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	125020	A. BUILDING ______ B. WING ______	04/05/2024

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AVALON CARE CENTER - HONOLULU, LLC	**1930 KAMEHAMEHA IV RD HONOLULU, HI 96819**

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance on 04/05/24. The facility was found not to be in substantial compliance with 42 CFR 483, Subpart B. Complaints and a facility reported incident were investigated, Aspen Complaint and Incident Tracking (ACTS) #10422, #10410 and #10600. This facility was not in compliance with 42 CFR 483, Subpart B related to ACTS complaint #10410. Survey Dates: 04/02/24 to 04/05/24 Survey Census: 96 Sample Size: 22	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	F 550		5/7/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 05/02/2024

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 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her 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, interviews, and facility policy review, the facility failed to promote care for residents in a manner that maintains and enhances each residents' dignity for three of 22 sampled residents (Resident (R) 32, R47, and R40). Staff members referred to R47 and R32 as feeders; and a staff member stood over R40 and used her personal phone while providing assistance during meals. Findings include: 1) On 04/02/24 at 12:05 PM, during lunch observation at the Waikiki Dining Room, observed six residents in the dining room and five family members. At 12:07 PM, Director of Nursing	F 550	Immediate Actions Residents R32, R47 were assessed for concerns of/indicators for decrease in quality of life related to being called a “feeder”; none were identified. Resident R40 was assessed for concerns of/indicators for decrease in quality of life related to being fed while staff was standing and using personal phone; none were identified. Administrator/designee to educate DON, regarding resident rights on 4/30/24. DON/designee to educate CNA42,	

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F 550	Continued From page 2 (DON) was standing next to the tray cart and directed a staff member to serve one of the food trays last because it was for a "feeder." R47 was observed to be sitting right next to the tray cart when DON made the statement. R47 was observed to need assistance with her meals and was served her tray last. 2) On 04/02/24 at 01:51 PM, interview with Certified Nurse's Aide (CNA) 42 was done. Observed R32 choking while eating, inquired with CNA42 if R32 needed assistance with his meals, CNA42 stated R32 was a "feeder" while standing right next to R32. On 04/05/24 at 10:16 AM, inquired with Administrator if there is a situation when staff members can call residents "feeders," Administrator stated never. 3) R40 is an 80-year-old male admitted to the facility on 06/15/20. R40's medical diagnoses include but not limited to, hemiplegia (one sided paralysis), hemiparesis (one sided weakness) affecting the right side following cerebral infarction (reduced blood supply to the brain), and dysphagia (difficulty swallowing). Concurrent observation and interview were conducted on 04/03/24 at 08:01 AM with Certified Nurse's Aide (CNA) 40 in R40's room. CNA40 was observed assisting R40 with his meal, on her personal phone and standing up next to R40's head. When asked if she should be sitting while assisting with R40's feeding, CNA stated yes, she should be sitting down. Interview was conducted with Unit Manager (UM) 87. UM87 stated that the CNAs should all be	F 550	CNA40 regarding resident rights by 5/7/24. Identify Others Current residents have the potential to be affected by this practice. An audit was completed of current residents to validate that there is available seating for staff if residents require assistance with eating on 4/25/24. Systemic Changes DON/designee will reeducate nursing staff regarding Resident's Rights (dignity, do not call residents "feeders", assisting residents to dine at eye level and not using personal devices/ chart while providing resident care) by 5/7/24. Monitor DON/designee will conduct 5 meal observation audits weekly x4 weeks then monthly x2 months to validate that staff are assisting with meals at eye level and are not using personal devices/ charting while providing resident care. DON/designee will present findings at the facility's Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency.	

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F 550	Continued From page 3 sitting while assisting residents with their meals. Interview was conducted with the Director of Nursing (DON) on 04/04/24 at 10:40 AM in the DON's office. DON stated that facility staff should not be on their personal phone while providing care to the residents. The facility policy titled, "Resident Rights: Respect and Dignity," with a revised date of 09/20/22 documented, "1. The resident has a right to be treated with respect and dignity." A review of the facility document titled, "Employee Handbook," dated March 2024 was conducted. The handbook documented, "To promote a productive work environment and the safety of our staff and residents, employees are expected to make personal calls or send personal text messages only during breaks and in a non-working area."	F 550		
F 568 SS=D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced	F 568		5/7/24

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F 568	Continued From page 4 by: Based on interviews and facility document review, the facility failed to provide quarterly statements and provide statements upon request to one of one residents sampled (Resident (R) 45). Findings Include: R45 is a 53-year-old female, admitted to the facility on 01/07/21. Interview was conducted with R45 on 04/02/24 at 11:05 AM. R45 stated that her personal funds are managed by the facility. When asked how often the facility provides account statements, R45 stated that she had never received a statement since she had been admitted. Additionally, R45 stated that she had requested a statement a while ago and had not received one thus far. R45 did not know the balance on her account. Interview and attempted record review was conducted with facility Business Office Manager (BOM) on 04/03/24 at 03:34 PM. BOM stated that she does not keep a recorded log or a tracking system to ensure that the residents are provided their account statements quarterly. BOM's current process is printing out the statements and placing the piece of paper on the residents' bedside table. Interview was conducted with R45 on 04/04/24 at 10:40 AM. R45 called out to State Agency (SA) while SA was passing her room. R45 stated that one of the staff members (Administrator) had finally provided her with her account statement the evening of 04/03/24. R45 stated that it was the first statement she had ever received.	F 568	Immediate Actions Resident (R45) was provided with an account statement on 4/3/24. Identify Others Residents with a personal funds account have the potential to be affected by this practice. Business Office Manager/designee will audit residents to validate those who have personal funds accounts have been provided financial statements by 5/7/24. Systemic Changes Administrator will educate Business Office Manager/Assistant by 5/7/24 regarding the facilities responsibility to provide a financial statement to the resident(s) through quarterly statements and upon request, as well as maintain a system that assures a full and complete and separate accounting of each resident’s personal funds entrusted to the facility. Monitor Business Office Manager/designee will validate current residents with personal funds accounts received a quarterly statement within the past quarter or upon request. Audits will be completed monthly x2. Administrator/designee will present	

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F 568	Continued From page 5	F 568	findings at the facility's Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency.	
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		5/7/24

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F 578	Continued From page 6 individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to assure three of six residents sampled (Resident (R) 147, R67 and R48) who had surrogate forms filled out also included the physician's documentation stating R147, R67 and R48 did not have capacity to make their own healthcare decisions, as according to State Law. The deficient practice could affect other residents in the facility who do not have advanced healthcare directives and who have surrogate forms filled out incompletely. Findings include: 1) On 04/03/24, record review of R147's electronic health record (EHR) found no copy of her advanced healthcare directive. On 04/03/24 at 02:51 PM, interviewed Social Services Assistant (SSA) 6. Inquired if R147 had an advanced healthcare directive (AHCD). SSA6 stated R147's son stated he is R147's Power of Attorney (POA) but has not submitted the AHCD. SSA6 stated they have asked R147's son a couple of times for a copy of the AHCD and he has not provided a copy. SSA6 stated they had son fill out the form to be the surrogate for R147 that identifies her son as the person who will make healthcare decisions for her based on	F 578	Immediate Actions 1. Resident (R147) discharged from the facility 2. Resident (R67), (R48) will be reviewed by the medical provider and provider to determine that resident does not have capacity to make their own healthcare decisions by 5/7/24. Identify Others 1. Residents with current surrogate forms in place have the potential to be affected. 2. Administrator/designee will audit residents with current surrogate forms by 5/7/24. If the provider determines that the resident does not have capacity to make their own healthcare decisions, updated surrogate forms will be initiated. Systemic Changes 1. Administrator will educate Social Workers regarding individuals who are deemed incapacitated, and facilities updated designated-surrogate form by 5/7/24. Monitor 1. Administrator/designee will audit 5 new admissions weekly x4 weeks then	

F 578

Continued From page 7

R147 not having capacity. Review of the form found R147's physician had not filled out any documentation stating that R147 lacked capacity to make her own healthcare decisions. Requested SSA6 provide documentation from the physician stating resident does not have capacity to make her own healthcare decisions. This was not provided.

On 04/05/24 at 08:50 AM, interviewed Administrator who confirmed R147's physician had not filled out a form or provided documentation stating R147 lacked capacity to make her own healthcare decisions.

2) R67 is an 87-year-old female admitted to the facility on 01/04/24.

A review of R67's medical document titled, "Declaration of Authority to Act as Surrogate for a Patient," dated 01/10/24 was conducted. Although the form was completed, it was lacking documentation from R67's primary physician determining that R67 lacked capacity to make healthcare decisions.

A review of the facility policy titled, "Resident Rights: Advance Directives," dated 11/2017, was conducted. The policy documented, "10. The facility identifies the primary decision-maker. This includes assess the resident's decision-making capacity and identifying or arranging for an appropriate representative for the resident assessed as unable to make relevant health care decisions."

Interview with Administrator was conducted on 04/04/24 at 11:29 AM. Administrator stated that there is no documentation from R67's primary

F 578

monthly x2 months to validate those with BIMS <9 and who do not have a current Advance Directive in place will beassessed by MD to determine if they lack capacity and require an updated surrogate form.
2. Administrator/designee will present findings at the facility□s Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency.

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F 578	Continued From page 8	F 578		

physician determining her lack of capacity to make healthcare decisions. She also added, moving forward they will have a process in place in the future.

3) R48 is a 78-year-old male admitted to the facility on 06/15/21 with diagnoses not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominate side, dysphagia following cerebral infarction, vascular dementia, moderate, without behavioral disturbance.

On 04/02/24 at 02:36 PM, review of R48's electronic health record (EHR) found no copy of his AHCD. The EHR included a document titled, "Declaration of Authority to Act as Surrogate for a Patient," dated 04/20/23. The document established a surrogate for R48 and instructed, "who has been determined by the primary physician to lack capacity to make health care decisions and no agent or guardian has been appointed or the agent or guardian is not reasonable available." The applicable box "B. Appointed ("Non-Designated") Surrogate marked "Adult Child" as the selected person to act as R48's surrogate. "2. The following persons took part in my selections...3. The following individuals interested persons but did not participate in selection...and 4. Additional facts and circumstances to establish claimed authority (if any) Attach additional sheets of papers and relevant documents as necessary" was not completed. Documentation of the primary physician determining R48 lacked capacity to make health care decision was not found.

On 04/04/24 at 08:46 AM, an interview with Social Services Assistant (SSA) 7 was done. SSA7 reported she did not know if the physician

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F 578	Continued From page 9 documented R48 lacked capacity to make health care decisions. Review of the Hawaii Revised Status (HRS) Section 327E-5 (b) "A surrogate may make a health-care decision for a patient who is an adult...if the patient has been determined by the primary physician to lack capacity and no agent or guardian has been appointed or the agent or guardian is not reasonably available, Upon a determination that a patient lacks decisional capacity to provide informed consent or refusal or medical treatment, the primary physician or the physician's designee, shall make reasonable efforts to locate as many interested persons as practicable, and the primary physician may rely on such individuals to notify other family members or interested persons."	F 578		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		5/7/24

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F 584	Continued From page 10 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 observation and staff interview the facility failed to assure the vent and ceiling outside of residents rooms were kept clean. This deficient practice could affect all residents in the facility if their environment is not kept sanitary, putting them at risk for exposure to increased risk of infection. Findings Include: On 4/02/24 at 12:34 PM, while standing in the hallway outside of a resident's room looked up and saw the ceiling and vent had black residue of an unknown source. The black residue was on the edge of the vent that meets the ceiling and	F 584	Immediate Actions 1. Affected air vents and ceilings will be cleaned by 5/7/24. Identify Others 1. Current residents who are residing in the facility have the potential to be affected; none were identified. Systemic Changes 1. Housekeeping director/designee will educate housekeeping and maintenance staff regarding keeping a clean homelike environment by 5/7/24. 2. Monthly inspections of ceiling/vents will	

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F 584	Continued From page 11 spread across the ceiling spreading to both walls outside of the resident's rooms. On 04/03/24 at 11:38 AM, approached facility staff, Heavy Cleaner (HC) 1, in the hallway under the vent with black residue and inquired why the vent had black residue. HC1 stated "It's from the AC, I think it's mold." HC1 stated he tried to vacuum it but vacuuming did not clean off the blackened areas. Requested to speak with his supervisor. HC1 left at 11:52 AM and returned at 11:55 AM with cleaning solution in a spray bottle and said "I will try this." Requested to speak with his supervisor again and the Housekeeping Director (HD) met with surveyor. Concurrent interview was conducted with HD. HD stated she called maintenance in Utah, at their cooperate office, to find out what should be done. HD stated Utah cooperate office told her because of Hawaii's weather they are prone to these types of particles. HD stated the cleaning solution that was being used today included hydrogen peroxide. Requested logs of cleaning maintenance. On 04/04/24 at 2:00 PM, requested of HD to view cleaning logs HC1 does each month. Review of the AC /Exhaust Vents Monthly Cleaning Log found the following AREA/ROOM: ST 1 ROOMS/HALLWAY 1. Vacuum all bathroom Exhaust Vents. 2. Vacuum bedroom AC & Exhaust Vents. 3. Ensure all screens are clean of dust and debris. 4. Sign log when job completed. Logs were completed through March 2024. After the log review inquired with HD if staff know to report if they cannot clean an area and it remains dirty and HD confirmed this. Requested a copy of the facility policy for cleaning of the facility.	F 584	be conducted to ensure a clean environment. Monitor 1. Housekeeping director/designee will audit vents weekly x4 weeks then monthly x2 months. Any findings will be promptly addressed. 2. Housekeeping director/designee will present findings at the facility□s Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency	

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AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

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F 584	Continued From page 12 On 04/05/24, reviewed facility policy titled Resident Rights Safe, Clean and Comfortable Environment dated 07/2018 which states Guidelines: 4. The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior.	F 584		
F 623 SS=E	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;	F 623		5/7/24

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F 623	Continued From page 13	F 623		

(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for 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

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F 623	Continued From page 14 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide, four of four sampled residents (Resident (R) 40, R48, R58, and R246) or their representatives, written notification of transfer/discharge as soon as practical or at least 30 days before residents are transferred or discharged Findings include: 1) On 04/02/24, Record Review (RR) of R246's Electronic Health Record (EHR) found he is a 73	F 623	Immediate Actions Resident (R246), (R58) discharged from the facility. Notice was provided to (R58) on 1/5/24. Documentation that Notice of Proposed Transfer was provided, completed on 5/1/24. Resident (R48), (R40) was provided on 1/5/24. Documentation that Notice of Transfer was provided, completed on 5/1/24. Identify Others	

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F 623	Continued From page 15 year old male who was admitted to the facility on 05/24/23 with diagnoses that include, but are not limited to, history of falling, presence of right artificial knee joint, other chronic pain, low back pain unspecified, difficulty in walking, not elsewhere classified, muscle weakness, unspecified diastolic (congestive) heart failure and need for assistance with personal care. During the RR found facility notified resident on 07/06/23 of upcoming discharge to home planned for 07/25/23 and resident had refused to sign the form. On 04/04/24 at 1:28 PM, requested copy of notification that was sent to the ombudsman of R246's scheduled discharge on 07/25/23 from administrator. Administrator explained facility emails Discharge/Transfer Notice to Ombudsman and she provided a copy of this notification that was emailed to the Ombudsman on 07/19/23. Inquired of Administrator why resident was not given 30 days notification of discharge and she stated she did not know the facility had to give 30 days notification. 2) R48 was transferred and admitted to the hospital on 10/25/23 with diagnoses of hyperglycemic state and failure to thrive. A review of R48's EHR found no documentation that a written notification for transfer to the hospital was provided to R48 or his representative. On 04/04/24 at 01:24 PM, an interview with Social Services Aide (SSA) 7 was done. SSA7 reported they do not give written notification for transfer/discharge to residents or their representatives, but the nursing staff do.	F 623	Current residents who require transfer have the potential to be affected by this practice. Administrator/designee will review patients who transferred to acute care and admitted in the past 30 days to validate that a Notice of Transfer/Discharge was provided and documented in the resident□s chart by 5/1/24. Systemic Changes RNC educated Administrator on 4/26/24 regarding Notice of Transfer to resident and/or responsible party in a timely manner. Monitor RNC/designee will audit 5 discharge patients monthly x3 months to validate that written notice of bed hold policy is provided and documented in a timely manner. RNC/designee will present findings at the facility□s Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency.	

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F 623	Continued From page 16	F 623		

On 04/04/24 at 02:03 PM, an interview with Administrator was done. Administrator reported she sends the written notification of transfer/discharge to residents or their representatives. Administrator reported the process has changed but last year she reviewed the hospital tracking portal for the month and would put a check mark next to the resident's name if she sent a transfer/discharge form to the resident or their representative. Concurrent review of the form indicated a check mark next to R48's name but the form does not indicate what the check mark is for. Administrator reported they do not keep a copy of the written transfer/discharge form that was sent out to residents or their representatives as documentation it was sent.

3) R58 was transferred and admitted to the hospital on 12/02/23 with diagnosis of acute metabolic encephalopathy.

A review of R58's EHR found no documentation that a written notification for transfer to the hospital was provided to R58 or his representative.

On 04/04/24 at 02:03 PM, an interview with Administrator was done. Concurrent review of the monthly hospital tracking portal form indicated a check mark next to R58's name but the form does not indicate what the check mark is for. Administrator reported they do not keep a copy of the written transfer/discharge form that was sent out to residents or their representatives as documentation it was sent.

4) Resident (R) 40 was transferred and admitted

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F 623	Continued From page 17 to the hospital on 11/28/23 for sepsis (blood infection). A review of R40's Electronic Health Record (EHR) was conducted. The EHR did not contain documentation, that a written notification for R40's transfer to the hospital was provided to R40's representative. Interview was conducted with the Administrator on 04/04/24 at 02:00 PM. During the interview, the Administrator failed to provide documentation that a written notification regarding R40's transfer was provided to R40's representative. The facility policy titled, "Admission, Transfer, and Discharge: Notice requirements Before Transfer/Discharge," dated 07/2018 was reviewed. The facility policy documented, "Before the facility transfers or discharges a resident, the facility will notify the resident and resident's representative(s) of the transfer/discharge and the reasons for the move in writing, in a language and manner they understand."	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing	F 625		5/7/24

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F 625	Continued From page 18 facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure written notification of the facility's bed hold policy was provided to three residents of four sampled (Residents (R) 40, R48, R58) and their representative. This deficient practice has the potential to affect all residents at the facility who are discharged to an acute care hospital. Findings Include: 1) R40 was transferred and admitted to the hospital on 11/28/23 for sepsis (blood infection). A review of the R40's Electronic Health Record (EHR) was conducted. The EHR did not contain documentation, that a written notification regarding the facility's bed hold policy was provided to R40's representative. Interview was conducted with the Administrator	F 625	Immediate Actions Resident (R58) discharged from the facility. Bed Hold Policy was provided on 1/5/24. Documentation that Bed Hold Policy was provided, completed on 5/1/24. Resident (R48), (R40) was provided on 1/5/24. Documentation that Bed Hold Policy was provided, completed on 5/1/24. Identify Others Current residents who require transfer or discharge have the potential to be affected by this practice. Administrator/designee will review patients who transferred to acute care and admitted in the past 30 days to validate that a Bed Hold was sent and documented in the resident□s chart by 5/1/24.	

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Continued From page 19

on 04/04/24 at 02:00 PM. During the interview, the Administrator failed to provide documentation that the facility's bed hold policy was provided to R40's representative.

A review of the facility policy titled, "Admission, Transfer and Discharge: Notice of Bed Hold Policy Before/Upon Transfer," with a revised date 11/2018, was conducted. The facility policy documented, "The facility will provide written information to the resident or resident representative specifying the duration of the state bed-hold policy, if any, during which time the resident is permitted to return and resume residence in the facility ...This information will be provided to the resident and the resident representative before a transfer or therapeutic leave and at the time of transfer of a resident for hospitalization or therapeutic leave."

2) R48 was transferred and admitted to the hospital on 10/25/23 with diagnoses of hyperglycemic state and failure to thrive.

A review of R48's EHR found no documentation that a written notification regarding the facility's bed hold policy was provided to R48 or his representative.

On 04/04/24 at 01:24 PM, an interview with Social Services Aide (SSA) 7 was done. SSA7 reported they do not give written notification regarding the facility's bed hold policy but call the family members.

On 04/04/24 at 02:03 PM, an interview with Administrator was done. Administrator reported she sends the written notification of the facility's bed hold policy to residents or their

F 625

Systemic Changes
RNC educated Administrator on by 4/26/24 regarding Bed Hold Policy to resident and/or responsible party in a timely manner.

Monitor
RNC/designee will audit 5 discharge patients monthly x3 months to validate that written notice of bed hold policy is provided and documented in a timely manner.
RNC/designee will present findings at the facility□s Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency.

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F 625	Continued From page 20 representatives. Administrator reported the process has changed but last year she reviewed the hospital tracking portal for the month and would put a check mark next to the resident's name if she sent a written bed hold policy form to the resident or their representative. Concurrent review of the form indicated a check mark next to R48's name but the form does not indicate what the check mark is for. Administrator reported they do not keep a copy of the written notification of the facility's bed hold policy form that was sent out to residents or their representatives as documentation it was sent. 3) R58 was transferred and admitted to the hospital on 12/02/23 with diagnosis of acute metabolic encephalopathy. A review of R58's EHR found no documentation that a written notification regarding the facility's bed hold policy was provided to R58 or his representative. On 04/04/24 at 02:03 PM, an interview with Administrator was done. Administrator reported she put a check mark on the monthly printed hospital tracking portal next to the resident's name if she sent a written bed hold policy form to the resident or their representative. Concurrent review of the form indicated a check mark next to R58's name but the form does not indicate what the check mark is for.	F 625		
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		5/7/24

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F 641	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the Discharge Assessment for Resident (R) 94 accurately reflected the resident's discharge status. Findings include: Record review done on 04/04/24 at 01:42 PM noted Resident (R) 94 was admitted to the facility on 01/17/24 and discharged to home on 02/06/24. Review of Minimum Data Set (MDS) Discharge Assessment with an Assessment Reference Date (ARD) of 02/06/24 noted R94 was incorrectly documented as discharged to "Short-Term General Hospital (acute hospitals, IPPS [inpatient prospective payment system])." On 04/04/24 at 02:07 PM, an interview was done with MDS Director (MDSD) 13 in his office. MDSD13 confirmed that R94's Discharge Assessment had been incorrectly documented and transmitted. MDSD13 stated that R94 had been "discharged home with home health services."	F 641	Immediate Actions R94's MDS discharge assessment was corrected and transmitted on 4/4/24. MDS director/designee educated involved MDS staff regarding accuracy of assessments on 4/25/24. Identify Others Discharged residents have the potential to be affected. MDS discharge assessments that were transmitted from 4/15-4/28/24 were audited for accuracy of discharge location (A2100) by 5/3/24. Any inaccuracies will be corrected and transmitted. Systemic Changes MDS director/designee will educate MDS staff regarding accuracy of discharge location (A2100) by 5/7/24. Monitor MDS director/designee will audit 5 discharge MDS assessments to validate accuracy of discharge location (A2100) weekly x4 weeks then monthly x2 months. MDS director/designee will present findings at the facility's Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency.	
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	F 656		5/7/24

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F 656	Continued From page 22 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate 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.	F 656		

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F 656	Continued From page 23 §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, interview, and record review, the facility failed to develop and implement a person-centered Comprehensive Care Plan (CP) for one of 22 residents (Resident (R) 25) sampled. As a result of this deficient practice, staff did not have the information necessary to adequately care for R25 contractures, ensuring the resident meets his highest potential of physical and psychosocial well-being. Findings include: Cross Reference to F688, Increase/Precent Decrease in ROM/Mobility. The facility failed to provide the proper care and treatment for the contracture in R25's left hand as ordered. Review of R25's nursing restorative monthly review dated 05/31/23 documented "Resident completed OT [Occupational Therapy] services with recommendation...Left hand wound require rolled up towel under fingers. Will update care plan." Review of R25's CP found rolled gauze or towel to left hand every shift as ordered was not in the CP. On 04/05/24 at 09:33 AM interview with Director of Nursing (DON) was done. Concurrent review of R25's CP found treatment to left hand to prevent contractures was not care planned. DON reported	F 656	Immediate Actions R25's RNA plan of care was reviewed and updated. R25's order for rolled gauze/towel was discontinued on 4/5/24. Identify Others Current residents on RNA caseload are at risk to be affected. RNA care plans and interventions were reviewed and updated as appropriate by 5/7/24. Systemic Changes RNA program tracking log was updated to include care plan updates. DON/designee will educate clinical staff about developing comprehensive care plans by 5/7/24. Monitor DON/Designee will review the RNA program tracking log to validate that planned RNA program changes were implemented in the care plan weekly x4 weeks and monthly x2 months. DON/designee will present findings at the facility's Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency.	

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F 656	Continued From page 24 the facility would not specifically document the form of treatment to left hand to prevent contractures but put a generalized statement but did not know where it would be put in the CP. Inquired if everyone in the facility needed a rolled gauze or towel to their left hand, DON reported "no." Further inquired if the statement is generalized in the CP would it be person-centered, DON agreed it wouldn't. Review of the facility's policy and procedure "Comprehensive Care Plans" dated 11/2017 documented "The care plan will be comprehensive and person-centered. It will drive the type of care and services that a resident receives and will describe the resident's medical, nursing, physical, mental, and psychosocial needs and preferences; as well as how the facility will assist in meeting these needs and preferences."	F 656		
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).	F 657		5/7/24

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F 657	Continued From page 25 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 record review and interview, the facility failed to ensure a resident's person-centered comprehensive Care Plan (CP) was reviewed and revised for one resident (Resident (R) 48) sampled. As a result of this deficient practice, R48 was at risk of a decline in his quality of life, not attaining his highest practicable well-being, and the potential for serious harm and/or death due to complications with his new diagnosis of diabetes. Findings include: R48 is a 78-year-old male admitted to the facility on 06/15/21 with diagnoses not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominate side, dysphagia following cerebral infarction, vascular dementia, moderate, without behavioral disturbance, hypertension, chronic kidney disease, muscle weakness, and need for assistance with personal care. On 04/02/24 at 02:16 PM interview with Family Member (FM) 11 was done. FM11 reported R48	F 657	Immediate Actions R48's care plan was reviewed and updated on 4/5/24 to reflect current condition. Identify Others Current residents who were readmitted to the facility have the potential to be affected. DON/designee will complete care plan review for current residents who were readmitted back to the facility in the past 30 days. Care plans will be revised to reflect current conditions and interventions implemented by 4/30/24. Systemic Changes DON/designee will educate licensed nursing staff about updating care plans for readmissions by 5/7/24. Monitor DON/Designee will review care plans of residents who were readmitted to validate revisions were made to reflect the	

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F 657	Continued From page 26 developed diabetes while living at the facility and did not have diabetes prior to admission. FM11 stated his father was not exercising at the facility and was just sitting in bed. FM11 and other family members bring sweet food for R48 to eat when they visit. At the end of last year, R48 was hospitalized and sent to the hospital because he went into "diabetic shock." R48 is currently taking insulin. Review of R48's Electronic Health Record (EHR) found R48 was transferred and admitted to the hospital on 10/25/23 with diagnoses of hyperglycemic state and failure to thrive. On 10/31/23, R48 was re-admitted to the facility with a new diagnosis of type 2 diabetes. On 04/05/24 at 09:23 AM interview with Director of Nursing (DON) was done. DON confirmed R48 was diagnosed with diabetes after he was hospitalized on 10/25/23 and that the CP was not revised and should have been to include treatment and care for R48's new diagnoses of diabetes.	F 657	resident’s current status weekly x4 weeks and monthly x2 months. DON/designee will present findings at the facility’s Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care 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:	F 684		5/7/24

F 684

Continued From page 27

Based on interview, and record review, the facility failed to effectively assess, identify, and manage, constipation for 1 of 1 resident (Resident (R) 197) sampled. As a result of this deficient practice, R197 experienced no bowel movements for more than five days and abdominal pain/discomfort causing her distress. This deficient practice has the potential to affect all the residents at the facility at risk of constipation.

Findings include:

R197 is a 78-year-old female admitted to the facility from an acute care hospital for short-term rehabilitation on 04/01/24, following a loss of consciousness, and a fall at home. R197's current diagnoses include, but are not limited to, diabetes, chronic kidney disease with heart failure, leukemia, chronic pain, low back pain, and pain in both hips. As a result of her pain, R197 had physician orders for routine acetaminophen 1000 milligrams (mg) every 8 hours, and as needed oxycodone (a powerful opioid) 5mg-7.5mg every 6 hours for moderate to severe pain. One of the common side effects of an opioid is constipation.

A review of R197's Medication Administration Record (MAR) from the acute care hospital noted that the hospital had managed her constipation by giving her senna plus (laxative plus stool softener) twice daily until discharge, as needed lactulose (laxative) on 03/27/24, 03/28/24, and 03/29/24, and an as needed bisacodyl (laxative) suppository on 03/30/24.

A review of R197's electronic health record (EHR) at the facility noted no documentation that anyone

F 684

Immediate Actions
R197 had a bowel movement on 4/5/24. Resident has been having regular bowel movements since 4/5/24. Resident discharged from the facility on 4/26/24.

Identify Others
New residents have the potential to be affected by this practice.
DON/designee will audit date of last bowel movements of current residents admitted in the past 3 days on 4/29/24. Residents who have not had a bowel movement in 2 days will be offered bowel prep per MD orders.

Systemic Changes
Facility will determine via hospital records review and patient interview when last bowel movement was and will initiate bowel protocol if indicated.
DON/designee will reeducate licensed nurses to assess for last bowel movement upon admission by 5/7/24.

Monitor
DON/designee will audit new admits for LBM weekly x4 weeks then monthly x2 months to validate residents without regular bowel movements are being addressed appropriately.
DON/designee will present findings at the facility�s Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency.

F 684 Continued From page 28 F 684

had assessed when her last bowel movement was upon admission. Review of R197's physician orders noted the following orders to manage constipation:

Bisacodyl EC (enteric coated) tablet 5mg at every bedtime for constipation.

Polyethylene Glycol 17 grams as needed for no bowel movement in 2 days.

Bisacodyl suppository 10mg as needed for no bowel movement after Polyethylene Glycol.

Review of the nurse progress notes revealed that on 04/02/24 at 02:01 PM, the Admissions Registered Nurse (RN) documented that R197 had brought a bottle of bisacodyl tablets with her to the facility, verbalized that she had taken it nightly at home, and expressed her wishes to continue taking them. No documentation is noted of why R197 routinely took a laxative, or of when her last bowel movement was. On 04/02/24 at 02:40 PM, RN37 documented R197's last bowel movement as 03/31/24, the day prior to her admission.

On 04/03/24 at 08:30 AM, an interview was done with R197 (noted to be alert and oriented to person, place, and time) at her bedside. When asked about pain, R197 reported that she had not had a bowel movement (BM) since before she was admitted and that she was feeling uncomfortably constipated. R197 continued to explain that she frequently experienced constipation and took a daily laxative at home to manage it. When asked if she could get up to the bathroom, R197 responded that she was working with physical therapy, but was not able to safely

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ambulate yet. Surveyor informed RN53 of R197's discomfort at 08:40 AM.

On 04/03/24 at 04:08 PM, RN53 documented "[R197] Requested ... [polyethylene glycol] to have BM." The progress note has no documentation when R197's last bowel movement was or whether the requested medication was effective or not.

A review of R197's MAR for 04/03/24 revealed RN53 had marked the polyethylene glycol as administered at 09:06 AM and was ineffective for resulting in a bowel movement.

On 04/04/24 at 02:17 PM, an interview was done with R197 at her bedside. When asked about pain, R197 reported that she was still uncomfortably constipated. With her hands guarding her stomach and a painful expression on her face, R197 described her constipation as so uncomfortable, she had difficulty discerning where her pain was coming from, and whether the pain she felt was because of positioning, or constipation. Confirmed with R197 and her husband at the bedside, that it had been more than 4 days since her last BM. Surveyor informed Unit Manager (UM) 81 of R197's constipation discomfort/pain at 02:40 PM.

On 04/05/24, a review of R197's EHR noted that on her Bowel Elimination record, R197 had been consistently documented as having no bowel movement from admission on 04/01/24 until 04/05/24. Review of R197's MAR noted the as needed polyethylene glycol had been administered only once, and the as needed bisacodyl suppository had not been administered at all.

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F 684	Continued From page 30 On 04/05/24 at 08:55 AM, an interview was done with the Director of Nursing (DON) in the Administrator's office. DON stated that there should have been an automatic alert in the EHR after 3 days of no BMs to prompt nursing staff. DON confirmed that polyethylene glycol had not been administered after 2 days of no BM, as ordered by the physician, and the bisacodyl suppository had not been administered when the Polyethylene Glycol had proven ineffective, as ordered by the physician. DON stated that her expectation is that additional intervention should have been taken within 24 hours of the polyethylene glycol not working. DON could not find any documentation that follow-up had occurred until UM81 was notified by the Surveyor at 02:40 PM the previous day. DON agreed that the opioids R197 was taking, and that she was not able to get up out of bed, placed her at high risk of constipation. DON also agreed that the facility should have monitored, assessed for, identified, and addressed the constipation problem earlier.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to	F 688		5/7/24

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prevent further decrease in range of motion.

§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure a resident with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion for one of two residents (Resident (R) 25) sampled. R25 was not provided proper care and treatment for contracture to his left hand as ordered.

Findings include:

R25 was admitted to the facility on 08/17/17 with diagnoses of dysphagia, anemia, unspecified dementia without behavioral disturbance, and contracture to right and left hand.

Review of R25's Electronic Health Record (EHR) found under physician's order to place rolled gauze or towel to left hand every shift, ordered on 11/18/20 and revised on 10/17/21.

During observations on 04/02/24 at 09:46 AM, 12:29 PM, 12:35 PM, 12:46 PM, on 04/03/24 at 08:57 AM, 02:26 PM, on 04/04/24 at 08:13 AM, 10:19 AM, 12:39 PM, and on 04/05/24 at 08:58 AM, observed R25 in bed, both hands contracture with no rolled-up gauze or towel to left hand.

On 04/04/24 at 10:34 AM an interview with Restorative Aide (RNA) 108 and RNA200 was

F 688

Immediate Actions
R25 order for rolled gauze/towel was discontinued on 4/5/23. ROM exercises are being completed per RNA program.

Identify Others
Current residents have the potential to be affected by this practice.
DON/designee will complete an audit on current treatment orders to validate completion by 5/3/24.

Systemic Changes
DON/designee will educate licensed nursing staff about following MD orders and appropriate documentation by 5/7/24.

Monitor
DON/Designee will audit 5 residents treatment administration logs to validate treatment orders are being completed, weekly x4 weeks and monthly x2 months.
DON/designee will present findings at the facility's Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency.

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done. Inquired if R25's RNA program included passive range of motion (PROM) to hands and if they put splints, rolled gauze or towel to hands, both RNA108 and RNA200 reported they only do PROM to lower extremities and a knee brace for R25. Both reported nursing staff are to put rolled gauze or towel to hands but have never seen R25 with a rolled gauze or towel in hands.

On 04/04/24 at 11:43 AM an interview and concurrent record review with Director of Rehab (DOR) was done. DOR provided R25's most recent Occupational Therapy (OT) note dated 05/04/23, the note documented the left first digit proximal interphalangeal (PIP) joint 90 degrees extension, left second digit PIP joint 60 degrees extension, right first digit PIP joint 180 degrees extension, and right second digit PIP joint 100 degrees extension. Discharge plan to "RNA program for splint/contracture management ...(L [left] hand requiring towel d/t [due to] tight MP [metacarpophalangeal] joints) ..." DOR confirmed upon OT discharge the RNA Plan dated 05/20/23 included PROM to both hands seven times a week and noted left hand required rolled up towel under digits.

On 04/04/24 at 12:39 PM an interview with Certified Nurse Aide (CNA) 42 was done. Inquired if R25 gets a rolled gauze or towel to left hand every shift, CNA42 reported he did a long time ago, but it has not been done lately.

On 04/04/24 at 12:45 PM an interview with MDS Director (MDSD) 15 was done. MDSD15 confirmed she oversees the RNA program and reported R25's RNA program included PROM to lower extremities and splint to left knee daily. Inquired if the RNA program included PROM to

F 688 Continued From page 33 F 688

bilateral hands as well, MDSD clarified the RNAs should be providing PROM to bilateral hands and lower extremities. Informed MDSD that the RNA staff reported they do not do PROM to bilateral hands. MDSD further reported the order for rolled gauze or towel to left hand is completed by licensed nursing staff because they are supposed to mark it in the Treatment Administration Record (TAR).

On 04/04/24 at 01:49 PM, RNA108 wanted to clarify a miscommunication during the interview at 10:34 AM. RNA108 reported the RNA staff provided PROM exercises to R42's bilateral hands. RNA108 confirmed the RNA staff do not put rolled gauze or towel to left hand and further confirmed he has never seen rolled gauze or towel to R42's left hand.

On 04/05/24 at 08:58 AM an interview with Licensed Practical Nurse (LPN) 1 was done. LPN1 reported she has been working for the facility for a long time and recently started working in the unit R25 resides and that the facility used to put a rolled gauze or towel to left hand every shift but has not seen it done since she has been working on the unit R25 resides. LPN1 stated the CNA are to do it, but the licensed nursing staff mark it in the TAR.

On 04/05/24 at 09:33 AM an interview with Director of Nursing (DON) was done. DON confirmed order rolled gauze or towel to left hand and reported the licensed nursing staff would put the rolled gauze or towel to left hand and not the CNAs but can ask them to do it.

On 04/05/24 at 09:59 AM a second interview with DOR was done. Inquired what the purpose of

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F 688	Continued From page 34 rolled gauze or towel to hands, DOR reported to prevent contractures to the fingers and prevent the nails from digging into the hand when rolled in a fist. DOR further explained residents, especially with dementia, do not use their fingers as much and so their hands fold into a fist.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to provide adequate supervision and assistance to prevent accidents to one of seven sampled residents (Resident (R) 40). This failed practice has the potential to negatively affect residents who require staff assistance with feeding. Findings Include: R40 is an 80-year-old male admitted to the facility on 06/15/20. R40's medical diagnoses include but not limited to, hemiplegia (one sided paralysis), hemiparesis (one sided weakness) affecting the right side following cerebral infarction (reduced blood supply to the brain), and dysphagia (difficulty swallowing). Concurrent observation and interview were	F 689	Immediate Actions Resident R40 was assessed for complications from being provided the wrong textured food on 4/3/24; no adverse effects were identified. DON/designee to educate CNA40 regarding checking meal ticket, assisting with eating at eye level, and not to use personal phone while providing care to residents by 5/7/24. Identify Others Current residents have the potential to be affected by this practice. Systemic Changes DON/designee will reeducate nursing staff regarding reviewing meal tickets during tray pass, assisting residents to dine at	5/7/24

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conducted on 04/03/24 at 08:01 AM with Certified Nurse's Aide (CNA) 40 in R40's room. CNA 40 was observed standing up near the head of R40's bed, looking down at her personal phone. When CNA40 looked up from her phone, State Agency (SA) asked CNA40 how R40 was doing with his breakfast. CNA40 stated that she feels it might be too dry for him, pointing at the scrambled eggs and muffin on the plate. R40 was observed with scrambled eggs in his mouth and coughing. The meal ticket and the food items on the breakfast tray belonged to another resident. The food on the meal tray was regular consistency with thickened liquids. R40 has a diet order of pureed with thickened liquid. The wrong meal ticket and food items were brought to the attention of CNA40, who quickly grabbed the tray and placed it back into the meal cart. CNA40 then searched the meal cart for R40's correct breakfast tray.

Interview was conducted with Unit Manager (UM) 87 on 04/03/24 at 08:05 AM at the nurse's station. UM87 was made aware of the observation made in R40's room. UM87 stated that staff passing out the meal trays are trained to check the meal tickets when distributing to residents. CNA40 should have checked the meal ticket and should have caught the error prior to assisting R40 with his meal.

Interview was conducted with the Director of Nursing (DON) on 04/04/24 at 10:40 AM in the DON's office. DON stated that facility staff should not be on their personal phone while providing care to the residents.

A review of the facility document titled, "Employee Handbook," dated March 2024 was conducted. The handbook documented, "To promote a

F 689

eye level and not to use personal phones while providing care by 5/7/24.

Monitor
DON/designee will conduct 5 meal observation audits to validate that staff are assisting with meals at eye level, are not using personal devices/ charting while providing resident care, and residents are receiving the right textured food and food trays weekly x4 weeks then monthly x2 months.
DON/designee will present findings at the facility’s Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency.

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F 689	Continued From page 36 productive work environment and the safety of our staff and residents, employees are expected to make personal calls or send personal text messages only during breaks and in a non-working area."	F 689		
F 697 SS=E	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, interview and record review, the facility failed to prevent and manage pain adequately for 3 of 3 residents sampled for pain (Residents (R) 197, R146, and R13). Specifically, the facility failed to effectively evaluate pain on admission so that an effective, resident-centered care plan could be developed. As a result of this deficient practice, these residents were prevented from attaining or maintaining their highest practicable level of well-being. Findings include: 1) Resident (R) 197 is a 78-year-old female admitted to the facility for short-term rehabilitation on 04/01/24 following a loss of consciousness, and a fall at home. R197's current diagnoses include, but are not limited to, diabetes, chronic kidney disease with heart failure, leukemia, chronic pain, low back pain, and pain in both hips. As a result of her pain, R197 has current	F 697	Immediate Actions Thorough pain assessment was completed for R197 on 4/5/24. Pain is being monitored and controlled. R13, R146 were discharged from the facility. RA106 and RA200 were educated about pain management on 5/2. UM90 and ARN2 were educated about thoroughly completing pain assessments on 4/30/24. Identify Others New admissions have the potential to be affected by this practice. DON/designee will review new admission NSG Pain Evaluation in the past 30 days. Any residents with incomplete NSG Pain Evaluation will have their pain reassessed and care plan updated by 5/1/24. Systemic Changes	5/7/24

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F 697	Continued From page 37 physician orders for routine acetaminophen 1000 milligrams (mg) every 8 hours, and as needed oxycodone (a powerful opioid) 5mg-7.5mg every 6 hours for moderate to severe pain. On 04/02/24 at 08:46 AM, concurrent observation and interview were done with R197 at her bedside. R197 was grimacing and guarding her neck, barely turning her head to speak. When asked if she was OK, R197 complained of back and neck pain that she rated 8 out of 10. Asked if she had taken anything yet for the pain, R197 stated "I'm still waiting." Surveyor notified Registered Nurse (RN) 37 that R197 was requesting pain medication. On 04/02/24 at 09:09 AM, observed two Restorative Aides (RAs), RA106 and RA200, weighing R197 on a mechanical lift scale. R197 appeared to be in great pain, grimacing, moaning, and wincing, as she was lifted in the mechanical lift harness. As she hung in the air, grimacing in pain, RA106 noted that the scale had shut itself off due to inactivity. As a result, the RAs had to lower R197 back to the bed, turn the scale on, and lift her in the harness a second time. When asked, R197 stated that she did just receive her pain medication, but it had not "kicked in yet." On 04/03/24 at 08:31 AM, observed R197 grimacing and guarding in pain as she lay in bed. When asked, R197 complained of pain to her left buttock and back that she rated 7 out of 10. Surveyor notified RN53 of R197's pain. RN53 stated that she was just about to prepare her oxycodone. On 04/05/24 at 07:18 AM, conducted a review of R197's Pain Evaluation, initiated at admission on	F 697	DON/designee will educate licensed nursing staff on pain management and completing the NSG Pain Evaluation by 5/7/24. Monitor DON/designee will audit 5 NSG Pain Evaluations weekly x4 weeks then monthly x2 months to validate the evaluations are being completed thoroughly. DON/designee will present findings at the facility's Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency.	

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F 697	Continued From page 38	F 697		

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04/01/24 by Unit Manager (UM) 90. Noted that only the first section of the evaluation had been completed. The first section consisted of the following 5 questions:

Is the resident able to verbalize pain?

Are you taking any pain medications now?

Do you have pain now?

Have you had pain in the last five (5) days?

Do you have a history of pain or chronic pain?

Every question in the first section had been marked as "yes," yet there were no follow-up questions asked, such as current pain level, location of pain, what makes the pain better or worse, or what is her pain goal (what level of pain she would find tolerable/acceptable). The Evaluation had been marked as complete, and indicated a final assessment score of 0.0, reflecting a low risk for pain.

On 04/05/24 at 08:49 AM, an interview was done with the Director of Nursing (DON) in the Administrator's office. Concurrent review of the Pain Evaluation was done with the DON. DON confirmed that the Pain Evaluation was incomplete, and that all additional questions should have been asked. DON agreed that an incomplete pain evaluation hindered the development of an effective and resident-centered care plan for pain.

On 04/05/24 at 11:20 AM, an interview was done with UM90 in the conference room. UM90 confirmed that she should have completed

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F 697	Continued From page 39	F 697		

R197's Pain Evaluation, especially since every question in the first section had been answered yes. UM90 also agreed that because the Pain Evaluation was not complete, R197's care plan for pain management was incomplete.

2) On 04/02/24 at 02:39 PM, interviewed R146 about his pain. R146 stated he had right leg and hip pain that was shooting down his leg, and was also dull and cramping which kept him up at night. During this interview, R146 was sitting and had some grimacing when talking about his leg and hip pain. During the interview, noticed R146's right foot was swollen. Inquired if R146 had reported pain to his nurse and he confirmed he had.

On 04/03/24, record review of R146's electronic health record (EHR) found he is 79 years old, admitted to the facility on 03/28/24 and his diagnoses include, but are not limited to, other intervertebral disc degeneration, lumbar region, pain, unspecified, and pain in right leg. R146's NSG (nursing) Pain Evaluation - V1 was filled out on 03/28/24 at 18:15 (06:15 PM) by Admission Registered Nurse (ARN) 2. Review of the NSG (Nursing) Pain Evaluation found the following: 1. Evaluation A. Is the resident able to verbalize pain? Yes. When ARN2 filled out section 2. Location he documented description of R146's pain as intermittent pain to right leg. ARN2 did not include type of pain such as stabbing, burning, sharp, dull or throbbing which is listed in this section. Under section 7. Medications/Treatments/Modalities A. Describe all methods of alleviating pain and their effectiveness this area was left blank.

On 04/05/24 at 11:57 AM, interviewed Director of

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F 697	Continued From page 40 Nursing (DON) and she confirmed staff did not fully fill out R146's pain evaluation upon admission and she stated she would have hoped the nurse would have filled out the areas in question: type of pain and resident to describe all methods of alleviating pain and their effectiveness. 3) On 04/02/24 at 03:53 PM, interviewed R13 about her pain. R13 complained about her pain in her right leg when she moved it or tried to stand. R13 remained in bed during this interview, so as not to aggravate her leg and increase the pain. On 04/03/24, record review of R13's EHR found she is a 77 year old, admitted to the facility on 03/13/24 and her diagnoses include, but are not limited to, displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, pain, unspecified, other, chronic pain, bilateral primary osteoarthritis of knee, history of falling, difficulty in walking, not elsewhere classified, unsteadiness on feet, need for assistance with personal care and muscle weakness, generalized. R13's NSG (Nursing) Pain Evaluation - V1 was filled out on 03/13/24 at 14:56 (02:56 PM) by Unit Manager (UM) 90. Review of the NSG (Nursing) Pain Evaluation found the following: 1. Evaluation A. Is the resident able to verbalize pain? Yes. The following sections were left blank: 3. Current Pain Level A. Pain score out of 10 where 1 is mild pain and 10 is worst pain possible. 4. What makes the pain better? 5. What makes the pain worse? and 6. Effects of pain on ADLs. Does pain negatively impact: Sleep and rest, Social activities (friends and service projects), Appetite, Physical activity and mobility, Emotions, Intimacy, Additional notes. 7. Medications/Treatments/Modalities A.	F 697		

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F 697	Continued From page 41 Describe all methods of alleviating pain and their effectiveness. On 04/05/24 at 01:24 PM, interviewed DON and she confirmed staff did not fully fill out R13's pain evaluation upon admission, stated she will be talking to her nurses regarding this.	F 697		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents'	F 726		5/7/24

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F 726	Continued From page 42 needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staff competency in narcotic log documentation and reconciliation. This deficient practice hinders the process necessary to promptly identify loss or potential diversion of controlled medications. Findings include: On 04/04/24 at 08:45 AM, an inspection and reconciliation of the narcotic log on medication cart 2C was done with Registered Nurse 37. Noted blister pack for Resident (R) 3's Tramadol 50 milligrams (mg) had thirty-nine (39) tablets remaining while the narcotic log reflected a balance of forty (40) tablets remaining. At this moment, RN37 took the narcotic log from Surveyor and signed out one tablet of Tramadol for R3. When asked why he was only signing the Tramadol out at that moment (wrote signed out at 08:47 AM), RN37 stated he had just given it and got back to the cart. Surveyor pointed out that he did not just get back to the cart after administering the medication to R3, because Surveyor had just observed him crushing six different medications, pouring two medications, then leaving to administer those medications to a different resident before returning to the cart. RN37 agreed that he had given R3's medication earlier, and that he should have signed her Tramadol out before he moved on to anything else or prepped another resident's medications. On 04/04/24 at 08:55 AM, an interview was done with Unit Manager (UM) 81 outside of room 223.	F 726	Immediate Actions Narcotic count was completed for all med carts on 4/4/24. All narcotics were accounted for. DON/designee reeducated RN37 regarding narcotic log documentation and reconciliation during medication pass on 5/2/24. Identify Others Residents who are receiving narcotics have the potential to be affected. Systemic Changes DON/designee will reeducate licensed nurses regarding narcotic log documentation and reconciliation during medication pass by 5/7/24. Monitor DON/designee will conduct 5 random medication pass observations weekly x4 weeks, then monthly x2 months to validate appropriate narcotic log documentation and reconciliation. DON/designee will present findings at the facility's Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency.	

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F 726	Continued From page 43 UM81 confirmed that the expectation is that narcotics are signed out (of the narcotic log) when they are pulled. On 04/04/24 at 10:08 AM, an interview was done with the Director of Nursing (DON) in the conference room. DON also confirmed that narcotics should be signed out when they are pulled, not after administering.	F 726		
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	F 761		5/7/24

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F 761	Continued From page 44 by: Based on observation, interview, and record review, the facility failed to ensure all medications used in the facility were labeled in accordance with professional standards. Proper labeling of medications is necessary to promote safe administration practices and decrease the risk for medication errors. This deficient practice has the potential to affect all residents in the facility taking medications. Findings include: On 04/04/24 at 08:27 AM, upon inspection of medication cart 2B with Registered Nurse (RN) 61, noted an albuterol inhaler pulled from the emergency kit (e-kit), with no name, and no date, despite it being clearly opened and used. RN61 confirmed that it had been used, as it would not have been pulled from the e-kit unless it was needed for immediate use but could not explain why it was not properly labeled. On 04/04/24 at 08:39 AM, an interview was done with Assistant Director of Nursing (ADON) 2 near medication cart 2B. ADON2 confirmed that the inhaler and the box that it was in should be labeled with a minimum of a resident name and the date it was opened. On 04/04/24 at 10:00 AM, the following was noted in a review of the facility's policy and procedure, Pharmacy Services Labeling and Storage of Drugs and Biologicals, dated 11/2017: "5. For medications designed for multiple administrations (e.g., inhalers, eye drops), the label identifies the specific resident for whom it was prescribed."	F 761	Immediate Actions Unlabeled ekit medication was discarded on 4/4/24. Identify others Residents residing in the facility have the potential to be affected by this practice. All medication carts were audited for unlabeled medications on 5/1/24. Any unlabeled medications were disposed of immediately. Systemic Changes DON/designee will re-educate licensed nursing staff about proper labeling medications, including ekit medication by 5/7/24. Monitor DON/designee will conduct medication cart audits weekly x4 weeks, then monthly x2 months to validate that all medications are appropriately labeled. DON/designee will present findings at the facility's Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency.	

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F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		5/7/24

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;
(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

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F 842	Continued From page 46 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 a resident's (Resident (R) 25) medical record was accurately documented. Findings include: Cross Reference to F688, Increase/Precent Decrease in ROM/Mobility. The facility failed to provide the proper care and treatment for the contracture in R25's left hand as ordered.	F 842	Immediate Actions R25 order for rolled gauze/towel was discontinued on 4/5/23. Identify Others Current residents have the potential to be affected by this practice. DON/designee will complete an audit of current treatment orders to validate completion by 5/3/24.	

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F 842	Continued From page 47 Review of R25's Electronic Health Record (EHR) found under physician's order to place rolled gauze or towel to left hand every shift, ordered on 11/18/20 and revised on 10/17/21. During observations on 04/02/24 at 09:46 AM, 12:29 PM, 12:35 PM, 12:46 PM, on 04/03/24 at 08:57 AM, 02:26 PM, on 04/04/24 at 08:13 AM, 10:19 AM, 12:39 PM, and on 04/05/24 at 08:58 AM, observed R25 in bed, both hands contracture with no rolled-up gauze or towel to left hand. Review of R25's Treatment Administration Record (TAR) in April, during the survey period, documented, administered, "Place ROLLED GAUZE or TOWEL to LEFT HAND," on all shifts, day, evening, and night from 04/02/24 to 04/04/24. On 04/04/24 at 12:39 PM an interview with Certified Nurse Aide (CNA) 42 was done. Inquired if R25 gets a rolled gauze or towel to left hand every shift, CNA42 reported he did a long time ago, but it has not been done lately. On 04/05/24 at 08:58 AM an interview with Licensed Practical Nurse (LPN) 1 was done. LPN1 reported she has been working for the facility for a long time and recently started working in the unit R25 resides and that the facility used to put a rolled gauze or towel to left hand every shift but not seen it done since she has been working on the unit R25 resides. LPN1 stated the CNA are to do it, but the licensed nursing staff mark it in the TAR. On 04/05/24 at 09:33 AM an interview and concurrent record review with Director of Nursing	F 842	Systemic Changes DON/designee will educate licensed nursing staff about following MD orders and appropriate documentation by 5/7/24. Monitor DON/Designee will audit 5 residents treatment administration logs to validate treatment orders are being completed, weekly x4 weeks and monthly x2 months. DON/designee will present findings at the facility□s Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency.	

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(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 842	Continued From page 48 (DON) was done. DON confirmed order rolled gauze or towel to left hand and reported the licensed nursing staff would put the rolled gauze or towel to left hand and not the CNAs but can ask them to do it. DON confirmed the TAR documented the treatment was being done. Reported to DON that staff are saying the treatment is not being done but marking it as it is and inquired what should be marked, DON reported the nursing staff should not mark it was completed and if the resident refused it should be marked as refused instead. DON confirmed if staff are saying they are not providing the treatment and marking it as completed, the medical record is not accurately recorded, and staff are not following the order.	F 842		
F 880 SS=F	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	F 880		5/7/24

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	125020	A. BUILDING ______ B. WING ______	04/05/2024

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F 880	Continued From page 49	F 880		

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 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

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F 880

Continued From page 50
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, interview, and record review, the facility failed to ensure appropriate protective and preventive measures for communicable diseases and infections. This is evidenced by the facility failing to ensure staff followed transmission-based precautions (TBP) by wearing the proper personal protective equipment (PPE), as well as follow standard precautions by performing hand hygiene in between glove changes. These deficient practices have the potential to affect all residents in the facility, as well as all healthcare personnel, and visitors at the facility.

Findings include:

1) On 04/02/24 at 08:20 AM, an interview was done with the Infection Preventionist (IP) in her office. IP reported that Resident (R) 18 had shingles and was currently on Droplet and Contact Precautions. IP confirmed that the expectation was that staff entering R18's room would don an N-95 respirator, a face shield, a gown, and gloves.

On 04/02/24 at 12:17 PM, observed two Certified Nurse Aides (CNAs), CNA42 and CNA84, assisting R18 back into bed from her wheelchair. Noted that CNA42 did not have a face shield on.

On 04/02/24 at 12:25 PM, an interview was done

F 880

Immediate Actions
R52, R146 and residents that were in rooms 211 were reviewed, no new facility acquired infections were identified.
CNA42, CNA62, CNA84 were re-educated regarding droplet precautions, and donning and doffing PPE by 5/7/24.
Rehab department was reeducated on proper disposal of PPE on 5/1/24.

Identify Others
Current residents have the potential to be affected by this practice.

Systemic Changes
Infection Preventionist/designee re-educated staff regarding isolation precautions, donning and doffing PPE, proper disposal of PPE and to keep drainage bags off the floor to prevent infection by 5/7/24.

Monitor
Infection Preventionist/designee will conduct random observation audits for 10 staff weekly for 4 weeks, then monthly x 2 months to validate transmission-based precautions are being implemented, appropriate PPE usage and appropriate disposal of PPE.

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F 880	Continued From page 51 with CNA42 outside R18's room. CNA42 admitted that she "forgot face shield" and confirmed that she should be wearing one. On 04/02/24 at 01:02 PM, while observing lunch delivery to the residents in their rooms, noted CNA84 delivering a lunch tray to the resident in the bed right next to R18. CNA84 was not wearing any personal protective equipment (PPE) at all. When questioned, CNA84 stated that isolation precautions are only for the specific resident that has been placed on it. Since the resident he delivered the tray to was not on any precautions, he did not have to wear any PPE. At 01:05 PM, observed CNA62 deliver a lunch tray to R195, another resident in R18's room, wearing no PPE. At 01:09 PM, observed CNA42 and CNA62 enter R18's room to reposition R195 in bed. Neither CNA was wearing an N-95 respirator or a face shield. On 04/02/24 at 01:15 PM, an interview was done with IP outside her office. IP stated that since R18 was on droplet precautions, the expectation is that staff should be donning all PPE every time they enter R18's room, no matter who they are helping. A review of the CDC guidelines (provided by the DON) the facility follows for droplet precautions notes that everyone entering the room must be wearing an N-95 respirator, and eye protection. 2) On 04/02/24 at 12:33 PM, while in the hallway outside of a resident's room observed staff pull open the drawer of the cart that had personal	F 880	Infection Preventionist/designee will check 5 drainage bags weekly for 4 weeks, then monthly x 2 months to validate that they are not laying on the floor. Infection Preventionist/designee will present findings at the facility’s Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency.	

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F 880	Continued From page 52 protective equipment (PPEs) for staff to use such as gowns and gloves. Staff noticed a crumpled up gown that was placed in the drawer where the new gowns are kept. Staff stated she did not know why someone would do this and threw away the gown. On 04/02/24 at 12:38 PM, interviewed Unit Manager Registered Nurse (UMRN) 87 who confirmed the crumpled up gown should have been thrown away and not placed back in with the new gowns. 3) On 04/02/24 at 1:58 PM, while interviewing resident (R) 52 observed two drainage bags with tubes from resident's right kidney that were laying on the ground. Inquired with R52 about drainage bags on the ground and he was not aware of where staff placed them. On 04/05/24 at 01:12 PM, interviewed UMRN87 who explained R52 has two nephrostomy tubes from his right kidney with drainage bags that collects R52's urine. UMRN87 confirmed staff are to hang the drainage bags from resident's bed and not to place them on the ground. 4) On 04/02/24 at 02:24 PM while interviewing R146 observed a glove that was turned inside out and placed at the end of R146's bed on his blanket. Inquired of R146 who had placed the glove on his bed and he stated "it was the therapist." On 04/02/24, during record review of R146's electronic health record (EHR) found R146 had worked with the physical and occupational therapist that day.	F 880		

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F 880	Continued From page 53 On 04/03/24 at 12:02 PM, interviewed the manager for the physical and occupational therapy department. Inquired what therapists are expected to do with gloves when they take them off. Manager stated throw them away and sanitize hands. Manager stated she will follow up with therapist and do on the spot training.	F 880		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain resident (R)148's bed cord control, that raises and lowers the bed, in safe operating condition. The bed cord was frayed in multiple places putting the resident and staff at risk for electrocution. The deficient practice could affect all residents with a bed control. Findings Include: On 04/02/24 at 12:32 PM, observed R148's bed control was placed in her dresser drawer at the bedside. Noticed the cord for the bed control was frayed in multiple places. R148 stated she was tired and was going to sleep because she had a "rough night" so was not able to answer any questions about the bed control. On 04/05/24 at 09:58 AM, met with Unit Manager Registered Nurse (UMRN) 87 who confirmed the bed control cord was frayed, not safe and she would have maintenance fix this.	F 908	Immediate Actions R148's bed control was replaced on 4/5/24. Identify Others Current residents have the potential to be affected. Facility wide audit was completed to ensure proper functioning and in good working order of bed controls on 4/24/24. Systemic Changes Staff were educated to promptly report items that are not in good working order or condition by 5/7/24. Monitor Maintenance director/designee will conduct random audits on 10 beds weekly x 4 weeks then monthly x2 months. Maintenance director/designee will present findings at the facility's Quality Assurance and Performance	5/7/24

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F 908	Continued From page 54	F 908	Improvement meeting monthly until QAPI team recommends a lesser frequency.	