or incompetent, and the provider cannot obtain the signature of the enrollee's representative through direct person contact. If the provider is personally unable to deliver a NOMNC to a person acting on behalf of an enrollee, then the provider should telephone the representative to advise him or her when the enrollee's services are no longer covered. The date of the conversation is the date of the receipt of the notice. Confirm the telephone

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F 582	Continued From page 11 contact by written noticed mailed on that same date."	F 582		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: 2) On 05/13/24 at 02:30 PM, interviewed R10. Inquired how he had received a large bruise to his right forearm which is right below his dialysis	F 609		

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access site. R10 reported he got the bruise because he "slid down a chair at dialysis because they put the pillow too far in back of me" and this occurred after the dialysis staff had placed the dialysis needle in his right forearm and R10 stated "the needle bent when I pushed myself up." Inquired when this occurred and R10 stated about 2-3 weeks ago.

On 05/15/24 at 03:19 PM, interviewed Unit Manager (UM) Registered Nurse (RN) 23 regarding R10's bruise to his right forearm, asked if the dialysis center had communicated this injury with the facility. UM RN23 inquired with R10's assigned nurse, RN83 to find out how R10 acquired the bruise. RN83 stated she was endorsed by the night shift nurse that R10 had the bruise but she could not say how he got it.

On 05/15/24 during a record review R10's Electronic Heath Record (EHR) review of communication forms supplied by the dialysis center found there was no communication of this injury documented to the facility. During this record review found resident has a doctor's order to check AVG (arteriovenous graft) Bruit/thrill to RFA (right forearm) every day and night shift which was ordered on 11/26/2023. Review of progress notes and skin assessments in R10's EHR did not find any documentation that resident had acquired a bruise to his right forearm.

On 05/15/24 at 04:27 PM, interviewed R10 again who clarified the "needle moved in his arm" at dialysis, "not bent", and that caused the bruising. At this time met with UM RN23 who stated she told R10's assigned nurse to take a picture of resident's right forearm and put a progress note about it in his EHR.

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F 609	Continued From page 13 On 05/16/24 03:41 PM, spoke with Dialysis Center and they denied an incident occurred with a bruise injury to R10's forearm. Dialysis Center stated they had documentation from the hospital R10 went to on 05/13/24 that stated his blood pressure was taken on his upper right arm, the same arm that R10 has his dialysis access site. Blood pressures are not to be taken on the same arm where the dialysis access site is because it can damage the dialysis access site. On 05/16/24 at 3:50 PM, interviewed DON who stated he is having his nurses investigate how R10 acquired the bruise on his right forearm. DON was reminded to report this to the State Survey Agency. Based on record review and interviews, the	F 609		

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facility failed to report an allegation of abuse immediately but no later than two hours after the allegation was made or allegation of mistreatment and an injury of an unknown origin within 24 hours to the State Survey Agency (SA) for two of two residents sampled (Resident (R) 34 and R10).

Findings include:

Review of the facility's policy and procedure "Abuse Investigation and Reporting" with no effective, revision or review date documented "All alleged violations involving abuse, neglect, exploitation, including injuries of an unknown source and misappropriation of poverty will be reported by the facility Administrator, or his/her designee, to the following persons or agencies:...The State licensing/certification agency responsible for surveying/licensing the facility...will be reported immediately, but no later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violations does not involve abuse AND has not resulted in serious bodily injury."

1) On 05/10/24 at 08:36 AM, the SA was informed by the Long-Term Care Ombudsman (LTCO), on 05/08/24 during the LTCO's resident visits at the facility, he walked in R34's room when he heard R34's family member (FM) 6 yell at Certified Nurse's Aide (CNA) 16 to get out of R34's room and not to return. LTCO reported FM6 was upset because R34 was mistreated by CNA16. R34 reportedly told LTCO, CNA16 barges into her room without knocking and slams the door open, insist she needs to be changed although she tells her she is dry, used intimidation tactics and was

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rough with care. When washing R34's hair she reportedly does not like getting her face wet but CNA16 would grab her neck and put her face under the water. The LTCO informed the Director of Nursing (DON) and Administrator on 05/08/24 and requested they send a report for an allegation of physical and verbal abuse to the SA and Adult Protective Services (APS).

On 05/13/24 at 10:47 AM, an interview was done with FM6. FM6 reported he found out R34 was mistreated by CNA16 on 05/08/24. R34 reportedly told FM6 that CNA16 would talk and provide care roughly to her and doused her head with water when showering. FM6 reportedly informed the head nurse and requested CNA16 not to provide care to R34, 10 minutes later CNA16 walked in R34's room and FM6 and requested for her to get out of R34's room, during that time the LTCO walked in.

Review of the "Event Report" submitted to the SA on 05/10/24 regarding staff to resident abuse documented the initial report and completed report was submitted on 05/10/24. The facility did not report the allegation of abuse immediately but no later than two hours or the allegation of mistreatment within 24 hours after the allegation was made.

On 05/16/24 at 12:53 PM, an interview with DON was done. DON confirmed the LTCO reported the incident and allegation on 05/08/24 and he sent the initial and completed investigation on the same day, 05/10/24, to the SA. DON further confirmed allegations of abuse should be reported within two hours and was not reported timely.

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F 610	Continued From page 16	F 610		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to prevent further potential abuse or mistreatment while the investigation was in progress for Resident (R) 34. The facility did not remove Certified Nurse's Aide (CNA) 16 from the facility providing access to the resident and/or other vulnerable residents while the investigation was in process. Findings include: Cross reference to F609. The facility failed to report an allegation of abuse immediately but no later than two hours or allegation of mistreatment within 24 hours after the allegation was made to the State Survey Agency (SA) for R34.	F 610		

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On 05/10/24 at 08:36 AM, the SA was informed by the Long-Term Care Ombudsman (LTCO), of an incident that occurred on 05/08/24 during the LTCO's resident visits at the facility. The LTCO reportedly informed the Director of Nursing (DON) and Administrator on 05/08/24 of possible resident to staff abuse between R34 and CNA16 and requested they send a report for an allegation of physical and verbal abuse to the SA and Adult Protective Services (APS).

On 05/13/24 at 10:47 AM, an interview was done with Family Member (FM)6. FM6 reported he found out R34 was mistreated by CNA16 on 05/08/24. R34 reportedly told FM6 that CNA16 would talk and provide care roughly to her and doused her head with water when showering. FM6 reportedly informed the head nurse and requested CNA16 not to provide care to R34, 10 minutes later CNA16 walked in R34's room and FM6 and requested for her to get out of R34's room, during that time the LTCO walked in.

On 05/14/24/ at 09:32 AM, an interview with R34 was done. R34 recalled the day the LTCO visited her when FM6 requested CNA16 to leave her room. R34 stated she felt CNA16 was harassing her during her stay at the facility and made her take a shower when she did not want to. R34 explained she commonly gets ear infections and does not want her face or ears to get wet. CNA16 no longer aids her but knows when CNA16 comes in her room, possibly providing care to her roommate, based on her perfume smell. R34 also sees CNA16 walk past her room in the hallway.

On 05/15/24 at 11:17 AM, an interview CNA4 was done. CNA4 reported on 05/08/24 she was asked

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to provide care to R34 instead of assigned CNA16 and CNA16 came into work the next day, 05/09/24. Review of "Staff Interviews" from the facility found staff members, including CNA4, were interviewed on 05/10/24 during the facility's investigation regarding the allegations against CNA16. Resident interviews were found to be done on 05/10/24.

On 05/15/24 at 02:40 PM, an interview with CNA16 was done. CNA16 reported on 05/08/24 she was confused when FM6 requested her to leave R34's room and did not understand the reason. R34 had always been pleasant when she provided care and never complained. After the incident, at approximately 10:00 AM, the facility interviewed her and asked her to do a series of trainings for the rest of the day. The next day, 05/09/24, she returned to work on the third floor, as usually assigned. The facility did not tell her she was under investigation.

Review of the "Daily Assignment" form provided by the facility found CNA16 worked on 05/09/24 and 05/10/24 on the third floor.

Review of the "Event Report" submitted to the SA on 05/10/24 regarding staff to resident abuse documented the initial report and completed report was submitted on 05/10/24.

On 05/16/24 at 12:53 PM, an interview with DON was done. DON confirmed the investigation was not completed until 05/10/24 and stated he should have taken CNA16 off the floor until the investigation was completed. The facility found the allegation of abuse and mistreatment to be unsubstantiated after the completed investigation.

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F 610	Continued From page 19 Review of the facility's policy and procedure "Abuse Investigation and Report" with no effective, revision or review date documented "The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation."	F 610		
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. (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	F 623		

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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 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

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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 interviews, the facility failed to ensure written notification of transfer/discharge was provided to the resident or resident's representative, as soon as practicable, before transferred or discharged and send a copy of that notice to a representative of the Office of the State Long-Term Care Ombudsman (LTCO) for one of three residents sampled (Resident (R) 29).

Findings include:

R29 was transferred and admitted to the hospital

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F 623	Continued From page 22 on three separate occasions, on 01/01/24 to 01/09/24 with diagnoses of tachycardia and recurrent aspiration pneumonia, on 02/01/24 to 02/06/24 with diagnosis of acute aspiration pneumonia, and on 03/26/24 to 04/01/24 with diagnosis of acute respiratory failure with hypoxia. A review of R29's Electronic Health Record (EHR) found no documentation that a written notification for transfer to the hospital was provided to R29 or his representative and LTCO for the three hospitalizations. On 05/15/24 at 01:02 PM, an interview with Social Services Director (SSD) was done. SSD reported the facility did not give written notification for transfer/discharge to R29 or his representative and LTCO for the three hospitalizations due to the resident's Veteran Affairs (VA) insurance status. Review of the facility's policy and procedure "Transfer and Discharge (including AMA)" with no effective, revised or reviewed date documented "The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand ...The Social Services Director, or designee, will provide copies of noticed for emergency transfers to the Ombudsman ..."	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		

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F 641	Continued From page 23	F 641		

Based on record review and interview the facility failed to re-assess Resident (R) 15 for falls quarterly. The deficient practice puts all residents who are at risk for falls or have had a change in their fall risk if the assessment is not completed and interventions added and implemented to the care plan.

Findings include:

On 05/14/24, during record review of R15's Electronic Health Record (EHR) found R15's last fall assessment was dated 12/12/23. The next quarterly fall assessment was due 3/12/24 and this was not done.

On 05/14/24 at 03:15 PM interviewed Registered Nurse (RN) 79, nurse assigned to R15 and inquired when was the last fall assessment completed for R15 and how often are they due. RN79 stated she is new to facility and does not know but will find out and let me know. RN79 stated the computer will generate when the next assessment has to be done and will make it available for the nurses to fill out.

On 05/15/24 at 03:52 PM, interviewed Director of Nursing (DON) and inquired when fall assessments are due and he stated quarterly. Inquired about R15's last fall assessment and DON provided a copy of the last fall assessment that was completed on 12/12/23. At this time requested and received a copy of facility's policy on Fall Prevention Program dated 6/2023. DON stated the last falls assessment for R15 was due on 3/12/24 and showed this on R15's EHR. DON confirmed the fall assessment was not done.

On 05/15/24, review of facility policy titles Fall

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F 641	Continued From page 24 Prevention Program, Date Implemented: 06/2023 states for 5. Low/ Moderate risk Protocols: g. Complete a fall risk assessment every 90 days and as indicated when the resident's condition changes.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		

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F 655	Continued From page 25 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to include Resident (R) 35's daily preferences to her baseline care plan which is to be developed within 48 hours of a resident's admission. Findings Include: On 05/13/24, record review of R35's Electronic Health Record (EHR) found she was admitted to the facility on 04/22/24. R35 is a 78 year old resident with diagnoses that include, but are not limited to adjustment disorder, unspecified, functional quadriplegia who has a tracheostomy (breathing tube in neck) and uses a ventilator (machine) to help her breath. Review of R35's baseline care plan found it was filled out on 04/23/24. Section 1. General Information and Initial Goals D. Daily Preferences that Resident Prefers was left blank. Resident prefers the following (check all that apply) 1. Choosing clothes to wear. 2. Caring for personal belongings. 3. Receiving tub bath. 4. Receiving shower. 5. Family or significant other involvement in care decisions and 6. Other (specify). This	F 655		

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F 655	Continued From page 26 section was left blank. On 05/14/24 at 11:05 AM, interviewed R35 who preferred to have her daughter present during the meeting. R35's daughter shared she and her sister, R35's daughters, are at the facility every day and are involved with their mother's care decisions. On 05/16/24 at 3:40 PM interviewed Director of Nursing (DON) and inquired if nurses who admit residents to the facility are required to include resident's daily preferences in their baseline care plan and he confirmed this, stated all areas are to be filled out of the baseline care plan within 48 hours.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		

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F 656	Continued From page 27 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to develop and implement a comprehensive person-centered care plan (CP) for three of 34 residents sampled (Resident (R) 4, R12, and R29) with psychotropic and sedative medications. Non-pharmacological interventions and monitored behaviors were not included in the residents' CP. Findings include: Cross Reference to F758. The facility failed to	F 656		

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specify and monitor behaviors related to the psychotropic medications administered.

1) R4 was admitted to the facility on 02/18/22 with diagnoses of, but not limited to, major depressive disorder, generalized anxiety disorder, and insomnia.

Review of R4's physician orders included psychotropic medications, trazodone (antidepressant) 200 milligrams (mg) daily as needed (PRN) for insomnia, trazadone 50 mg PRN every eight hours for anxiety, and sertraline (antidepressant) 175 mg a day for depression.

On 05/16/24 at 11:31 AM, concurrent record review and interview with Registered Nurse (RN) 23 was done. Review of R4's CP found non-pharmacological interventions and monitored behaviors for the three psychotropics medications used for insomnia, anxiety, and depression were not included in R4's CP.

2) R12 was admitted to the facility on 01/02/24 with diagnoses of, but not limited to, dementia, major depressive disorder, anxiety disorder, restlessness and agitation, and noncompliance with other medical treatment and regimen due to unspecified reason.

Review of R12's physician orders included psychotropic medications, lorazepam (benzodiazepines) PRN for agitation and escitalopram (antidepressant) for depression.

On 05/16/24 at 11:20 AM, concurrent record review and interview with RN23 was done. Review of R12's CP found non-pharmacological interventions and monitored behaviors for the two

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F 656	Continued From page 29 medications used for anxiety and depression were not included in R12's CP. 3) R29 was admitted to the facility on 12/28/23 with diagnoses of, but not limited to, adjustment disorder with anxiety and post-traumatic stress disorder (PTSD). Review of R29's physician orders included psychotropic medications, venlafaxine (antidepressant) twice a day (BID) for PTSD, aripiprazole (antipsychotic) for adjustment disorder with anxiety and lorazepam (benzodiazepines) 0.5mg PRN for anxiety. On 05/16/24 at 10:40 AM, concurrent record review and interview with RN23 was done. Review of R29's CP found non-pharmacological interventions and monitored behaviors for the two medications used for anxiety and depression were not included in R29's CP.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		

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the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to update the care plan for one Resident (R) 27 with treatment plans and recommendations. R27 has a tracheostomy and wears a Passy Muir valve (PMV) to improve communication. R27's representative's decision to not have a tracheostomy cap (T-cap) trial were discussed at the interdisciplinary team (IDT) meeting but not included in the care plan. The deficient practice has the potential to dishonor R27 and her representative's rights.

Findings include:

Cross reference to F551 rights exercised by representative.

On 05/16/24 at 08:30 AM, requested a copy of R27's care plan and IDT meeting minutes for the past six months.

Received and reviewed a written copy of the IDT meeting dated: 09/11/23 at 09:00 AM from Director of Nursing (DON). Handwritten care plan

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F 657	Continued From page 31 summary with IDT. No documentation found on the report to include capping the trachea (trach) or to wean off of the trach. Reviewed the social services quarterly IDT meeting dated 03/20/24. Respiratory Summary: "Reviewed and discussed current treatment. Verbalized understanding. 3. No T-cap trials. respiratory therapy (RT) to continue to consult with family member (FM) as needed." Care plan reviewed: R27's diagnosis included tracheostomy related to acute respiratory failure with hypoxia. Interventions on the care plan include monitor/ document respiratory rate, depth and quality and suction, as necessary. No documentation found regarding use of the PMV for communication or R27's representatives wishes for no T-cap trials. On 05/16/24 at 01:33 PM interview with the respiratory therapy supervisor (RTS). RTS gave an account of the incident with the T-cap (cross reference to F551) to the surveyor. The surveyor asked if there was a discussion with the family before the trial. RTS stated no, R27's FM told the speech therapist that she didn't want R27 to do the trial because of a problem with her vocal cord. "Normally it would be part of the IDT meeting. We discuss everything at the care plan meeting."	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		

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by:
Based on observation, interview and record review, the facility failed to ensure residents were provided with supplies necessary to maintain optimal nutrition, grooming, and personal and oral hygiene for seven residents in the sample (Resident (R) 1, R7, R26, R27, R31, R33, and R4). Six of the seven residents in the sample are receiving enteral nutrition (fed by tube) by gravity instead of a pump due to a shortage of the pump tubing, and R33 had significant weight loss; R27 frequently runs out of suction toothbrushes needed for her increased secretions; and R4 is provided briefs to small for him. The deficient practice places residents who require maximal/ dependent assistance in the facility at risk of achieving maximum physical health and well-being.

Findings include:

1) Random observations conducted in residents' rooms on 05/13/24 at 10:55 AM, 11:00 AM; 02:15 PM and 05/14/24 at 09:35 AM; 02:00 PM; 04:30 PM. Observed R1, R7, R26, R27, R31, and R33 with tube feedings being provided by gravity drip with pumps that were not in use attached to the poles. Electronic Health Record (EHR) reviewed for R33 revealed a significant weight loss and a stage four pressure ulcer.

2) On 05/14/24 at 10:49 AM, observation and interview with Resident (R)7's family member (FM) 8. During the interview FM8 said the facility often runs out of green toothbrushes for R7 that have suction. R7 has a lot of saliva, so when she bushes her teeth, the green brush takes care of the excess secretions. When she runs out, she has to use the small pink sponges and they don't

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clean her teeth. FM8 added that they also run out of absorbent disposable pads and have to use the cloth pads instead, which gets soaked. R7 has a lot of fluid and soaks her brief. The absorbent pads are better when her brief leaks. "I don't know if it's a problem with the budget, or the person in charge of ordering them but frequently they run out."

3) On 05/15/24 at 08:51 AM, observation during medication (med) pass with Registered Nurse (RN) 79, who was preparing a tube feeding for R31. Observed the tube feeding pole with a white pump. A tube feeding bag was also hanging from the pole but not attached to the pump. RN79 said that all of our tube feedings are gravity feedings because the supplies for the current pumps are back ordered. When asked how long the pumps have not been in use she stated, "I came in February of this year and since then we haven't been using the pumps."

On 05/15/24 at 01:30 PM, confidential interview with a staff member (SM). The surveyor asked if there are any supplies that are in short supply. "The facility runs out of the chucks (disposable absorbent pads) a lot. Now they are using cloth pads, and it makes a lot of laundry. I'm not sure what the problem is, but it happens a lot."

On 05/16/24 at 2:39 PM, interview with the Supply Supervisor (SS). The surveyor asked SS what the process is to ensure the facility has enough medical and non-medical supplies in stock. SS explained that the supply budget is 18,000 per month and is set by the Administrator. "We try to stay in the budget. Since we don't have a big storage here, I restock our supply weekly. We have problems getting certain supplies and our

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main supplier has items we need on back order. When this happens, we either go with local vendors or ask other facilities for supplies." When asked about the green toothbrushes for R7 that have been running out, SS said the respiratory and nursing staff need to let the Administrator know when they run out. When asked about the tube feeding supplies, SS said "the bags for the pumps we have are back ordered till August 2024. The nursing staff are having to use gravity bags for the tube feedings instead. I have brought this up to the Administrator but was told that no one from the respiratory or nursing department has complained about it. For anything that goes over the budget I go to the Administrator. The goal is to eventually change to a different pump that uses a bag with tubing that will be readily available and in stock."

On 05/16/24 at 3:02 PM, interview with Registered Dietician (RD). The surveyor asked RD how the weight loss for R33 is being managed. RD explained, "once the weight loss was identified for R33, we increased the gravity feedings to 350 cubic centimeters (cc) five times per day. The resident also has a wound that progressed to stage four. If he doesn't improve, I may change him to a continuous feeding." When asked if he was aware that the tubing for the feeding pump is not currently available, RD said yes, "I am aware, and the situation is not ideal, but we have to work with what we have. It would be better to use the pump to have a more accurate volume intake. With the gravity drip it is not the best situation."

4) During review of the facility's "Resident Council Minutes" for February, March, and April 2024

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F 677	Continued From page 35 monthly meetings, on 04/29/24 the minutes documented R4 inquiring "What's going on regarding have the supplies being ordered and delivered? Always running out of briefs, disposable pad/reusable pad." On 05/15/24 at 10:31 AM, during a meeting with Resident Council members, inquired if the members had concerns with supplies in the facility. R4 reported the facility runs out of disposable pads and briefs and he had to wear a smaller brief size yesterday due to the lack of supplies. R4 stated it is uncomfortable to wear a smaller size brief. On 05/15/24 at 11:30 AM, a confidential interview with SM was done. SM confirmed the facility is frequently out of extra extra large (XXL) briefs and did not have any available yesterday. SM stated the biggest size that the facility has in stock is XXL but even that size can be small for some of the residents, including R4. On 05/16/24 at 02:48 PM, an interview with SS was done. SS confirmed the facility has been out of the larger size briefs for two to three days, however, sometimes the other floors don't check each other's floors if available. The facility orders XXL and large briefs but must get them from warehouse stores and local vendors until their supply vendors are restocked to deliver. SS reported there are larger sizes then XXL the facility can order, but staff members have not special requested the larger sizes.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		

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Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure a resident received treatment and care in accordance with professional standard of practice for one of 16 residents sampled (Resident (R) 29). The facility did not follow the physician ordered bowel instruction and as a result, R29 was placed at increased risk of avoidable skin breakdown, infection and discomfort.

Findings include:

R29 was admitted to the facility on 12/28/23 with diagnoses of, but not limited to, chronic kidney disease stage 4, gastrotomy status, tracheostomy status, muscle weakness, other abnormalities of gait and mobility, bed confinement status, long term use of antibiotics, unspecified Escherichia coli (E. coli) as the cause of diseases classified elsewhere, pneumonia, and abnormalities of gait and mobility.

Review of R29's physician orders included Senna-Docusate (stool softener), give one tablet via G-Tube two times a day for constipation, hold for loose stool.

Review of R29's Electronic Health Record (EHR) found R29 had loose stools in March, April, and

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May. In March, on 03/03/24 to 03/06/24; on 03/08/24 to 03/10/24; on 03/14/24 to 03/18/24; on 03/20/24; on 03/22/24 to 03/24/24, a total of 31 loose stools at various times during those dates were documented. In April, on 04/07/24; on 04/24/24 to 04/27/24, a total of six loose stools at various times during those dates were documented. In May, on 05/1/24 to 05/02/24; on 05/04/24; on 05/07/24; and on 05/14/24, a total of six loose stools at various times during those dates were documented. R29's stool softener medication (Senna) was administered and not held during those dates except on 03/22/24 in the afternoon and on 05/14/24 in the morning.

On 05/16/24 at 10:40 AM concurrent record review and interview with Registered Nurse (RN) 23 was done. Concurrent review of R29's daily recorded bowel movement and Medication Administration Record (MAR) in April and May, RN23 confirmed R29's stool softener medication should have been held as ordered by the physician on the days R29 had loose stools and was not done. RN23 reported based on the discovery, the communication between the Certified Nurse's Aides and Nurses needs to be looked at. Inquired if R29 was at further risk of skin breakdown due to loose stools, RN23 confirmed he was. Concurrent review of R23's weekly skin assessments documented R29 had a rash on groin and coccyx on 04/20/24, redness to buttocks on 04/27/24, redness to groin and buttocks on 05/04/24, and "still has" redness to groin and buttocks on 05/11/24. Concurrent review of R29's daily recorded bowel movement and Medication Administration Record (MAR) in April and May, RN23 confirmed R29's stool softener medication should have been held as ordered by the physician on the days R29 had

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F 684	Continued From page 38 loose stools and was not done. Review of the facility's policy "Bowel Elimination" documented "It is the policy of the facility to ensure that staff providing care and services to resident via regular monitoring of bowel patterns and adjustment of bowel regiment to prevent complications. Facility bowel elimination care and services will be provided in accordance with resident needs and professional standards of practice ...Holding of stool softeners for 24 hours following each loose bowel movement ...C. Difficile testing via stool sample following 3 loose stools in 24 hours."	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to change a suction cannister half full of red-brown secretions and clots for one of three residents in the sample (Resident (R) 1). The deficient practice placed residents receiving tracheostomy care at an increased risk of illness. Findings include:	F 695		

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F 695	Continued From page 39 Cross reference to F880. Electronic Health Record (EHR) reviewed. R1 is a dependent female resident admitted on 4/30/24 A sputum culture was obtained that resulted in a bacterial infection on 05/06/24, R1 was started on intravenous (IV) antibiotics. Random observations were conducted in R1's room on 05/13/24 at 11:16 AM, and 05/14/24 at 09:14 AM. R1's suction cannister noted with dark red brown fluid with clots, volume 50 percent full. The date on the cannister was smeared and not readable. On 05/14/24 at 01:45 PM, observed the cannister was replaced with a new cannister with the current date. On 05/14/24 at 02:09 PM interview with Respiratory Therapist (RT) 22 and the Respiratory Therapist Supervisor (RTS). The surveyor explained that the suction cannister for R1 was noted to be half full of red-brown fluid with clots during observations on Monday and Tuesday and asked how often the suction cannisters are emptied or changed. RT22 said the respiratory therapists change the cannisters once per week on Tuesday or when it is full. Facility infection control-disposable equipment policy change-out reviewed. "Policy: Disposable equipment will never be reused. Equipment changes will be performed according to a specific frequency and may be replaced as needed (PRN) when not clean in appearance by either a licensed nurse or respiratory therapist. Goals: To provide infection control guidelines to decrease the likelihood of transmitting nosocomial infections to residents."	F 695		
F 732 SS=F	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)	F 732		

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§483.35(g) Nurse Staffing Information.
§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:
(i) Facility name.
(ii) The current date.
(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
(A) Registered nurses.
(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).
(C) Certified nurse aides.
(iv) Resident census.

§483.35(g)(2) Posting requirements.
(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.
(ii) Data must be posted as follows:
(A) Clear and readable format.
(B) In a prominent place readily accessible to residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:

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F 732	Continued From page 41 Based on observation and interview the facility failed to provide Nursing Staffing Information to include hours worked by Registered Nurses (RNs), Certified Nurse Aides (CNAs) and resident census each day. Findings Include: On 05/15/24 at 08:40 AM, observed facility's Daily Assignment sheet that was posted near the nurse's station on the treatment cart. The posting listed RN and CNA names and area they were assigned to work that day and the shift. No hours worked were posted for the RNs and CNAs and no resident census for the day was included on this posting. On 05/16/24 at 02:06 PM interviewed Director of Nursing (DON). During this interview shared requirements of F732. DON confirmed his posting was missing resident census and total numbers of hours worked by RNs and CNAs.	F 732		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any	F 756		

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drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure the attending physician documented in the residents' medical record that a review of the medication regimen review (MMR) recommendation from the pharmacist was reviewed and what, if any, action had been taken to address it for three of five residents sampled (Resident (R) 4, R12, and R29).

Findings include:

1) Review of R4's physician orders included psychotropic medications, trazodone

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(antidepressant) 200 milligrams (mg) daily as needed (PRN) for insomnia and trazadone 50 mg PRN every eight hours for anxiety.

Review of R4's monthly MRR found recommendations in August 2023, October 2023, and November 2023 with no documentation from the physician that the MRRs were reviewed. In August, October, and November the pharmacist recommended the physician to provide a specific stop date or time period and a clinical rationale to continue trazodone PRN psychotropic medications past 14 days.

On 05/16/24 at 11:31 AM, concurrent record review and interview with Registered Nurse (RN) 23 was done. Concurrent record review found the physician did not provide a rationale to continue the trazodone PRN medications past 14 days and did not document the review of the MRR recommendations.

2) Review of R12's monthly MRR found recommendation in November 2023 dated 12/07/23, "Please add supplemental directions "Do not exceed 3 grams APAP [acetaminophen] in 24 hours from all sources" to each of the APAP containing orders." No documentation the physician reviewed the MRR was found.

On 05/16/24 at 11:20 AM, concurrent record review and interview with RN23 was done. Concurrent review of R12's physician orders found an order for acetaminophen not to exceed 4 grams. Inquired if the physician reviewed the MRR and responded to the pharmacist regarding the recommendations to not exceed 3 grams, RN23 was not able to find documentation.

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F 756	Continued From page 44 3) Review of R29's physician orders included psychotropic medications, venlafaxine (antidepressant) twice a day (BID) for PTSD and aripiprazole (antipsychotic) for adjustment disorder with anxiety. Review of R29's monthly MRR found recommendation in February 2024 dated 03/12/24, "Please add a behavioral monitor sheet for this resident. Record specific behaviors and any side effects notes with use of psychoactive medications given. If side effects are noted, physician should be notified. Record all behaviors noted, even if medication is not given as the intervention. (aripiprazole: side effects (antipsychotic) venlafaxine: side effects (antidepressant) ...This resident continues to receive an atypical antipsychotic. Please consider ...Lipid Panel ...LFTs [Liver Function Test] ...A1c [hemoglobin]". No documentation the physician reviewed the MRR was found. On 05/16/24 at 10:40 AM, concurrent record review and interview with RN23 was done. Concurrent review of R29's Treatment Administered Record (TAR) and Medication Administered Record (MAR) found no specific behaviors in the behavior monitor sheet (Cross Reference to F758). RN23 found Lipin Panel, LFTs, and A1c was not ordered by the physician after the recommendation had been made. RN23 was not able to find documentation that the physician reviewed and responded to the pharmacist's recommendation on the MRR.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs.	F 758		

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F 758	Continued From page 45 §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and	F 758		

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indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews, the facility failed to specify and monitor behaviors related to psychotropic and sedative medications for three of five residents sampled (Resident (R) 4, R12, and R20); and failed to ensure a PRN (as needed) psychotropic medication was limited to 14 days or ensure the physician document their rationale to extend the 14 days in a residents medical record for one of five residents sampled (R4).

Findings include:

1) R4 was admitted to the facility on 02/18/22 with diagnoses of, but not limited to, major depressive disorder, generalized anxiety disorder, and insomnia.

Review of R4's physician orders included psychotropic medications, trazodone (antidepressant) 200 milligrams (mg) daily as needed (PRN) for insomnia, trazadone 50 mg PRN every eight hours for anxiety, and sertraline (antidepressant) 175 mg a day for depression.

On 05/16/24 at 11:31 AM, concurrent record review and interview with Registered Nurse (RN) 23 was done. Review of R4's Treatment Administered Record (TAR) and Medication Administered Record (MAR) found no specified

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monitored behaviors for the three psychotropics medications used for insomnia, anxiety, and depression. Registered Nurse (RN) 23 confirmed documentation that behaviors were being monitored in the Electronic Health Record (EHR) were not found and documentation that the physician provided a rationale for the extended use of the two trazadone PRN medications ordered past 14 days was not found (cross reference to F756).

Review of the facility's policy and procedure "Antipsychotic Medication Use" with no effective, revise, or review date documented "The need to continue PRN orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale fo the extended order."

2) R12 was admitted to the facility on 01/02/24 with diagnoses of, but not limited to, dementia, major depressive disorder, anxiety disorder, restlessness and agitation, and noncompliance with other medical treatment and regimen due to unspecified reason.

Review of R12's physician orders included psychotropic medications, lorazepam (benzodiazepines) PRN for agitation and escitalopram (antidepressant) for depression.

On 05/16/24 at 11:20 AM, concurrent record review and interview with RN23 was done. Review of R12's TAR and MAR found no specified monitored behaviors for the two medications used for anxiety and depression. RN23 confirmed documentation that behaviors were being monitored in the EHR were not found.

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F 758	Continued From page 48 3) R29 was admitted to the facility on 12/28/23 with diagnoses of, but not limited to, adjustment disorder with anxiety and post-traumatic stress disorder (PTSD). Review of R29's physician orders included psychotropic medications, venlafaxine (antidepressant) twice a day (BID) for PTSD, aripiprazole (antipsychotic) for adjustment disorder with anxiety and lorazepam (benzodiazepines) 0.5mg PRN for anxiety. On 05/16/24 at 10:40 AM, concurrent record review and interview with RN23 was done. Review of R29's TAR and MAR found no specified monitored behaviors for the two medications used for anxiety and depression. RN23 confirmed documentation that behaviors were being monitored in the EHR were not found (cross reference to F756).	F 758		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations of two of four residents (Resident (R) 17 and R31), record review, one closed record review for R37 and interview the facility failed to ensure its medication error rate was not five percent or greater, an error rate of 38.36 percent (10 errors out of 26 opportunites). This deficient practice could put all residents at risk for medication errors which could include	F 759		

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medications given the wrong route and receiving medication when it should be held which could put the residents at risk for harm.

Findings Include:

1) On 05/15/24 at 08:50 AM observed Registered Nurse (RN) 80 prepare and pass medication to R17 on the third floor. Prior to medication pass the nurse reported R17's blood pressure was 116/65 and pulse was 67. R17 is a 44 year old resident who was admitted to the facility on 08/11/2023 with diagnoses including, but are not limited to,cognitive communication deficit, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side and anoxic brain damage, not elsewhere classified. During medication preparation RN80 read each medication blister pack and popped out the medication into an individual medication cup which she labeled. Observed RN80 crushed all the medications except clopidogrel bisulfate and polyethylene glycol 3350. Each crushed medication was put into the labeled individual medication cups. RN80 took R17's medications to him in his room. RN80 communicated with R17 to let him know what she was going to do. RN80 put Clopidogrel Bisulfate 75 milligrams (mg) tablet in apple sauce and fed it to R17. RN80 administered each crushed medication via R17's gastrostomy tube (G-tube) by adding water to the crushed medication in each individual medication cup, stirring and draw up the contents into a large syringe. The medications were given one by one to the resident via his G-tube and a 10-20 cc flush was given after each medication. The crushed medications that were ordered to be given via G-tube to R17 were:
Aspirin 81 mg chewable tablet Give 1 tablet via

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F 759	Continued From page 50 G-tube one time a day related to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side Carvediol 12.5 mg tablet Give 1 tablet via G-tube two times a day for related to essential hypertension hold for systolic blood pressure below 110 and heart rate below 55 The following medications were crushed and given to R17 via his G-tube but are ordered to be given by mouth resulting in medication administration errors. 1. losartan potassium 25 mg tab 1 tab by mouth one time a day related to essential (primary) hypertension Hold for systolic blood pressure below 110 2. hydralazine HCL 25 mg tablet give 1 tablet by mouth one time a day related to essential (primary) hypertension Hold for systolic blood pressure below 110 3. meclizine HCL 12.5 mg tablet give 1 tablet by mouth three times a day related to vertigo of central origin 4. multivitamin adults oral tablet Give 1 tab by mouth one time a day for supplement 5. stimulant laxative plus tablet give 1 tablet by mouth two times a day for constipation, hold for constipation 6. vitamin D 5,000 unit tab give 1 tablet by mouth one time a day for supplement The following medications were given by mouth as ordered for R17: polyethylene glycol 3350 Give 1 packet by mouth one time a day for constipation dissolve in 4-8 oz water or juice, then administer Clopidogrel Bisulfate 75 mg tablet give 1 tablet by mouth one time a day related to hemiplegia and hemiparesis following cerebral infarction affecting	F 759		

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F 759	Continued From page 51 right dominant side DO NOT CRUSH On 05/15/24 at 11:15 AM, interviewed Unit Manager (UM) Registered Nurse (RN) 23 regarding medication pass provided by RN80 to R17. Inquired about five rights, if nurses are expected to give medication by right route and UM RN23 confirmed this. Inquired if nurses receive annual training on medication pass and five rights and UM RN23 stated she will follow up with Director of Nursing (DON). UM RN23 confirmed medications are to be documented accurately when given. Inquired if R17 had an order that it was ok to crush all his medications and give via his G-tube and UM RN23 confirmed there was no order for this. On 05/15/24 during record review of R17's Electronic Health Record (EHR), found R17's medication orders matched what was provided by the pharmacy on the individual medication blister packs. On 05/15/24 at 02:15 PM, DON provided a copy of the facility's training from Relias which the nurses do upon hire and annually, Avoiding Common Medication Errors. Section 2: Common Medication Errors states "Rights" The "rights of medication administration" is the most important guideline that you must follow when administering medications. The five original "rights" include the: Right person Right medication Right dose Right time and frequency Right route At this time DON also provided a copy of RN80's Initial/Annual Competency Evaluation. On the	F 759		

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F 759	Continued From page 52	F 759		

Skilled Check List under Medications 7 Rights of Medication Administration is listed which RN80 completed on 02/01/24.

2) On 05/15/24 during closed record review of R37's EHR found on 02/27/24 RN72 gave R37 his Carvediol 3.125 mg tablet 0800 (8 AM) dose. Review of this medication found it has a hold parameter ordered by the physician that states hold if BP less than 110/60 or pulse less than 60. R37's BP was recorded by RN72 as 104/47 and pulse 61. RN72 documented this medication was given to R37.

On 05/16/24 at 02:05 PM, interviewed DON who confirmed the medication should have been held as ordered by the physician.

Review of the facility policy Administering Medications states under Policy Interpretation and Implementation 3. Medications must be administered in accordance with the orders, ...

3) On 05/15/24 at 08:28 AM medication administration observation with RN79 in the front unit on second floor. The following medications were administered to R31:
1. Aspirin 81 milligrams (MG) oral tablet chewable (Aspirin). give 1 tablet via gastrostomy (G)-tube (T) one time a day via G-tube.
2. Baclofen oral tablet 10 MG give 1 tablet via G-tube three times a day.
3. Guar Gum Powder give 4 Gm via G-Tube one time a day.
4. Levetiracetam oral solution 100 MG/ML give 7.5 ml via G-tube every 12 hours.
5. Metoprolol tartrate oral tablet 25 MG give 1 tablet via G-tube two times a day for hypertension (HTN) hold systolic blood pressure (SBP) below

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F 759	Continued From page 53 100 or HR below 60. 6. Senna Oral Tablet 8.6 MG (Sennosides) Give 2 tablets via G-tube one time a day for Constipation Hold for loose stool. During the medication observation all of the medications were poured in one cup and given together. On 05/15/24 at 11:30 AM, discussed the observation of the six medications that were crushed, poured in one cup then given via G-tube with RN79, she stated that she was trained to give the GT medications that way and is her current practice. Discussed the observation with the nurse manager, she stated that RN79 was a new staff, and she wasn't aware that she was giving the medications that way. The nurse manager concurred that the medications are supposed to be given one at a time when administered via the G-tube. Administering medications policy reviewed. Page two, #27 "The Charge Nurse must accompany new nursing personnel on their medication rounds for a minimum of three (3) days to ensure established procedures are followed and proper resident identification methods are learned."	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		

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F 761	Continued From page 54 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: 3) On 05/15/24 at 09:45 AM, inspected medication cart RN80 was using. While checking narcotics reviewed Narcotic Endorsement Log and found two blank spaces dated 05/03/24 0700-1900 ON and 1900-0700 OFF. Inquired of RN80 why these were left blank and RN80 stated someone forgot to sign the form. On 05/17/24 at 03:40 PM interviewed DON and inquired if nurses are expected to sign the Narcotic Endorsement Log after the narcotic count is done and he confirmed this. Showed DON the May 2024 Narcotic Endorsement Log and he stated staff forgot to sign the form.	F 761		

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Based on observation, record review and interview, the facility failed to label medications in accordance with acceptable professional standards, including expiration date, and store medications in a locked compartment when left unattended by authorizing administering nursing staff for three residents sampled (Resident (R) 1, R4, and R14) .The facility also failed to assure the narcotic medication count was endorsed each shift by having the nurses sign the Narcotic Endorsement Log when coming on shift and going off shift. The deficient practice placed the residents who are receiving medications on the unit at risk for illness due to unsafe medication storage.

Findings include:

On 05/15/24 at 09:52 AM observation on the back unit on the second floor with registered nurse (RN) 71 during a random inspection of the medication cart. Observed one Insulin pen in the top drawer of the cart with a label with a large dark gray-black smear. Unable to read the name of the resident on the label. Asked RN71 who the pen is for, she turned it over and R1's name was handwritten on a post it label. Confirmed with the nurse manager after showing her the pen. The nurse manager noted the smeared label and said when the resident was re-admitted, the medication was not available so the pen was taken from the emergency stock and should have been discarded. A bottle of Polyethylene glycol suspension with an open date of 01/25 written on the label was found in the bottom drawer of the cart. No expiration date was noted on the bottle.

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RN71 stated the resident is no longer on that medication and discarded the bottle.
2) On 05/13/24 at 11:42 AM, during observation and interview with R4, RN74 walked in R4's room placed a small clear plastic cup on his bedside table and informed R4 it was his pain medication, oxycodone and Tylenol, a total of three medication tablets. RN74 then asked for R4's pain level and if he needed a refill of water. R4 reported his pain level was a six. RN74 quickly left with R4's water bottle leaving his medications unattended. At 11:44 AM, RN74 returned with R4's water bottle, placed it on his bedside table and quickly left without ensuring R4 took his medications. Inquired with RN74 as she was leaving R4's room if it was common practice for her to leave without watching R4 take his medication, R74 stated she assessed he can take it on his own and that it was okay for her to leave.

Review of R4's Electronic Health Record (EHR) found no assessment, or indication in R4's comprehensive care plan that he is currently on a self-administration of medication program. Review of R4's diagnoses include, but not limited to, major depressive disorder, generalized anxiety disorder, and insomnia. Review of R4's Medication Administration Record (MAR) documented R4 was administered Acetaminophen Tablet 500 milligrams (mg) give two tablets by mouth every six hours for routine mild pain and oxycodone (a narcotic/opioid and Schedule II controlled medication) tablet 5 mg give 1 tablet by mouth every 6 hours for moderate pain at 12:00 PM.

On 05/16/24 at 12:45 PM, an interview with Director of Nursing (DON) was done. DON

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reported nursing staff should physically be there and watch residents take their medications. If they are unable to, or the resident does not want to take the medication at the time of administration the nurse should keep it in a locked compartment. Inquired if a resident has a diagnoses of major depressive disorder and anxiety disorder, would it be appropriate to leave a an opioid medication, with a resident unattended. DON stated he would not leave an opioid, especially because it is a controlled medication and would watch the resident take it. DON further stated, "they could be taking and hiding it, after 2-3 days the have a handful and take a large quantity at the same time ...could be suicidal and overdose themselves."

Review of the facility's policy and procedure "Medication Storage" with a reviewed/revised date of 05/30/23 documented "During a medication pass, medications must be under the direct observation of the person administering medication or locked in the medication storage area/cart ...Schedule II drugs ...are stored under double-lock key."

3) Cross referent to F842. The facility failed to accurately document in R14's medical record. A cup full of medications left on R14's bedside table unattended was documented in the MAR as administered.

On 05/14/24 at 09:53 AM, observed R14 in her bed sleeping. Her bedside table was over her bed and small clear plastic container filled with approximately seven various medication tablets of different sizes and colors were found in the container. The medications could be seen from the hallway outside of R14's room and was left

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F 761	Continued From page 58 unattended. Review of R14's MAR found R14 was administered nine different medications in the morning during 08:00 AM medication pass. At 05/15/23 at 09:33 am, an interview with R14 was done. R14 confirmed the nurses' will sometimes leave her medication at bedside table because she likes to take her time and takes a long time swallowing her medications. R14 stated it's based on a "honor system, they trust me." R14 reported she does not like taking certain a certain medication with her other medication because it makes her stomach queasy and admitted she still has the medication on her bedside table to take later. Review of R14's Electronic Health Record (EHR) found no assessment, or indication in R14's comprehensive care plan that she is currently on self-administration of medication program.	F 761		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:	F 838		

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F 838	Continued From page 59 §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources,	F 838		

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F 838	Continued From page 60 such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on review of the Facility Assesment (FA), the facility failed to conduct, document, and annually review its facility-wide assessment. The facility used a facility assessment tool as a template in place of an up to date and accurate assessment to identify the needs of its residents. The deficient practice placed all residents in the facility at an increased risk of harm. Findings include: On 05/16/24 at 03:43 PM, FA reviewed. "Requirement. Nursing facilities will conduct, document, and annually review a facility-wide assessment, which includes both their resident population and the resources the facility needs to care for their residents." The FA was missing accurate and up to date information regarding special treatments and conditions. Acuity 1.5; respiratory treatments, oxygen therapy 0-15, suctioning 0; tracheostomy care 0; ventilator or Respirator 0. Facility matrix reviewed. 24 Residents with tracheostomies; 15 residents on mechanical ventilators and require special respiratory treatments.	F 838		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		

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F 842	Continued From page 61 §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 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	F 842		

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F 842	Continued From page 62 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. §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 observation, record review and interview, the facility failed to ensure nurses accurately documented in two sampled residents' record (Resident (R) 17 and R14). The nurse did not accurately document the route Resident (R) 17 received his medications and a cup full of medications left on R14's bedside table unattended was documented in the Medication Administration Record (MAR) as administered. This deficient practice could put all residents at risk for incorrect documentation of medications	F 842		

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administered to them.

Findings Include:

1) Cross reference to F759 . The facility failed to assure it was free of medication error rate of five percent or greater with a nurse incorrectly documenting medications given the wrong route resulting in medication administration errors and documentation errors for Resident (R) 17.

On 05/15/24 at 08:50 AM, observed Registered Nurse (RN) 80 prepare and pass medication to R17. During medication preparation RN80 read each medication blister pack and popped out the medication into an individual medication cup which she labeled. Observed RN80 crushed all the medications except clopidogrel bisulfate and polyethylene glycol 3350. The crushed medications were put into the labeled individual medication cups. RN80 took R17's medications to him in his room. RN80 administered each crushed medication via R17's gastrostomy tube (G-tube) by adding water to the crushed medication in each individual medication cup, stirring and draw up the contents into a large syringe. The medications were given one by one to the resident via his G-tube and a 10-20 cc flush was given after each medication. The crushed medications that were ordered to be given via G-tube to R17 were:
Aspirin 81 mg chewable tablet Give 1 tablet via G-tube one time a day related to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side
Carvediol 12.5 mg tablet Give 1 tablet via G-tube two times a day for related to essential hypertension hold for systolic blood pressure below 110 and heart rate below 55

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F 842	Continued From page 64 The following medications were crushed and given to R17 via his G-tube but are ordered to be given by mouth resulting in medication administration and documentation errors. 1. losartan potassium 25 mg tab 1 tab by mouth one time a day related to essential (primary) hypertension Hold for systolic blood pressure below 110 2. hydralazine HCL 25 mg tablet give 1 tablet by mouth one time a day related to essential (primary) hypertension Hold for systolic blood pressure below 110 3. meclizine HCL 12.5 mg tablet give 1 tablet by mouth three times a day related to vertigo of central origin 4. multivitamin adults oral tablet Give 1 tab by mouth one time a day for supplement 5. stimulant laxative plus tablet give 1 tablet by mouth two times a day for constipation, hold for constipation 6. vitamin D 5,000 unit tab give 1 tablet by mouth one time a day for supplement The following medications were given by mouth as ordered for R17: polyethylene glycol 3350 Give 1 packet by mouth one time a day for constipation dissolve in 4-8 oz water or juice, then administer Clopidogrel Bisulfate 75 mg tablet give 1 tablet by mouth one time a day related to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side DO NOT CRUSH After RN80 administered R17's medications RN80 signed all the medications given as ordered in R17's electronic health record. On 05/15/24 at 11:15 AM, interviewed Unit	F 842		

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Manager (UM) Registered Nurse (RN) 23 regarding medication pass provided by RN80 to R17. UM RN23 confirmed medications are to be documented accurately when given. Inquired if R17 had an order that it was ok to crush all his medications and give via his G-tube and UM RN23 confirmed there was no order for this.
2) Cross reference to F761. The facility failed to ensure medications were not left unattended by authorized staff and stored in locked compartments.

On 05/14/24 at 09:53 AM, observed R14 in her bed sleeping. Her bedside table was over her bed and small clear plastic container filled with approximately seven various medication tablets of different sizes and colors were found in the container.

At 10:10 AM, review of R14's MAR found medications aspirin, atorvastatin, cranberry extract, folic acid, losartan potassium, pantoprazole, carvedilol, lacosamide, and levetiracetam were marked in the MAR as administered in the morning at 08:00 AM.

At 05/15/23 at 09:33 am, an interview with R14 was done. R14 confirmed the nurses' will sometimes leave her medication at bedside table because she likes to take her time and takes a long time swallowing her medications. R14 stated it's based on a "honor system, they trust me." R14 reported she does not like taking certain a certain medication with her other medication because it makes her stomach queasy and admitted she still has the medication on her bedside table to take later.

Review of R14's Electronic Health Record (EHR)

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F 842	Continued From page 66 found no assessment, or indication in R14's comprehensive care plan that she is currently on self-administration of medication program. R14's care plan documented R14 " ...is resistive to care in that at times she refuses medication and is at risk for complications including constipation." On 05/16/24 at 12:45 PM, an interview with Director of Nursing (DON) was done. DON reported nursing staff should not mark administered medication on the MAR unless they physically watched the resident take the medication. DON stated, "how do I know if they throw it in the rubbish."	F 842		
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	F 880		

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F 880	Continued From page 67 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (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.	F 880		

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§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observations, interview and policy review, the facility failed to ensure it established and maintained an infection prevention control program to prevent the spread of infections evidenced by the following: Environmental cleaning of resident's rooms was not being routinely conducted; resident care equipment was not cleaned and left in resident rooms; disposable care equipment was reused; and an infection control and prevention policy was not complete for the provision of infection prevention and control based on recognized guidelines, facility assessment; environmental cleaning and disinfection for resident care areas and equipment; and the kitchen was found with areas where residents food could be contaminated.
The deficient practice places all residents in the facility at an increased risk for illness.

Findings include:

1) Random observations were conducted in R31's room on 05/13/24 and 05/14/24 of resident R31's suction canister, cross reference to F695.

On 05/15/24 at 08:51 AM observation in room 201A. Observed a feeding pump attached to a pole that wasn't in use with brown stains on the front. The surveyor showed the pump with the residual to Registered Nurse (RN) 79 and asked why the pumps are kept in the residents' rooms when they are not being used. RN79 stated that she didn't know why. Maintenance is responsible

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for the equipment and the nurses should keep the equipment clean.

On 05/15/24 at 4:10 PM, observation in room 207. The residents residing in the room were identified to be on enhanced barrier precautions with three of the four on mechanical ventilators. Observed the floors throughout the room were soiled with brown smudges and black marks. Pieces of tape, paper and plastic caps were on the floor. There were red droplets 3-4 inches wide dried on the tiled floor. A waste can that was half full of pads and paper was placed in the middle of the room outside of each bed's curtain. Observed the table in between the A and D bed had two books; a small figurine; an open gauze packet with a medication cup with white cream laying on top of it on its side; two plastic cups half filled with water and a gastric tube (GT) syringe that was laying on top of the plastic wrapper. The surveyor shared the observations with RN62 who had entered the room. The surveyor asked her who is responsible for ensuring the resident care areas are kept clean. RN62 replied that it is a team effort, the staff who are providing the care are responsible to keep the tables clean. Housekeeping is responsible for cleaning the other areas of the room. RN62 said she will talk to her manager about the room, adding that the room should be clean.

On 05/16/24 at 12:34 PM, interview with the Unit Manager (UM) RN23. When asked whose responsibility it is to keep the bedside tables clean, she said it's everyone's responsibility to ensure the area is clean.

On 05/16/24 at 10:00 AM, interview with Director of Maintenance (DOM) and Housekeeping Staff

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(HS) 87. DOM said currently there are four staff although one staff will be leaving soon. The three staff are working only on day shift. Responsibilities include cleaning the facility: sweep, mop, dusting and pick up trash in the resident's rooms. They don't clean the tables because the residents have medical equipment, so the nursing staff are responsible to clean the overbed tables. If a resident is discharged, they will clean the room with a terminal cleaning. The surveyor asked how he ensures the rooms are being cleaned. DOM stated that he does a daily check of all floors in the building. The surveyor and DOM conducted a brief tour of the second-floor locations where the surveyor made observations the previous day. The surveyor showed the areas of the floor that are soiled and have debris on the floor stating that no observations were made of staff cleaning in the following rooms 205, 206, 207, and 208 during random observations on 05/13/24 through 05/16/24. The surveyor asked DOM when staff clean the resident rooms. DOM replied with the short staff we have they can only clean the room once per day.

Environmental cleaning and disinfection of resident care areas and equipment policy was not available for review.

2) On 05/15/24 at 08:51 AM, observation with RN79, administering a GT feeding for resident (R31). Observed RN79 pour the formula into the bag and prime the line. When the line was not priming, she checked the tip and stated to the surveyor, the tip is clogged, it must be from night shift. I'll go ahead and wash it. RN79 took the tip into the restroom to clean it and returned to reconnect it to the tubing. After a few minutes,

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the formula began moving down the line. The surveyor asked her how often the purple tips are replaced. RN79 explained that right now we are out of purple caps and so were re-using them, cross reference to F677. When asked, are they being cleaned after each tube feeding or once per shift, she stated that she washes the purple tip after each GT feeding.

Infection control-disposable equipment change-out policy reviewed. "Policy: Disposable equipment will never be reused. Equipment changes will be performed according to a specific frequency and may be replaced as needed (PRN) when not clean in appearance ...To provide infection control guidelines to decrease the likelihood of transmitting nosocomial infections to residents."

On 05/16/24 at 11:42 AM, interview with Infection Preventionist (IP). The surveyor shared observations of the environment in resident rooms where the floors appeared dirty, side table were unclean with dirty items left in patient care areas and asked if the facilities IPCP involves the housekeeping department. IP said DOM attends the Quality Assurance (QA) committee but wasn't actively involved in the IP program and confirmed that they weren't conducting any rounding for housekeeping.

The surveyor asked IP if she was aware that the nursing staff were reusing the purple tips for the G-Tube feedings. IP said no, she wasn't aware of this. "If the nursing staff are having to reuse them, they should be washing them with soap and water after each use." IP shared the facility currently has three residents with infections and one with pneumonia. The surveyor requested a copy of

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the facility's infection prevention control program policy from IP. IP provided separate policies that were printed online. IP stated she wasn't sure if there was a facility ICPC policy and deferred to Director of Nursing (DON).

3) On 05/16/24 at 12:39 PM, DON provided the following to the surveyor: Operational policy and procedure manual for long-term care infection control table of contents, 2001 MED-PASS, INC. (Revised April 2024) that didn't include the contents. The facility provided several separate policies that were printed from MED-PASS, INC. Of those policies reviewed, the following were missing: Environmental infection control which includes cleaning and disinfection of environmental surfaces and resident-care items and equipment; isolation precautions that included enhanced barrier precautions; the reporting protocol for the occurrence of reportable diseases specific to the state of Hawaii. The surveyor reviewed the signature page of the annual infection control policy. The signatures included only the Administrator and DON, and did not include the infection preventionist or any of the committee members. The surveyor verified with DON that the facility is using Medline as the facility policy and procedures and does not have their own infection prevention program policy.

Surveyor: Shimabuku, Barbara
4) On 05/13/24 at 08:50 AM, during initial tour of the kitchen found the ceiling had paint that was peeling which was located above the food prep area. Interviewed the Director of Dietary who stated he emailed maintenance regarding the peeling paint on the ceiling. Requested a copy of the email.

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F 880	Continued From page 73 On 05/13/24 at 11:05 AM while in the kitchen with Director of Dietary he stated he had not emailed maintenance about the peeling paint on the ceiling but instead had told him by mouth and there was no copy of the email to provide. During this time while making observation of the trayline, noticed there was a feather floating near the sprinkler head above, which was off to the side of the trayline. Showed Director of Dietary and he disposed of the feather. 5) On 05/13/24 at 09:05 AM while talking with Resident (R)22 noticed a discarded glove on her windowsill. Inquired of Activities Coordinator, who came into the room at that time, why the inside out glove was left upon the windowsill and she stated she did not know, said maybe someone forgot to throw it away. Activities Coordinator put on a clean glove, picked up the dirty glove and discarded the glove. Inquired of R22 if she knew who had left the dirty glove on her windowsill and she stated she did not know who put it there. 6) On 05/13/24 at 09:45 AM went into R21's room and noticed his fall mat was dirty with dark soiled spots. On 05/16/24 at 12:38 PM interviewed Unit Manager (U)M Registered Nurse (RN) 23 and inquired who is responsible for making sure fall mats are cleaned. UM RN23 stated everyone is responsible for cleaning the mat, nursing would notify housekeeping if something needs to be cleaned.	F 880		