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ARCADIA RETIREMENT RESIDENCE	1434 PUNAHOU STREET HONOLULU, HI 96822

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 10/31/23-11/03/23. The facility was not in compliance with 42 CFR 483 Subpart B. Facility Reported Incidents (ACTS #10333, 10518) was also investigated. There was non-compliance in ACTS 10333. Survey Census: 72 Sample Size: 21	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		12/15/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/24/2023

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

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F 550	Continued From page 1 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 and interviews, the facility failed to ensure the resident's right to a dignified existence for two residents sampled. As a result of this deficient practice, residents are at risk for more than minimal harm. Findings include: On 11/02/23 at 09:57 AM, observed Activity Staff (AS)4 standing next to Resident (R)25 looking out the window, in the activity room/dining room looking out the window. Observed R25 tap AS4's arm with the back of her right hand. AS4 responded to the incident by quickly hitting away the resident's hand and immediately moving away from the resident. AS4 initially appeared annoyed by R25 touching him/her and rubbed the area if his/her arm that R25 touched. At 10:12 AM, while conducting activities, another resident stood up from the chair, observed AS4 walk behind the resident, put both hands on her shoulders and applied some force to the resident's shoulders,	F 550	On 11/3/23, the Activities Supervisor talked with AS4 about the incidents mentioned by the surveyor and explained that the facility must ensure a resident's right to a dignified existence and that the actions displayed with R25 and the other resident were not appropriate. By 12/1/23, AS4 was retrained on techniques to be used when redirecting a resident. All residents in the facility have the potential to be affected by this deficient practice. All staff will be trained by 12/15/23 on techniques to be used when redirecting a resident. Measures and systemic changes that will be implemented to ensure this deficient practice does not recur are members of the Interdisciplinary Team will conduct random weekly visual audits of staff interacting with residents observing	

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F 550	Continued From page 2 prompting the resident to sit back into the chair, twice. The third time the resident stood from the chair, AS4 placed his/her right hands on the resident's left shoulder while standing at the resident's side and applied force to ensure the resident would sit. While conducting an interview with the Director of Nursing (DON) and an Advising DON (AADON) on 11/03/23 at 10:19 AM, informed them of the observations of AS4's interactions with two residents. The DON was able to identify both residents involved in the observations and confirmed staff should never use force to make the resident sit and staff should not assist residents into a seated position from behind, staff should be within the resident's view to avoid a potential accident. On 11/03/23 at 12:18 PM, conducted an interview with AS4 regarding his/her interaction with both residents. AS4 confirmed hitting R25's hand away to avoid the resident grabbing him/her. It was explained that the resident had made contact with AS4 using the back of her hand and was not grabbing the staff. AS4 stated he/she could have inquired with the resident to see if the resident needed assistance instead of immediately moving away from R25. AS4 also confirmed, applying force on the resident's shoulders to get the resident to sit was not a dignified manner of interacting with the resident.	F 550	practice of the techniques staff were trained on. This will ensure residents are treated with dignity and respect in an environment and manner that enhances the resident's quality of life and recognizes his/her individuality. (F550 – Attachment 1 – F550 Resident Rights Random Audit Check ensuring resident's right to a dignified existence). The facility will monitor its performance on proper techniques used when redirecting a resident through weekly visual audits. The weekly audit will occur for 6 consecutive months and then transition to a quarterly audit. Findings from this audit will be reviewed and shared during the Quality Assurance Committee meeting quarterly.	
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	F 551		12/15/23

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F 551	Continued From page 3	F 551		

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 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

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F 551	Continued From page 4 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 care planning process. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure the resident representative's right to make decisions on behalf of the resident for one resident (Resident (R)70) sampled. As a result of this deficient practice, there is a potential risk of more than minimal harm. Findings include: R70 is an 86-year-old female who was admitted to the facility on 07/18/23 with diagnosis which include but are not limited to peripheral vascular disease, Dementia, diabetes mellitus type 2. Review R70's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/24/23, documented in Section C. Cognitive Patterns a score of 9 on the Brief Interview for Mental Status (BIMS), indicating the resident has moderate cognitive impairment.	F 551	Review of R70's medical record showed two signed consent forms for the Use of Psychoactive Medications. One consent form dated 7/20/23 that was signed by R70's POA upon admission and the other was signed on 8/7/23 by the resident. (F551 – Attachment 1). Progress note on 9/18/23 indicates R70's POA was informed when Consent for Use of a Potentially Restrictive Device was signed by R70 on 9/18/23. (F551 – Attachment 2). Record review also showed that R70 was seen by geriatric psychiatrist on 10/27/23 at which time a letter of incapacitation was issued. (See F551 – Attachment 3) Therefore, the resident was capable of signing the Consent for Use of Psychoactive Medications on 8/7/23 and	

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F 551	Continued From page 5 Review of the resident's documents and consent forms documented R70 has a Power of Attorney (POA) for health care decision and the POA is actively involved in exercising his/her right to make decisions on behalf of R70. Review of six consent forms in R70 Electronic Health Record (EHR) documented two consent forms: informed consent for use of psychoactive medications dated 08/07/23 and informed consent for use of a potentially restrictive device (dated 09/18/23). Both documents were signed by the resident and not the health care POA. The remaining consent forms were all signed by R70's health care POA. Review of a psychiatrist (P)2 note documented P2 assessed the resident for capacity and documented sue to R70's progressive Dementia, R70 is no longer able to participate in medical and financial decisions. On 11/03/23 at 10:09 AM, conducted a concurrent interview and record review of R70's EHR with the Director of Nursing (DON) and an Advising DON (AADON). DON and AADON reviewed both consent forms which were signed by R70 and confirmed from admission, R70's cognition has been impaired and both consent forms should have been reviewed and signed by the resident's health care POA, not the resident.	F 551	the Informed Consent for Use of a Potentially Restrictive Device on 9/18/23. Additionally, on 11/21/23, Social Worker reviewed R70's Brief Interview for Mental Status (BIMS) conducted on 7/24/23, one week after admission to the Health Care Center and confirmed a score of 9, which is moderate cognitive impairment. (Note: The BIMS test is used to get a quick snapshot of how well you are functioning cognitively at the moment.) In addition, Social Worker reviewed R70's quarterly BIMS conducted on 10/18/23 and confirmed that R70 scored a 15 at that time. On 11/21/23, Social Worker contacted R70's POA to ensure POA was aware of two consent forms signed by R70, (1) resident's use of psychoactive medications and (2) use of a potentially restrictive device. On 11/24/23 an audit of all residents in the facility was conducted to determine those residents who have letters of incapacitation on file to ensure that the designated respective POAs have appropriately signed required consent forms. The audit yielded two residents who have letters of incapacitation, which includes R70, and all consent forms are appropriately signed. (F551 – Attachment 4) Measures and systemic changes that will be implemented to ensure this deficient practice does not recur is before any	

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F 551	Continued From page 6	F 551	consent form is signed by a resident, staff will check resident record to determine if there is a letter of incapacitation. If a letter of incapacitation is on file, resident's POA will be required to sign consent forms. The facility will monitor its performance on appropriate completion of all consent forms through quarterly audits performed by the Quality Assurance Nurse. The audit results will be presented during the Quality Assurance Committee meeting on a quarterly basis.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to provide reasonable accommodation of resident's needs to one out of 21 sampled residents (Resident (R) 21). This failed practice has the potential to affect all the residents in the facility. Findings Include: R21 is a 100-year-old male admitted to the facility on 06/08/22. R21 is currently receiving hospice care in the facility.	F 558	To ensure that R21 and all residents have the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences, all Certified Nursing Assistants (CNA), CNA Interns and Health Service Assistants (HSA) were trained by the Director of CNA Services and CNA Supervisor on the 4 P's of Rounding – Possessions, Position, Pain and Potty by 12/15/23. On 11/24/23, a visual audit of all resident	12/15/23

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F 558	Continued From page 7 Concurrent observation and Interview were conducted on 11/01/23 at 10:17 AM in R21's room. R21 stated that he is constantly requesting for more water, and it takes telling two or three staff until someone finally provides him with more. The resident has two small cups on his bedside table. One cup was filled halfway with water and the other cup was filled with clear light brown liquid. Resident's water pitcher was located on top of the bedside dresser, which is located behind the resident. Due to the location, the resident is unable to reach the water pitcher. Observation was conducted on 11/01/23 at 12:10 PM in R21's room. R21's water pitcher remained on the bedside dresser, not within reach of R21. Observation and interview were concurrently conducted on 11/02/23 at 07:37 AM in R21's room. R21 did not have water on his bedside table in front of him. Water pitcher and cups remained on the bedside dresser. R21 stated that he does not get enough water and it was, "humbug because I can't reach it, I don't know why they don't put it closer."	F 558	rooms in the Health Care Center was conducted yielding no negative results – all water pitchers and desired personal possessions of residents were within reach. (F558 – Attachment 1). Measures and systemic changes that will be implemented to ensure this deficient practice does not recur are beginning 11/28/23, random weekly audit checks of resident rooms in the Health Care Center will be conducted by the Director of CNA Services and CNA Supervisor. If any resident water pitchers or desired personal possessions are found not within reach, the 4 P's of Rounding will be reviewed with assigned staff. (F558 – Attachment 2). Beginning 11/27/23 the onboarding and orientation process for newly hired CNAs, CNA Interns and HSAs, will include a review and demonstration of the 4 P's of Rounding. The weekly random audit checks of resident rooms will occur for 6 consecutive months and then transition to a quarterly audit. Findings from this audit will be reviewed and shared during the Quality Assurance Committee meeting quarterly.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify,	F 580		12/15/23

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F 580	Continued From page 8 consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in	F 580		

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§483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on interviews and record review, the facility failed to immediately consult with the resident's physician after a resident fell and had the potential for requiring physician interventions for one resident (Resident (R)70) sampled. R70 fell and sustained multiple bruises and reported hitting her head, was on medications which inhibit the resident's blood clotting abilities (Aspirin and Xarelto) placing the resident at higher risk for internal bleeding, and the physician was not notified until 1 hour and 40-minutes after the resident fell. Facility staff reported R70's physician is regularly difficult to contact. As a result of this deficient practice, all residents under the same care of R70's primary physician is at risk for potential of harm.

Findings include:

On 10/31/23 at 01:05 PM, conducted a review of R70's Electronic Health Record (EHR). Review of the resident's progress notes documented on 10/08/23 at 08:20 AM, R70 had a witnessed, unassisted fall in the dining room and sustained bruising to the right forearm, abdomen, left breast, and a lump of the forehead. R70 was attempting to leave the dining room and return to her room. R70 stood up from a chair, pushed the chair back, took 2-3 steps forward, then turned. and lost her balance. R70 reported hitting the front of her head and right elbow on floor. Staff

F 580

By 12/15/23 a training for all Licensed Nurses on incident reporting (including fall notification) was conducted by RKL, LLC, Arcadia's consultant. (F580 – Attachment 1 and 2).

All Licensed Nurses were also trained on how to utilize InterAct - SBAR (Situation, Background, Assessment, and Recommendation or Request) which is a structured communication framework that can help teams share information about the condition of a patient. Included in the training is the utilization of the Uniform Call Guidelines Template which guides the Licensed Nurses on when and how to make a call to the physician for urgent matters, urgent changes in condition and incidents and how to communicate after hours for non-immediate changes. The Emergency Assessment After Fall Protocol Template was updated to include information for all urgent situations if PCP is not reachable within 30 minutes, Medical Director will be contacted. For all routine/non critical situations if PCP is not reachable within 3 hours Medical Director will be contacted. (F580 – Attachment 1 and 2)

On 11/13/23 the Interdisciplinary Team

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found R70 on the floor, lying on left side. The resident's cane, newspaper and cup of water found on floor next to her. Review of notification documentation showed R70's physician was notified at 10:00 AM, which was 1 hour and 40 minutes after the resident sustained multiple bruises from an unassisted fall. Review of the R70's physician orders and Medication Administration Record (MAR) documented R70 was on scheduled Aspirin EC 81 milligrams (mg) once a day for cardiovascular health and Xarelto 2.5 mg two times a day status post angiogram until 11/05/23. Both Aspirin and Xarelto is used to prevent the blood from clotting and increase the resident's potential for bruising, bleeding, and serious injury from falling.

On 11/2/23 at 01:15 PM, conducted a concurrent interview and record review of R70's Electronic Health Record (EHR) with Nursing Staff (NS)42. Inquired about why there was a 1 hour and 40-minute delay in notifying R70's physician of the resident's fall, especially since the resident is on two medications which inhibit the resident's blood clotting abilities and places R70 at a higher risk of sustaining internal injuries/bleeding. NS42 stated it is difficult to get in touch with Physician (P)3. NS42 explained when staff call P3, the physician does not answer, and they are unable to leave a voicemail and the nurses must keep calling. NS42 stated if it is serious staff will call Medical Director (MD)8 but did not call in this instance.

On 11/03/23 at 10:22 AM, conducted a concurrent interview and record review of R70's EHR with the Director of Nursing (DON) and an Advising DON (AADON). After reviewing the timeline, DON confirmed MD8 should have been

F 580

(IDT) conducted a review of incident reports with a look back review period of one week and identified that notifications from nurses to physicians and physicians return calls had been completed in a timely manner in reference to the Uniform Call Guidelines Template.

Measures and systemic changes that will be implemented to ensure this deficient practice does not recur are on 11/17/23 the Uniform Call Guidelines Template (laminated golden rod sheet) was placed at each nursing station to serve as a guide for nurses on when and how to make a call to the physician for urgent matters, urgent changes in condition and incidents, as well as how to communicate after hours for non-immediate changes. The Emergency Assessment After Fall Protocol was updated to include information for all urgent situations if PCP is not reachable within 30 minutes, Medical Director will be contacted. For all routine/non critical situations if PCP is not reachable within 3 hours Medical Director will be contacted.

Beginning 11/13/2023, falls will be reviewed weekly by the IDT. These reviews will include an audit to ensure timely notification is being practiced following the Uniform Call Guidelines and to identify any incorrect practices that need to be corrected immediately.

The facility will monitor its performance on timely notification using the Uniform Call Guidelines through its Quality Assurance

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ARCADIA RETIREMENT RESIDENCE	1434 PUNAHOU STREET HONOLULU, HI 96822

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F 580	Continued From page 11 called, but was not. On 11/03/23 at 11:44 AM, conducted a telephone interview with MD8 regarding staff's continued difficulty with contacting P3 for the medical treatment of residents at the facility. MD8 was aware that staff was unable to contact P3 when physician oversight was necessary for several months. Inquired with the Medical Director if a corrective plan or action implemented or provided oversight for P3 to ensure the physician is available to staff when called. MD8 reported speaking to P3, the physician reported having issues with his/her mobile provider service and did not implement a corrective action plan for P3. Inquired what steps have P3 taken to resolve the issue with his/her mobile provider. MD8 was did not know what steps, is any, P3 took and has not followed up with P3 or staff to ensure this issue was resolved.	F 580	Program on a quarterly basis.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 584		12/15/23

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F 584	Continued From page 12 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain a safe, homelike environment as evidenced by two different areas of the building being in disrepair and staff not maintaining comfortable sound levels. Findings include: 1) Observation on 11/02/23 at 01:00 PM of the third floor Diamond Head Nursing Unit revealed two different areas of the building where there was broken corner protectors, cracked drywall and unfinished wall repair. This also created a	F 584	On 11/2/23 the broken corner protector located on the 3rd floor Diamond Head Nursing Unit was replaced. In addition, on 11/2/23 the cracked and unfinished drywall in room 336 was repaired to ensure the facility maintains a safe, homelike environment that does not pose a safety risk. (F584 – Attachment 1, F584 – Attachment 1a). By 12/15/23, a training for the Certified Nursing Assistants (CNA), CNA Interns and Health Service Assistants (HSA) will	

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F 584	Continued From page 13 risk for accident hazards. During staff interview on 11/03/23 at 07:40 AM, Housekeeping Supervisor (HSupvr) acknowledged the areas of disrepair but stated that they were not aware of it. HSupvr further stated that they would have the areas repaired immediately. 2) While conducting an interview with Resident (R)29 on 10/31/23 at 11:05 PM, the resident reported staff being very loud and waking up the resident, daily, when they come into the room at 04:30 AM to assist the resident's roommate to the bathroom. R29 confirmed she wants to sleep in and does not want to be awaken by staff at that hour. During an interview with the Director of Nursing (DON) and an Advising DON (AADON) on 11/03/23 at 10:19 AM, the DON confirmed staff should minimize the sound level to avoid disturbing resident's sleep.	F 584	be conducted by the Director of CNA Services and CNA Supervisor to include being mindful of voice volume for discretion of personal care needs and roommate consideration. On 11/2/23 the Environmental Services staff conducted an audit of the Health Care Center common areas and rooms to ensure the facility maintains a safe, homelike environment that does not pose a safety risk. The results of the audit yielded positive results and no repairs were required. (F584 – Attachment 2) On 11/24/23, a verbal check-in was completed with residents in shared rooms yielding zero concerns or complaints about noise and/or sleep disturbances. (F584 – Attachment 3) Measures and systemic changes that will be implemented to ensure this deficient practice does not recur include retraining of the Environmental Services staff on the Monthly Safety Checklists for the Health Care Center Rooms and Common Areas ("Monthly Safety Checklists") by 12/15/23. Additionally, review of the Monthly Safety Checklists will be conducted by the Environmental Services Supervisor to ensure any items identified are entered into the preventive maintenance work order system for completion. Beginning 11/28/23, random verbal check-ins will be completed with residents in shared rooms by the Director of CNA Services and CNA Supervisor on a weekly	

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F 584	Continued From page 14	F 584	basis. (F584 – Attachment 4). If any complaints about noise and/or sleep disturbances are made, mindfulness of voice volume will be reviewed with assigned staff. Additionally, beginning 11/27/23 the onboarding and orientation process for newly hired CNAs, CNA Interns and HSAs will include a review and demonstration of appropriate voice volume during personal care. The facility will monitor its performance on the completion of the Monthly Safety Checklists by having the Environmental Services Manager audit checklists to ensure that all work orders are completed in a timely manner. The audit results will be presented in the Quality Assurance Committee Meeting on a quarterly basis. The facility will monitor its performance on being mindful of voice volume for discretion of personal care needs and roommate consideration through weekly audits that will occur for 6 consecutive months and then transition to a monthly audit. (F584 – Attachment 4). Findings from this audit will be reviewed and shared during the Quality Assurance Committee meeting quarterly.	
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.	F 641		12/15/23

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Continued From page 15

This REQUIREMENT is not met as evidenced by:

2) Review of R70's quarterly MDS with an ARD of 10/18/23, Section C. Cognitive Patterns documented the resident's Brief Interview for Mental Status (BIMS) scored was documented as 15, indicating the resident does not have impaired cognition. However, review of physician notes documented the resident was unable to make health care or financial decisions due to advancing Dementia.

On 11/03/23 at 10:15 AM, during a concurrent interview and record review with the DON and Advising DON (AADON), DON confirmed the resident has cognitive impairment, does not have a BIMS score of 15, and the resident's quarterly MDS was inaccurate.

Based on interviews and record review, the facility failed to assure that two sampled residents (Resident (R)72 and R70) received an accurate assessment, reflective of the residents' status at the time of the assessment. This deficient practice places all the facility residents at risk for assessment inaccuracy.

Findings Include:

1) A review was conducted of R72's Electronic Health Record (EHR). R72's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 08/28/23 indicated that R72 had three stage two pressure ulcers that were not present upon admission.

Interview was conducted on 11/02/23 at 08:09 AM with R72 in the dining room. R72 stated that he had the pressure ulcer before admission to the

F 641

R72's three stage 2 pressure injuries were not present upon admission (8/22/23), and were not miscoded on the MDS. Based on review of the clinical record, no documentation indicated pressure injuries were not present upon admission. On 8/28/23, there is a progress note indicating three stage 2 pressure injuries on the mid-back. (F641 – Attachment 1). All three pressure injuries are resolved as of 11/2/23.

On 11/21/23, Social Worker reviewed R70's Brief Interview for Mental Status (BIMS) conducted on 7/24/23 yielding a score of 9. This BIMS was conducted one week after admission to the Health Care Center (HCC) while resident was transitioning into a new environment and as part of the resident's admission Minimum Data Set (MDS). Social Worker reviewed R70's quarterly BIMS conducted on 10/18/23 and confirmed that R70 scored a 15 at that time. (Note: The BIMS is a brief test used to get a quick snapshot of how well you are functioning cognitively at the moment.) R70's medical record showed that R70 was seen by geriatric psychiatrist on 10/27/23 and received a diagnosis of vascular Dementia and a letter of incapacitation at that time. (See F641- Attachment 3)

On 11/24/23, an audit of all residents with pressure injuries was completed to ensure that the MDS was coded correctly with respect to pressure injuries. The audit

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F 641	Continued From page 16 facility. Interview was conducted with Director of Nursing (DON) on 11/03/23 at 10:26 AM. DON stated that R72's pressure ulcers were present during admission and was miscoded on the MDS.	F 641	resulted in all MDS being coded correctly. On 11/24/23 an audit of the BIMS scores of all residents in the facility was conducted. Using the BIMS scoring legend of 0-7 suggests severe cognitive impairment, 8-12 suggests moderate cognitive impairment; and 13-15 suggests cognitive intactness, resident scores were reviewed to determine if there was a correlating diagnosis of cognitive impairment or dementia. (F641 – Attachment 2). The audit revealed residents who have a BIMS score between 13-15 who also have a diagnosis of cognitive impairment or dementia. Measures and systemic changes that will be implemented to ensure pressure injuries are not miscoded on the MDS is a weekly skin assessment audit performed by the Quality Assurance nurse. Measures and systemic changes that will be implemented to ensure there is correlation between the BIMS score and cognitive impairment such that if a resident scores between 13 to 15 on the BIMS, with a diagnosis of cognitive impairment or dementia, Social Workers will inform PCP and inquire with PCP to determine if a more comprehensive cognitive assessment is needed. The facility will monitor the above systemic changes through the facility's Quality Assurance Program on a quarterly basis.	

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F 655	Continued From page 17	F 655		
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). §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.	F 655		12/15/23

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F 655	Continued From page 18 (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 (RR) and staff interview the facility failed to include R12's choices for her advanced healthcare directives in her baseline care plan. The deficient practice could affect any newly admitted resident at the facility. Findings Include: On 11/02/2023 at 01:21 PM RR did not find a signed Baseline Care Plan form for R12. On 11/02/2023 at 04:33 PM medical records was able to provide a copy of the baseline care plan for R12. Baseline care plan was signed by staff completing the baseline care plan on 09/29/2023 for R12 who was admitted that day. Noted the Advanced Directives/Code Status section was left blank. On 11/03/2023 at 11:41 AM reviewed R12's baseline care plan with Interim DON who stated the Advanced Directives/Code Status section is to be filled out, this area was left blank. Requested and received a copy of the Baseline Care Plan policy, from the Interim DON, which is dated from 05/2022. Policy states: Purpose: The facility must develop a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered	F 655	Between 9/18/23 – 10/16/23, Arcadia was transitioning all MDS responsibilities to RKL, LLC, Arcadia's consultant. During this time, the Advanced Directive/Code Status section was left blank on R12's baseline care plan. R12's current care plan is up to date and the Advanced Directives/Code Status section is complete. (F655 – Attachment 1) By 11/30/23, an audit of all Baseline Care Plans (21-day look back) will be reviewed to ensure the Advance Directives/Code Status section is complete. By 11/24/23, the Baseline Care Plan Protocol was reviewed and updated. The Interdisciplinary Team and Licensed Staff will be trained by 12/15/23. Measures and systemic changes that will be implemented to ensure this deficient practice does not recur is beginning 12/1/23, RKL, LLC will review and verify weekly thorough completion of all baseline care plans completed during the seven day look-back period. The facility will monitor its performance on full completion of the baseline care plan	

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F 655	Continued From page 19 care of the resident that meet professional standards of quality care. The baseline care plan must be developed within 48 hours of a resident's admission to include the minimum healthcare information necessary to properly care for a resident including, but not limited to: 1) Initial goals based on admission orders, 2) Physician orders, 3) Dietary orders, 4) Therapy services, and 5) Social services. ... Day 3 (within 48 hours) 1. The MDS (Minimum Data Set) nurse will, review nursing admission assessment and care plan,-and incorporate pertinent information to baseline care plan. 2. MDS nurse will complete baseline care plan and summary within 48 hours.	F 655	through weekly audits for 6 months, and then transition to quarterly audits. Findings from these audits will be reviewed and shared during the Quality Assurance Committee meeting quarterly.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		12/15/23

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F 656	Continued From page 20 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 observation, record review (RR) and resident interview the facility failed to include use of a walker in Resident (R)35's comprehensive care plan and use of antidepressant in R12's comprehensive care plan. The deficient practice could affect any resident at the facility. Findings Include: 1. On 10/31/2023 at 09:29 AM met and spoke with R35 in her room. R35 asked surveyor if I saw her walker on the other side and she pointed towards the partition in her room. Looked on other side of partition but saw a walker that was	F 656	On 11/1/23, R35's care plan has been updated to include walker within reach. (F656 – Attachment 1). On 11/1/23, staff was updated on the change to care plan. On 11/24/23, R12's care plan was been updated to include 10/17/23 order for antidepressant. (F656 – Attachment 2). On 11/24/23, staff was updated on the change to care plan. By 11/30/23, an audit will be completed for those residents with assistive devices to ensure appropriate documentation is in	

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in the living space of R35's roommate. R35 stated a facility staff, nurse, had told her she could not use her walker. Inquired if R35 had fallen and she denied falling in the facility. R35 stated she walked in the hallway yesterday with the therapist and she took the walker away.

On 10/31/2023 at 10:00 AM spoke with R35's nurse and asked if she told resident she could not have her walker and nurse denied this.

On 11/02/2023 at 09:14 AM went to interview R35 and found her sitting in her room with her walker next to her. R35 said she saw it on the other side near the bathroom when staff assisted her to the bathroom. R35 stated she "will make big noise next time they take my walker".

On 11/02/2023 01:09 PM RR of R35's electronic health record (EHR) found resident's walker use was not included in her care plan that was initiated on 10/24/2023. Noticed facility staff added "Walker is to be kept within reach Date Initiated: 11/01/2023."

2. On 11/01/2023 at 03:43 PM During RR of R12's EHR noted she had escitalopram (antidepressant) 10 mg tablet one tablet by mouth daily ordered for anxiety and depression which was ordered on 10/17/2023. Reviewed R12's care plan and found she had a care plan for psychosocial management but it did not include her antidepressant use as an intervention.

F 656

each resident’s care plan stating that the assistive device is to be kept within reach of the resident.

By 11/30/23, an audit will be completed for those residents on a psychoactive medication to ensure appropriate documentation is in each resident’s care plan.

Measures and systemic changes that will be implemented to ensure this deficient practice does not occur are beginning 11/28/23, the Director of CNA Services and CNA Supervisor will conduct weekly visual audits of all residents who use assistive devices to ensure the assistive device is within reach of the resident. (F656 – Attachment 3) Additionally, the baseline care plan, initial comprehensive care plan and quarterly care plan will be reviewed by RKL, LLC, Arcadia’s consultant, to ensure resident’s functional level is accurately reflected.

Beginning 12/1/23, the Quality Assurance nurse will conduct monthly audits to ensure proper psychoactive medication documentation on resident care plans. Additionally, baseline care plan, initial comprehensive care plan and quarterly care plan will be reviewed by RKL, LLC, Arcadia’s consultant, to ensure resident’s psychoactive medication use is accurately reflected.

The facility will monitor its performance on care plan accuracy by reviewing findings from RKL, LLC, during the Quality

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F 656	Continued From page 22	F 656	Assurance Committee meeting quarterly.	
F 657 SS=D	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 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 interviews and record review, the facility failed to revise Resident (R)70's comprehensive care plan (CCP). R70 fell on 10/08/23 and sustained bruising to the right forearm, abdomen, left breast, and a lump on the	F 657	Due to R70's fall on 10/8/23, R70's care plan (Falls Section) was updated on 11/24/23 to reflect that Aspirin and Xarelto are used to prevent the blood from clotting and increase the resident's potential for	12/15/23

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F 657 Continued From page 23

forehead and is on daily scheduled medications which increases the resident's risk for bleeding and bruising. The resident's fall care plan was not revised after the fall and injuries sustained on 10/08/23 to include the risk for increased injury or additional monitoring related to the medication. As a result of this deficient practice, residents on anticoagulant/antiplatelet medication increases the severity of injury residents could sustain during a fall.

Findings include:

On 10/31/23 at 10:30 AM, initial observation of the resident documented the resident had bruising on the bridge of the nose. Inquired with nursing staff about the bruise on the resident's nose, staff stated they are unsure of how the resident got the bruise.

On 10/31/23 at 01:05 PM, conducted a review of R70's Electronic Health Record (EHR) and the resident's matrix which was provided by the facility. Review of the matrix documented R70 had a fall with injury. Review of the resident's progress notes documented on 10/08/23, R70 had a witnessed fall in the dining room and sustained bruising to the right forearm, abdomen, left breast, and a lump of the forehead. Review of the R70's physician orders and Medication Administration Record (MAR) documented R70 was on scheduled Aspirin EC 81 milligrams (mg) once a day for cardiovascular health and Xarelto 2.5 mg two times a day status post angiogram until 11/05/23. Both Aspirin and Xarelto is used to prevent the blood from clotting and increase the resident's potential for bruising, bleeding, and serious injury from falling. Review of R70's CCP documented the increased risk of injury as a

F 657

bruising, bleeding, and serious injury from falling. (F657 – Attachment 1).

By 11/30/23, RKL,LLC, Arcadia's consultant, will conduct a 30-day look back audit of all residents on anticoagulants to ensure that care plans reflect (in the Falls Section) resident's potential for bruising, bleeding, and serious injury from falling.

Measures and systemic changes that will be implemented to ensure this deficient practice does not recur will begin on 11/30/23 with RKL,LLC, Arcadia's consultant, ensuring that any resident on anticoagulants are noted to have the potential for serious injury from bruising, bleeding or falling reflected in their care plan under the Falls Section.

The facility will monitor its performance on completion of including anticoagulant risks in the Falls Section of a resident's care plan through the review of baseline care plan, initial comprehensive care plan and quarterly care plan. Additionally, this will be assessed weekly by the Quality Assurance Nurse when falls are reviewed.

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F 657	Continued From page 24 related to both medications were not included in R70's fall CCP. Although both medications are documented in the cardiovascular portion of the CCP, it does not address the implications of the medications as it relates to falls. Further review of the progress notes documented staff did not identify the increased risk for bruising and bleeding of Aspirin and Xarelto in relation to the multiple bruises the resident has sustained in various incidents. On 11/03/23 at 10:22 AM, conducted a concurrent interview and record review of R70's EHR with the Director of Nursing (DON) and an Advising DON (AADON). After reviewing R70's EHR in relation to the increased risk of injury given the resident's impulsive behavior and current medications, the DON confirmed that although Aspirin and Xarelto are addressed in the cardiovascular portion of the CCP, it should have been addressed and included in R70's fall CCP.	F 657		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure pain management was provided to the resident according to the resident's goals and preferences. R7 reported lumbar pain which impeded the resident from using the Hoyer lift to	F 697	On 11/2/23, nurse paged PCP and updated resident's episode of breakthrough pain despite routine Tylenol. PCP did not recommend Narcotics due to side effect and resident refusing when asked. A new order placed. (F697 –	12/15/23

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F 697	Continued From page 25 get out of bed for showers and/or socializing with staff and/or other residents. R7 reported receiving Lidocaine patches and Tylenol as the current plan for pain management, however, the medications are ineffective. R7 reported increased feeling of depression and being "worn down" by constant, unrelieved pain, and the inability to get out of bed. R7 goal and preferences for pain management is to be able to use the Hoyer lift, increased sleep, and minimal severe pain. The resident confirmed a strong medication option was not discussed or offered and she does want the option of receiving a stronger medication despite the potential for sedative side effects. As a result of this deficient practice, R7 has experienced physical and psychosocial harm related to ineffective pain management. Finding includes: During an interview with R7 on 10/31/23 at 10:15 AM the resident reported having back pain. Inquired about the origin of the pain, pain management offered to the resident, what was the resident's goals were for pain management, and how the pain has affected the resident. R7 stated the back pain started with no source of injury and started having pain a couple of days ago. The facility took an x-ray but it did not show anything and is currently receiving Tylenol and lidocaine patches for pain management. R7 stated the lidocaine patches and Tylenol are not working to relieve her pain. R7 reported since the back pain started, she has not been able to get out of bed to shower due to pain. The resident stated she does not get out of bed because her back hurts too much to be in the Hoyer lift, the lift requires her back to be in a certain angle and the	F 697	Attachment 1). PCP reported that R7 has impaired cognition due to stroke and is very inconsistent with pain reporting. He said on his visits, the patient reports "no pain" but he was called by nurse during the time of survey reporting that the patient had "pain everywhere" and increased current order. PCP conducted a follow-up visit on 11/9/23 and R7 denied having pain. He also mentioned that due to the recent increase in meds, he preferred more time to see if the interventions (recent increase in meds) were effective instead of adding additional medications. PCP felt that this patient was at risk for addiction and that narcotics were inappropriate. On 11/16/23, a training for the Licensed Nurses was conducted by RKL, LLC, Arcadia's consultant, on Pain Assessment including pain interview. (See F697 – Attachment 1a) On 11/21/23, the IDT reviewed and updated the protocol for Pain Management. A comprehensive pain assessment will be completed by a Licensed Nurse on every resident within seven days of admission, quarterly, and in the event of a Significant Change in condition. (F697 – Attachment 2). On 11/8/23 – Pain Tracking and utilization of pain medication was started with the look back review period of seven days. Pain scale and effectiveness of pain medication will be reviewed by the Quality	

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Continued From page 26

pain she experienced was unbearable. R7 further reported that her sleep has been affected and is not getting quality rest. R7 reported that as a result of the unmanaged pain and being stuck in the bed, she is feeling more down and depressed. Throughout the interview, R7 was visibly in pain as evidenced by grimacing and would wince when she attempted to move. Inquired if the resident was willing to take stronger medication, even if the medication could potentially be sedating. R7 immediately confirmed, with no hesitation, willingness to take a stronger pain medication if it would help with her pain, and stated, "then I could get in the Hoyer lift and be able to get out of the room." R7 also confirmed the physician did not offer the resident a strong medication to alleviate the resident's pain.

On 11/02/23 at 01:26 PM, conducted a concurrent interview and record review of R7's Electronic Health Record (EHR) with Nursing Staff (NS)42. Review of R7's November Medication Administration Record (MAR) and physician orders documented R7 was scheduled to receive:

-Gabapentin 300 mg by mouth at bedtime for pain (started on 07/24/23, prior to the back pain)
-Lidocaine patch 4% to lower back topically in the morning for lumbar spinal pain (started on 10/29/23)
-Acetaminophen 650 mg two times a day for lumbar spinal pain for 2 weeks (started 10/28/23)

NS42 reported that prior to reporting the lumbar pain, R7 would come out of bed, but since reporting lumbar pain, the resident has been refusing due experiencing too much pain when

F 697

Assurance nurse and shared with the Interdisciplinary Team semi-monthly. The team will share ideas how to individually manage chronic and breakthrough pain thru non-pharmacologicals such as physical therapy and/or pharmacological approach or interventions. These interventions will be shared to the staff and will be reflected in the resident's individualized care plan.

Pain scale and effectiveness of pain medication will be reviewed by the Quality Assurance nurse and shared with the Interdisciplinary Team (IDT) semi-monthly. The QA nurse will update and keep the nurses informed of the recommendation from the IDT. The physician will be informed of the status of the resident's pain in response to the currently ordered pain medication.

Dashboard in electronic health record system, Point Click Care (PCC), will be utilized as an additional tool to aid the QA nurse in the review of PRN pain medication usage and response. Findings will be shared to the physician in order to manage pain medication orders appropriately.

Effective 11/8/23 and ongoing, a weekly review and audit will be completed by the QA Nurse to ensure resident's pain is being manage appropriately. A semi-monthly audit and tracking report will be shared to IDT for any suggestions or recommendations. Pain Management Program will be shared during the

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F 697	Continued From page 27 attempting to use the Hoyer lift. Review of the MAR documented on 11/01/23 at 05:26 PM, the resident reported pain level 8/10 after getting out of be to shower and having to be in the Hoyer lift. Certified Nurse Aide (CNA)63, 58, and 12 was in the area and this surveyor inquired with staff regarding R7's pain. NS42, CNA63, CNA58, and CNA12 confirmed R7 did not recieve pain medication prior to the Hoyer lift and showering and upon returning to bed and receiving the Tylenol, R7's pain remained unrelieved and the resident was in visible pain as a result of being in the Hoyer lift. NS42 stated that R7 does refuse treatments and that is probably why the physician had only ordered Acetaminophen. Inquired and requested documentation of R7 refusing stronger pain medication or the offer for stronger pain medication. NS42 confirmed there was no documentation in R7's EHR to include but not limited to progress notes, physician notes, or care plan meeting notes of R7 refusing stronger pain medication. Inquired as to how NS42 would treat R7's break through pain or severe pain. NS42 confirmed the lidocaine patches and acetaminophen are the only pain relief medications as needed (PRN) medications that are ordered for R7 and have not been effective with break through pain or severe pain. On 11/03/23 at 10:27 AM, conducted a concurrent interview and record review of R7's EHR with the Director of Nursing (DON) and an Advising DON (AADON). The DON and AADON was informed of this surveyor's observations and interview with R7 regarding the reported lumbar pain. After reviewing R7's EHR, the DON and AADON confirmed R7's current pain management plan was not effectively treating the resident's pain and agreed that although the	F 697	quarterly Quality Assurance program.	

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F 697	Continued From page 28 resident may potentially refuse stronger medication, R7 should be offered or have the option to receive stronger medication break through pain or severe pain. DON and AADON also confirmed they were unaware that R7's pain was affecting the resident's activities of daily living and sleep.	F 697		
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. §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: Based on observation and staff interview the	F 761	On 11/21/23, the nursing staff was	12/15/23

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facility failed to assure a medication cart was locked when not being used by a nurse. The deficient practice could affect all residents, staff and visitors who could have access to the unlocked medication cart.

Findings Include:

On 11/02/2023 at 02:17 PM while standing in the hallway near the nurse's station on the second floor noticed a registered nurse (RN)5 walk away from the medication cart which she left unlocked. Surveyor remained with medication cart till RN5 returned. During this time the Interim DON came by and was shown the medication cart was left unlocked and unattended.

On 11/02/2023 at 02:24 PM RN5 returned to unlocked medication cart. RN5 confirmed the med cart is supposed to be locked when it is left unattended. Inquired with RN5 if she had training regarding this matter when she attended orientation and she stated she had orientation and the "locked cart is a known thing". RN5 denied getting separate training on this.

F 761

retrained on the Protocol for Medication Administration Guidelines and the Medication Pass Observation Form, which states, “During administration of medication, the medication cart must be clearly visible to the nurse administering medications. The medication cart is kept closed and locked when out of sight of the medication nurse”. (F761-Attachment 1, F761 – Attachment 2 and F761 – Attachment 3).

On 11/20/23, an audit of all medication carts in the Health Care Center was conducted during med pass administration on different floors, shifts and stations yielding no negative results – all carts were closed and locked when out of sight of the medication nurse. (F761 – Attachment 3).

Beginning 11/21/23, random audit checks of all medication carts in the Health Care Center will be conducted by the Interim DON on a weekly basis. (F761 – Attachment 4). If any carts are found unlocked, the Interim DON will address immediately with the nurse responsible for the specific medication cart that was found unlocked by retraining.

Measures and systemic changes that will be implemented to ensure this deficient practice does not recur is beginning 11/27/23 the onboarding and orientation process for newly hired nurses, will include a review of the Medication Administration Guidelines and Medication Pass Observation Form by the

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F 761	Continued From page 30	F 761	on-boarding nurse. Additionally, the Medication Administration Guidelines and Medication Pass Observation Form will also be included in the scheduled monthly skills checklist for all the nurses annually. (F761 – Attachment 3). The facility will monitor its performance on completion beginning 11/20/23, a visual audit will be conducted monthly by Interim DON and/or designee to ensure compliance with the locking of medication carts. The monthly audit will occur for 6 consecutive months and then transition to quarterly audits. Findings from this audit will be reviewed and shared during the Quality Assurance Committee meeting quarterly.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 842		12/15/23

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(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§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

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F 842	Continued From page 32 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 record review (RR) and staff interview the facility failed to maintain an accurate medical record for R59 putting her at risk for a fall from a bed that was care planned to "Do not not leave bed on lowest position." This deficient practice could affect all residents at the facility who have an impaired mobility. Findings Include: 1. During RR of R59's care plan noted under "Impaired Mobility/Falls" an intervention listed stated "Maintain fall precautions. Adjust height of bed to comfortable height for easy in/out of bed. Do not leave bed on lowest position." On 11/02/2023 at 02:01 PM met with Interim DON and looked at R59's bed. R59 was sleeping in her bed and facility staff showed the bed was at it's lowest position. R59's bed was a regular hospital bed and not a low to the ground bed. Interim DON stated it appears to be an error in the care plan, regarding the height of the bed.	F 842	On 11/24/23, R59's care plan was updated to remove "do not leave bed in the lowest position" under the Impaired Mobility/Falls Section. (F842 – Attachment 1). By 11/30/23, RKL, LLC, Arcadia's consultant, will conduct an audit of all residents who do not have an order for an Ultra-Low bed to ensure their care plans reflect documentation that states "Maintain fall precautions. Adjust height of bed to comfortable height for easy in/out of bed" in the Impaired Mobility/Falls Section. The measures and systemic changes that will be implemented to ensure this deficient practice does not recur, is that any change to a resident's bed height will be discussed during the daily stand up meeting with Interdisciplinary Team so that the change is reflected in the resident care plan. The facility will monitor its performance by having the Quality Assurance Nurse conduct monthly Bed Height audits that will be presented during the facility's	

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F 842	Continued From page 33	F 842	Quality Assurance Program quarterly.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (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	F 880		12/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125014	A. BUILDING ______ B. WING ______	11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA RETIREMENT RESIDENCE	1434 PUNAHOU STREET HONOLULU, HI 96822

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F 880	Continued From page 34 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure proper glove use procedures were followed by a staff member. This deficient practice places the residents at risk for the development and transmission of communicable diseases and infections. Findings Include:	F 880	On 11/2/23 the Infection Preventionist (IP) spoke to HK1 on proper glove use. On 11/24/23 the IP trained HK 1 on proper PPE/glove use. (See F880 – Attachment 1 and F880 – Attachment 2). All residents have the potential to be affected by this deficient practice. On	

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F 880	Continued From page 35 Concurrent observation and interview were conducted on 11/02/23 at 02:05 PM. Housekeeper (HK) 1 was observed entering the second floor through the stairwell access with gloves on. HK1 then entered the laundry room and immediately exited. Infection Control Coordinator (ICC) was present in the laundry room. When ICC was queried about HK1's glove use, ICC stated that HK1 should not have gloves on in the hallway.	F 880	11/21/23 all housekeeping staff were retrained on proper PPE/glove use. (See F880 – Attachment 3). Measures and systemic changes that will be implemented to ensure this deficient practice does not recur, beginning 11/27/23 the onboarding and orientation process for newly hired housekeepers will include a review of proper PPE/glove use. Beginning 12/1/23, a visual audit will be conducted monthly by the Housekeeping Supervisor to ensure compliance with proper PPE/glove use by all housekeepers. The monthly audit will occur for 6 consecutive months and then transition to a quarterly audit. Findings of this audit will be reviewed and shared during the Quality Assurance Committee meeting quarterly.	