STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125004	A. BUILDING _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN ISLE HEALTHCARE AND REHABILITATION CENTER	3-3420 KUHIO HIGHWAY, SUITE 300 LIHUE, HI 96766

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification survey was conducted by the Office of Healthcare Assurance on February 10, 2023. The facility was not in substantial compliance with 42 CFR 483 Subpart B. The highest scope and severity (S/S = F at F812, (Food Procurement, Store/ Prepare/Serve-Sanitary). Two complaints in Aspen Complaint Tracking System (ACTS) #9965 and #10081 were investigated and found in compliance at F622 (Transfer and discharge requirements); F623 (Notice requirements before transfer/discharge); F585 (Grievances); F684 (Quality of Care / Treatment). and F880 (Infection Prevention & control). One facility reported incident (FRI) was investigated and found not in compliance at F609 (Reporting of alleged violations); F610 (Investigate/Prevent/Correct Alleged Violation), and F684 (Quality of Care). Survey dates: February 7, 2023, to February 10, 2023. Survey Census: Sixty-one. Sample size: Twenty.	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.	F 550		5/5/23

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

Electronically Signed | 04/03/2023

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F 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to assure a dignified existence for one of three sampled residents (R)56.	F 550	This Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that	

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F 550	Continued From page 2 Findings include: During an interview and concurrent observation on 02/07/23 at 12:30 PM, R56 stated to this surveyor that "I don't like that I had to do it in my pants. I don't do this at home." R56 had his call light on and upon entering the room, he stated he needed to go. R56 stated that rehab had told him that he needed to walk and go to the bathroom. R56's call light was on and nursing station over 100 feet away. At 12:35 PM, surveyor walked to nursing station and asked who answers call lights? Registered nurse (RN) stated "we all do" Nurse's aide stated "I am." Meanwhile, nurse manager (NM) walked past the conversation and towards the room and nurse's aide followed. Upon reaching R56's room, R56 stated he went already. R56 asked staff to close the curtain or cover him up when they change him. On 02/07/23 at 01:30 PM, interview with R56 who stated, "I'm embarrassed because I don't wet my pants at home."	F 550	one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. Resident 56 was discharged. Therapy staff was inserviced regarding ensuring residents receive care as needed by the Director of Nursing (DON). Direct care staff was inserviced on answering call lights timely. Inservices will be ongoing as needed. 2. Facility residents have the potential to be affected by the alleged practice. 3. Call light audits were put in place by the Administrator. The Interdisciplinary Team (IDT), facility direct care staff and therapists were inserviced regarding answering call lights timely by the DON/Staff Development Coordinator (SDC)/designee. Facility direct care staff and therapists were inserviced regarding regular toileting of residents by the DON/SDC/designee. Inservices will be ongoing as needed. 4. The DON/SDC/Nurse Managers/designee will audit call light response timeliness and toileting through observations and resident interviews weekly for a minimum of 12 weeks or until compliance is achieved. The DON will bring the results of these audits monthly to the Quality Assurance and Performance Improvement Committee monthly for review and recommendations for a minimum of 3 months or until	

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F 550	Continued From page 3	F 550	compliance is achieved.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to	F 578		5/5/23

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F 578	Continued From page 4 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 interview and record review (RR), the facility failed to ensure an Advance Directive and/or discussions regarding Advance Directives was documented in one resident's (Resident 16) medical record. As a result of this deficient practice, Resident (R)16 was placed at risk of not having her wishes honored for future health care decisions, should she become incapacitated. This deficient practice has the potential to affect all residents who wish to have end of life plans at the facility. Findings include: On 02/08/23 at 10:51 AM, a review of Resident (R)16's electronic health record (EHR) noted no advance health care directive (AD) found, and no documentation that it had been discussed. AD documentation was requested from the Director of Nursing (DON). On 02/08/23 at 03:14 PM, a copy of R16's AD was provided by the facility. On 02/09/23 at 01:31 PM, during further review of R16's EHR, it was noted that the facility had discussed the AD with R16 and obtained a copy of it from the acute care hospital on 02/08/23, following the state agency's (SA) request for documentation. On 02/10/23 at 12:08 PM, during an interview	F 578	1. Resident 16's advanced directive was obtained during the survey. Social Services staff was inserviced regarding obtaining advanced directives, discussion about advanced directives with residents and documentation by the Director of Operations. Resident 16 has been discharged. 2. Facility residents have the potential to be affected by the alleged practice. 3. Current residents' advanced directives were audited for compliance and followed up with as needed. The Social Service staff were inserviced by the Director of Operations regarding obtaining advanced directives, discussion about advanced directives with residents and documentation. Inservices will be ongoing as needed. 4. The Administrator/Social Services/designee will audit advanced directives, discussion about advanced directives with residents and documentation through medical record audits weekly for a minimum of 12 weeks or until compliance is achieved. The Director of Social Services will bring the results of these audits monthly to the Quality Assurance and Performance	

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F 578	Continued From page 5 with social services staff (SW)2 in the Social Services office, SW2 confirmed that the facility did not document an AD discussion, or obtain a copy of R16's AD until after the SA had identified the deficient practice.	F 578	Improvement Committee monthly for review and recommendations for a minimum of 3 months or until compliance is achieved.	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the	F 585		5/5/23

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F 585	Continued From page 6	F 585		

facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions

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F 585	Continued From page 7 include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement a process to address grievances for one resident (R) as evidenced by the facility failing to acknowledge, document, investigate, and resolve verbal complaints filed by a resident's family representative as grievances. This deficient practice has the potential to affect all residents/representatives verbalizing complaints. Findings include: On 12/05/22, a complaint was received by the State Agency (SA) from Resident (R)169's son regarding her care, with one of the allegations being an inappropriate discharge. R169 is a	F 585	1. Resident 169 has been discharged from the facility. Social Services staff and the Administrator were inserviced regarding the grievance process by the Director of Operations. Inservices will be ongoing. 2. Facility residents have the potential to be affected by the alleged practice. 3. Grievance/situation log was reviewed. The Social Services staff, facility staff and the IDT were inserviced by the Administrator/designee regarding grievances and follow up. Inservices will be ongoing as needed.	

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F 585	Continued From page 8 94-year-old female admitted on 10/25/22 for short-term rehabilitation (rehab) following a stroke with diagnoses that include chronic kidney disease, high blood pressure, osteoarthritis, and osteoporosis. Per the complaint, R169 was discharged on 11/09/22 "because showed no progress [in rehab]", despite a request by R169's son that she remain "a bit longer because her house is not ready to comply with her needs." On 02/09/23 at 01:42 PM, an interview was done with the Administrator in the Ohana Room. When asked for information regarding a grievance investigation/response for R169, the Administrator stated the facility had no documentation of a grievance. The Administrator did produce a progress note (PN) by the discharge nurse documenting R169's son displaying signs of anger and distress at the time of discharge. On 02/10/23 at 12:08 PM, an interview was done with social services staff member (SS)2 in the Social Services office. SS2 stated that nursing and social services staff were well aware that R169's son did not want her to be discharged. When asked to describe how they knew, SS2 reported that R169's son stated he wanted her to stay, he was resistant to discharge teachings and trainings, and was heard stating that he thought it was silly to be shown the rehab teachings because he and their home were not equipped to provide the care and monitoring she needed. Despite staff being aware that R169's son was not in agreement with the facility's plan to discharge her home, SS2 confirmed that there was no documentation of a formal grievance being filed by him (or on his behalf), nor was there documentation that the grievance process	F 585	4. The Administrator/Social Services/designee will monitor grievances through review of grievance/situation log weekly for a minimum of 12 weeks or until compliance is achieved. The Director of Social Services will bring the results of these audits monthly to the Quality Assurance and Performance Improvement Committee monthly for review and recommendations for a minimum of 3 months or until compliance is achieved.	

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F 585	Continued From page 9 was offered in response to his verbal complaints to staff.	F 585		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff members, the facility failed to report an allegation of physical abuse to Adult Protective Services.	F 609	1. Resident 168's allegations were reported to Adult Protective Services (APS) as needed by Social Service	5/5/23

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F 609	Continued From page 10 Findings include: Cross Reference to F610. The facility submitted a report of abuse to the State Agency. Resident (R)168 alleged. staff shoved dirty gloves in his mouth when he yells; they beat me when they change or turn me, or during shower; staff will push him hard to the wall and it hurts his hands and arms during change of incontinence brief. Interview with social services staff, inquired whether this allegation was reported to Adult Protective Services (APS). It was reported that a phone call was made to report the allegation. Requested documentation of the contact with APS. The facility did not provide documentation of a referral to APS.	F 609	department. Administrator inserviced the social worker regarding reporting requirements. Inservices will be ongoing as needed. Resident 168 was discharged. 2. Facility residents have the potential to be affected by the alleged practice. 3. Office of Healthcare Assurance (OHCA) reports filed within the last 30 days were reviewed and followed up with APS as needed by the Social Service department. The Social Service staff and the IDT were inserviced by the Administrator/designee regarding appropriate reporting. Inservices will be ongoing as needed. 4. The Administrator/Social Services/designee will audit OCHA reports weekly for appropriate reporting to APS and documentation a minimum of 12 weeks or until compliance is achieved. The Administrator will bring the results of these audits monthly to the Quality Assurance and Performance Improvement Committee monthly for review and recommendations for a minimum of 3 months or until compliance is achieved.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged	F 610		5/5/23

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F 610	Continued From page 11 violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff members, the facility failed to complete a thorough investigation and maintain documentation that an allegation of physical abuse was thoroughly investigated. There was no documentation of the resident interviews that were reportedly conducted. The facility did not thoroughly investigate the allegation, the facility failed to investigate the root cause of the bruises on the resident's arms (injuries of unknown origin) which was not documented in their report, the private caregiver was not interviewed, and the facility did not follow up on staff member's witness of certified nurse aides asking resident about the resident about the allegation. Findings include: On 06/02/22 at 05:21 PM the facility transmitted an initial report regarding an allegation of abuse related to Resident (R)168. R168 reportedly informed Physical Therapist (PT) of foot pain. The Charge Nurse (CN)12 was informed and followed up with resident. R168 informed CN12,	F 610	1. Resident 168□s care plan was updated to reflect care to be given by two caregivers at a time. Resident 168 has been discharged. Staff were inserviced regarding abuse allegation investigations by the Administrator/designee. Inservices will be ongoing as needed. 2. Facility residents have the potential to be affected by the alleged practice. 3. Abuse allegations filed within the last 30 days were reviewed for a comprehensive investigation by the Social Service department and the Administrator and updated as needed. The Administrator inserviced the Social Service department and IDT regarding fully investigating abuse allegations. Inservices will be ongoing as needed. 4. The Administrator/Social Services/designee will audit abuse allegations weekly for a comprehensive	

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GARDEN ISLE HEALTHCARE AND REHABILITATION CENTER	3-3420 KUHIO HIGHWAY, SUITE 300 LIHUE, HI 96766

(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 610	Continued From page 12 "They beat me when they change me or turn me. They beat me when they shower me, but I didn't shower today". CN12 completed a skin assessment and noted no significant injuries. The initial report did not identify the alleged perpetrator. On 06/02/22, Social Services Staff (SS)1 interviewed R168. R168 informed SS1 that staff shove dirty gloves in his mouth, especially when he yells. The resident stated it happens mostly during the day when they change his personal brief. R168 did not know the name of the staff member and provided a physical description of the staff member. R168 informed SS1 that it happened yesterday (06/01/22) after breakfast. He also informed SS1 that during change of personal briefs they push him hard to the wall and it hurts his hands and arms. SS2 was documented as interviewing all nursing staff assigned to R168 on 06/01/22. On 06/03/22, SS1 showed the resident pictures of direct care staff that worked on his unit between 05/27/22 to 06/02/22 (there was a total of 43 staff). R168 identified four different staff members, one of which matched R168's physical description of the alleged perpetrator. On 06/05/22, SS showed the resident the photos again and R168 identified two of four staff members that were previously identified on 06/03/22. The staff member that reportedly matched R168's description (Certified Nurse Aide 5) was noted to have been on leave from 05/21/22 and returned to work on 06/02/22. Report also documented another skin check was done on 06/06/22 with "no significant injuries".	F 610	investigation for a minimum of 12 weeks or until compliance is achieved. The Administrator will bring the results of these audits monthly to the Quality Assurance and Performance Improvement Committee monthly for review and recommendations for a minimum of 3 months or until compliance is achieved.	

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On 02/08/23 at 02:42 PM a record review was done. R168 was admitted to the facility on 06/15/21 with diagnoses which include but not limited to hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting right dominant side, history of sepsis, chronic systolic (congestive) heart failure, and atherosclerotic heart disease of native coronary artery without angina.

A review of the annual/comprehensive Minimum Data Set (MDS) with assessment reference date of 04/21/22 notes R168 yielded a score of 14 (cognitively intact) when the Brief Interview for Mental Status was administered. R168 was not coded for having mood symptoms or exhibited behaviors (e.g., hitting kicking, threatening others, screaming at others, hitting, or scratching self, pacing). Also, R168 was not coded for rejection of care or wandering. R168 required extensive assistance with two plus persons physical assist for bed mobility (how resident moves to and from lying position, turns side to side), transfer (how resident moves between surfaces, including to or from bed, wheelchair, standing), and toilet use (how resident uses the toilet room, commode, transfers on/off toilet, cleanses self after elimination). R168 was also noted to require extensive assistance with one person physical assist for dressing (how resident puts on, fastens, takes off all items of clothing), eating (how resident eats and drinks), and personal hygiene (how resident maintains personal hygiene, including combing hair, brushing teeth, applying makeup, shaving). R168 has impairment to one side of the upper and lower extremities. R168 also noted as always incontinent of bowel and bladder. Subsequent quarterly evaluation with assessment reference date of 08/22/22 notes

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R168 continued to be cognitively intact. The resident now reports feeling down, depressed, or hoped once a day. R168 continued not to display behaviors, rejection or care, or wandering.

A review of the physician order dated 06/02/22 documents an order to observe weekly, right upper arm bruise 1.0 x 1.0 centimeters (cm); right arm (near elbow area) bruise 1.0 x 0.7 cm, and right elbow area bruise 1.0 x 0.7cm. Also noted left forearm bruise (4.0 x 2.8 cm), left arm (near AC) bruise (1.3 x 1.5 cm), and left upper arm bruise (5.0 x 1.0 skin intact). On 06/28/22, physician makes note of existing bruise in right arm, inner aspect of elbow, worsening and now measuring at 7 cm x 6 cm, please continue to monitor once a day on Sun 1530-2330. Medication orders include: albuterol, atorvastatin, Boost Plus with meals, cilostazol (anti-platelet), ferrous sulfate, Lasix, omeprazole, Procrit (treat anemia/low red blood cell count), and tamsulosin.

Review of progress note for 06/02/22 (05:21 PM) notes R168 with multiple bruises during skin check. Bruises include right upper arm bruise (1.0 x 1.0 cm); right arm, near elbow (1.0 x 0.7 cm); right elbow (1.0 x 0.7 cm); left forearm bruise (4.0 x 2.8 cm); left arm, near AC (1.3 x 1.5 cm); and left upper arm (5.0 x 1.0 cm). Review of progress notes prior to the identification of the multiple bruises on 06/02/22, found no documentation of bruises or skin impairment.

A request was made to the Administrator for the documentation of the facility's investigation. On 02/08/23 at 01:38 PM, the facility provided copies of their investigation which included: completed Event Report to the State Agency, interview/statements by staff members, and

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staffing schedule.

A review of the completed Event Report did not provide the name of an alleged perpetrator. Review documents at the time of the incident, R168 had a care plan in place for occasional behaviors of being resistive, combative to care if he doesn't get his way, which daughter acknowledged. Also noted R168 with occasional verbal aggression with daughter and yelling at staff. The facility reported interviewing other alert and oriented residents on R168's unit and they all stated, "they feel safe, comfortable, and they have not witnessed any abuse". The facility revised R168's care plan to "prevent a similar incident from happening", intervention was added to require two staff present during care. The facility surmised based on "interviews, results of the skin checks, and inconsistencies with the story, abuse and neglect has been ruled out".

The statement provided by the Physical Therapist (PT)1 documents on 06/02/22 around 09:30 AM, resident was asked about his progress with therapy and if there is pain. The resident replied he has pain to his feet, a rating of 7/10. PT1 reported this to the CN12.

A review of a written witness statement by CN12 noted R168 stated "They beat me when they change me". CN12 asked when this happened, the reply was "When they shower me, but I didn't shower today". R168 did not explain anymore and stopped talking. CN12 notified social services. A written statement from Certified Nurse Aide (CNA)3 documented, she provided AM (morning) care for R168. R168 refused a shower and was okay with a bed bath. CNA3 noted "bruises were already on his arm". CNA3

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also completed a statement of facts on 06/02/22 at 12:40 PM. CNA3 reported while feeding the resident lunch, resident stated he would get hurt while going to the shower.

SS1 documented, R168 was interviewed at 06/02/22 at 11:30 AM. R168 reported to SS1 that staff put/shove dirty gloves in his mouth specially when he yells, states it happens mostly all day when they change his personal brief. R168 did not know the name of the staff member and reported it only today, to the physical therapist. The resident also reported that during incontinence care, staff will push him hard to the wall and it hurts his hands and arms. R168 reported the last time it happened was yesterday (06/01/22) after breakfast. The resident provided a physical description of the alleged perpetrator.

On 06/03/22, Staff Member (SM)1 reported on 06/01/22 assistance was provided to R168 during the day shift but did not witness or was made aware of the alleged abuse. Reviewed statement by CNA4 (dated 06/06/22) who provided care on 06/01/22. CNA4 documents there were no complaints or report from the resident on that day and during morning care. SM2 provided written statement (no date of report) documenting on 06/02/22, while working, overheard two certified nurse aides asking R168 if he had been hurt by anyone. R168 reportedly replied, "yes". The CNAs were overhead asking when, R168 replied "all the time" and clarified it happened in the "morning". SM2 identified CNA3 and CNA 4 as the staff overhead interviewing R168. The statements by CNA3 and CNA4 does not document they approached and interviewed R168. There was no documentation investigator(s) followed up with CNA3 and CNA4

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of the conversation SM2 overheard to rule out possible intimidation/retaliation efforts by the CNAs.

On 02/10/23 at 09:55 AM, conducted interview with SS1 and SS2. Inquired who did the resident identify as the alleged perpetrator, staff explained the alleged perpetrator was out of work from 05/21/22 and the first day back was 06/02/22. Inquired who provided the last shower? There was no response to this question. SS1 explained the photos that were shown, R168 pointed to CNA5. R168 consistently pointed to CNA5. Further queried why was the staff out, they did not know.

SS2 reportedly conducted the interviews. Requested a copy of the interview that was conducted with CNA5. SS2 agreed to provide email regarding interview with CNA5. Also, requested to review documentation of the interviews that were done with the alert and oriented residents on R168's unit. Staff members confirmed there is no written documentation of resident interviews. Also inquired whether the facility interviewed the caregiver that takes R168 out on day pass. No confirmation this was done.

On 02/10/23 at 12:41 PM, the facility provided a copy of an email from SS2 which documented CNA5 was "interviewed and has not worked with [R168] in weeks and has not had any negative interactions" with the resident. The facility did not have documentation of questions that were asked during interview of CNA5. Review of the schedule provided by the facility for 05/31/22 and 06/01/22 (CNA5's reported first day back to work) did not list CNA5 on the schedule.

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F 610	Continued From page 18 On 02/10/23 at 11:03 AM, the Administrator was asked why CNA5 did not work from 05/21/22 to return on 06/02/22. Administrator was agreeable to follow up. Further inquired whether he interviewed the alleged perpetrator (CNA5), he responded social services conducted the interviews. Inquired whether they have documentation of the interviews with the residents on the unit, the Administrator responded it should be in the folder. Requested to review CNA5's personnel file to determine if there are any concerns regarding performance. Administrator was agreeable to follow up. Administrator returned and stated CNA5 was out on leave, which was not related to any disciplinary action. There was no documentation of staff to resident interactions or other allegations of abuse/neglect. On 02/13/23 at 02:14 PM an interview was conducted with CNA5 via telephone. CNA5 reported upon return to work she did not provide care to R168, she was not assigned to his unit. CNA5 recalled providing care for R168 when he was on another unit. CNA5 reported R168 was difficult to transfer, when touched, resident would complain of pain so staff would have to turn resident slowly and instruct the resident what to do. CNA5 recalled it was difficult to turn resident on his left side. CNA5 also reported staff would communicate with R168 on white erase board. CNA5 shared R168 would often yell when touched. CNA5 reported being on leave, being out until 05/31/22. Upon return, CNA5 reported she was not assigned to R168's group.	F 610		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)	F 622		5/5/23

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§483.15(c) Transfer and discharge-
§483.15(c)(1) Facility requirements-
(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-
(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the

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facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.

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F 622	Continued From page 21 (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to meet the requirements for a facility-initiated discharge for one resident (R) in the sample (R169) as evidenced by the lack of provider orders for discharge, a medical clearance for discharge, and/or a discharge summary completed by the provider documenting the reason(s) for discharge. As a result of this deficient practice, R169 was placed at an increased risk of injury and/or readmission to an acute care facility. This deficient practice has the potential to affect all facility-initiated discharges. Findings include: On 12/05/22, a complaint was received by the State Agency (SA) from Resident (R)169's son regarding her care, with one of the allegations being an inappropriate discharge. R169 is a 94-year-old female admitted on 10/25/22 for short-term rehabilitation (rehab) following a stroke, with diagnoses that include pancytopenia (a condition in which there is a lower-than-normal number of red and white blood cells and platelets in the blood), chronic kidney disease, high blood pressure, osteoarthritis, and osteoporosis. Per the complaint, R169 was discharged on 11/09/22 "because showed no progress [in rehab]", despite a request by R169's son that she remain "a bit longer because her house is not ready to comply with her needs."	F 622	1. Resident 169 has been discharged. Staff were inserviced on having on the documentation needed for discharge including physician orders, medical clearance, and a discharge summary by the Administrator. 2. Facility residents have the potential to be affected by the alleged practice. 3. Current residents scheduled for discharge were reviewed for the documentation needed for discharge including physician orders, medical clearance, and a discharge summary by the Social Service department and updated as needed. The Administrator inserviced the Social Service department and IDT regarding having on the documentation needed for discharge including physician orders, medical clearance, and a discharge summary. Inservices will be ongoing as needed. 4. The Administrator/Social Services/designee will audit upcoming discharges weekly for the documentation needed for discharge including physician orders, medical clearance, and a discharge summary through medical record reviews for a minimum of 12	

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F 622	Continued From page 22 On 02/10/23 at 11:42 AM, an interview was done with Nurse Manager (NM)1 at the Nurses' Station (NS). During a concurrent review of R169's electronic health record (EHR), NM1 confirmed that R169 was discharged with critical laboratory values (related to her pancytopenia) on 11/01/22 and again on 11/02/22 that were not rechecked prior to her discharge. When asked for a copy of the provider orders for discharge, a medical clearance for discharge, or a discharge summary completed by the provider, NM1 stated she needed to review the EHR further. At 01:05 PM, NM1 reported to the SA that with regards to discharge orders, the facility had documentation of physical and occupational therapy discharge recommendations that were signed by the physician on the day of discharge after R169 had already left. With regards to a medical clearance for discharge, NM1 stated there was no documentation found. With regards to a discharge summary by the provider, NM1 stated that although the provider does usually complete one, she could not find one completed for R169.	F 622	weeks or until compliance is achieved. The Administrator will bring the results of these audits monthly to the Quality Assurance and Performance Improvement Committee monthly for review and recommendations for a minimum of 3 months or until compliance is achieved.	
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	F 623		5/5/23

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discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would 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),

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and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental 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

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F 623	Continued From page 25 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 interview and record review, the facility failed to provide proper notification of discharge for three of the sample residents (Resident (R)169, R12 and R66) who were discharged home. The facility failed to provide written notification of the discharge to the resident or her representative, and/or failed to send notification of the discharge to the Office of the State LTC [long-term care] Ombudsman (LTCO). This deficient practice has the potential to affect all residents at the facility who are discharged or transferred. Findings include: Resident (R)169 is a 94-year-old female admitted to the facility on 10/25/22 for short-term rehabilitation, and was discharged fifteen (15) days later on 11/09/22. During a review of her electronic health record (EHR) on 02/08/23 at 03:30 PM, it was noted that there was no discharge notification or LTCO notification found for the discharge. Discharge notification was requested from the facility. On 02/09/23 at 01:42 PM, an interview was done with the Administrator in the Ohana Room. When asked for written discharge notification, the Administrator provided the Notice of Medicare Non-Coverage (NOMNC) signed by R169's son on 11/04/22. The NOMNC documented that coverage would end on 11/08/22, but did not specifically address discharge.	F 623	1. Residents 169, 12 and 66 have been discharged. The Ombudsman□s office was notified for each as needed. The Director of Operations inserviced Social Services staff and Administrator regarding discharge notifications. Inservices will be ongoing as needed. 2. Facility residents have the potential to be affected by the alleged practice. 3. Residents discharged in the last 30 days were reviewed by the Social Service department and the Administrator to ensure notification of discharge was made to Ombudsman and resident and updated as needed. The Director of Operations inserviced the Social Service department and IDT regarding notification of discharge to residents and Ombudsman. Inservices will be ongoing as needed. 4. The Administrator/Social Services/designee will audit residents□ scheduled discharges weekly for notification of discharge to resident and Ombudsman for a minimum of 12 weeks or until compliance is achieved. The Administrator will bring the results of these audits monthly to the Quality Assurance and Performance Improvement Committee monthly for review and recommendations for a	

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F 623	Continued From page 26 On 02/10/23 at 12:08 PM, an interview was done with social services staff member (SS)2 in the Social Services office. When asked about LTCO notification for R169's discharge, SS2 stated that the facility's current practice was to send LTCO notification only for emergency transfers/discharges to an acute care facility. 2) Resident (R)12 was admitted to the facility on 12/15/22 and discharged on 02/07/23. On 02/08/23 at 01:51 PM an interview was conducted with Social Services Staff (SS)2 regarding R12's discharge. SS2 reported R12 requested an appeal to the discharge. The appeal was submitted to the quality improvement organization (QIO). The facility provided a copy of the QIO's response to resident's request for an appeal. The QIO responded on 02/06/23 via letter, informing R12, she no longer met the Medicare coverage requirements for skilled nursing facility services. Requested a copy of notification to the LTCO. On 02/08/23 at 02:35 PM, the facility provided a copy of the "Notice of Resident Discharge/Transfer" on 02/06/23 to inform resident of effective discharge date home on 02/07/23. The reason for discharge was marked checked as, "The resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility." R12 signed the document on 02/06/23 to acknowledge receipt of notification and understanding of rights. Also noted three check boxes at the bottom of the form, the box for "Copy Provided/Mailed to Resident Representative on _____", had a handwritten note "declined 02/06/23." The other check boxes were not completed, "Copy Provided/Mailed to resident at listed address on _____" and "Sent to Ombudsman on _____." Interview with Social	F 623	minimum of 3 months or until compliance is achieved.	

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F 623	Continued From page 27 Services Staff (SS)1 inquired and requested a copy of notification to the LTCO of R12's discharge. SS1 responded notification was not sent to LTCO. SS1 clarified notification is only provided to the LTCO when there is an emergency and residents are sent to the hospital. Requested a copy of the facility's discharge policy and procedures. On 02/08/23 at 03:47 PM, SS2 provided a copy of the facility's policy and procedure titled, "Discharge/Transfer Notice Process." Review noted the following, "ii. Community initiated discharges, 1. SS/designee will issue a discharge notice 30 days prior to determination or as soon as possible [Notification must be made simultaneously], a. Resident/guest issued in person, b. Resident/guest representative (if applicable) listed home/mailing address, and c. Ombudsman via fax." Also noted, "2. All correspondence will be tracked on the bottom of the discharge notice." On 02/08/23 at 03:47 PM, SS2 provided a copy of the fax notifying the LTCO of R12's discharge. (3) Review of R66's progress notes showed that R66 was discharged home on 01/13/23. During staff interview on 02/10/23 at 08:35 AM, Social Worker (SW2) stated that the facility would only send a notification to the Ombudsman when a resident is sent to the hospital for an emergency. SW2 stated for R66, the facility did not send a discharge notification to the Ombudsman.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		5/5/23

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F 641	Continued From page 28 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to accurately record the discharge home status in the RAI, Minimum Data Set (MDS) for one Resident (R)66 of three residents sampled. As a result of this deficiency, the facility put R66 at risk for further RAI, MDS inaccuracy. Findings include: During review of R66's most recent MDS, Assessment Reference Date 01/13/23, Section A2100 was inaccurately marked as Acute Hospital which meant that R66 was discharged to acute hospital. Review of R66's progress notes showed that R66 was actually discharged home on 01/13/23. During staff interview on 02/09/23 at 08:40 AM, MDS Coordinator (MDS Coord) acknowledged that R66 was inaccurately marked as being discharged to acute hospital. MDS Coord stated that they would do the necessary correction. Review of the Long-Term Care Facility RAI 3.0 User's Manual read the following: The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20(b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status ... In addition, an accurate assessment requires collecting information from multiple sources,	F 641	1. Resident 66□s discharge location was updated by MDS. MDS Coordinator was inserviced regarding appropriate discharge location coding by Clinical Reimbursement Director. Inservices will be ongoing as needed. 2. Facility residents have the potential to be affected by the alleged practice. 3. Residents discharged in the last 30 days were reviewed by the MDS Coordinator to ensure proper discharge location coding and updated as needed. The MDS Coordinator inserviced the IDT regarding proper discharge location coding. Inservices will be ongoing as needed. 4. MDS Coordinator/designee will audit discharges weekly through medical record reviews for proper discharge location coding for a minimum of 12 weeks or until compliance is achieved. The DON will bring the results of these audits monthly to the Quality Assurance and Performance Improvement Committee monthly for review and recommendations for a minimum of 3 months or until compliance is achieved.	

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F 641	Continued From page 29 some of which are mandated by regulations ... As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		5/5/23

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F 655	Continued From page 30 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview with staff member, the facility failed to develop a baseline care plan which included minimum information necessary to properly care for the immediate needs of a resident admitted with a Foley catheter. Findings include: On 02/07/23 at 11:20 AM observed Resident (R)118 lying in bed and there was a covered catheter bag hanging from the side of the bed. The catheter tubing was observed to be touching the floor. R118 was admitted to the facility on 01/31/23 from an acute facility with hospice services. R118 was admitted with hospice services. A review of R118's care plan found the facility did not develop a baseline care plan to include Foley catheter care. Also noted there were no physician orders for the use of a Foley catheter and care related to the catheter. On 02/09/23 at 11:07 AM an interview and	F 655	1. Resident 118 has been discharged. DON inserviced licensed nurses regarding baseline care plans and foley catheters. Inservices will be ongoing as needed. 2. Newly admitted residents have the potential to be affected by the alleged practice. 3. DON/Nurse Managers/designee audited newly admitted residents for baseline care plans and also for information in the plan for foleys. Updates were completed as needed. DON/Nurse Managers/designee inserviced licensed nurses regarding baseline care plans and foley information/care. Inservices will be ongoing as needed. Baseline care plans on new admissions will be reviewed by the Nurse Administration team. 4. DON/designee will audit baseline care plans weekly to ensure they are in place and/or include foley information through medical record reviews for a minimum of	

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F 655	Continued From page 31 concurrent record review was conducted with Nurse Manager (NM)1. NM1 reported the order for use of a Foley catheter was not in the facility's physician orders, it is probably in the hospice orders. NM1 further stated although there is no order or baseline care plan, the nurses are aware R118 has a Foley catheter. NM1 confirmed a baseline care plan was indicated to include approaches which would include but not limited to checking for urine output, changing of the catheter bag, specifying catheter tubing and size, and providing peri care/cleaning.	F 655	12 weeks or until compliance is achieved. The DON will bring the results of these audits monthly to the Quality Assurance and Performance Improvement Committee monthly for review and recommendations for a minimum of 3 months or until compliance is achieved.	
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to facilitate the ongoing program of activities designed to meet the resident's psychosocial and physical needs. Activities were not carried out for one of four sampled residents (R)4. R4 was not observed out of room and up in wheelchair for stimulation to maintain R4's physical and psychosocial well-being and independence.	F 679	1. Resident 4□s activity care plan was reviewed and updated as needed. Resident 4 is assisted out of bed for small group activities as tolerated. New splints were obtained and are being applied as ordered. 2. Facility residents have the potential to be affected by the alleged practice.	5/5/23

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F 679	Continued From page 32 Findings include: R4's admission date was 01/12/11 according to the assessment reference date (ARD) on the minimum data set (MDS). Diagnoses include but is not limited to cerebral palsy. Observation on 02/07/23 at 10:58 AM shows resident in room in bed. Observation on 02/07/23 at 02:00 PM shows resident in room in bed. Record review (RR) of care plan(CP) done on 02/08/23 at 0900 AM indicates to "include R4 in small group activities to be with groups of people, include in all types of stimulating activities to observe. CP activity dated 06/03/21 indicates "Turn on R4's TV to all types of TV shows when awake, he likes watching all kinds of TV show or children's shows per his mother." RR of interdisciplinary care plan dated 01/13/21 indicates that certified nurses aide will transfer patient to wheelchair 2-3x/wk for up to 3 hrs as tolerated. Pictures included. Observation on 02/08/23 of R4 at 09:03 AM was done in his room. Has soft wraps on both arms. TV on to aquarium channel. Observation on 02/08/23 of R4 at 01:48 PM was done in his room. R4 did not have his splints on. Splints are on table and dirty. Interview was done on 02/09/23 at 10:52 AM with physical therapy manager (PTM) was done. PTM stated that R4 received OT and the result of the OT eval was to try and maintain positioning and not trying to restore but maintain, with the contractures. OT Care plan is sent to nursing to	F 679	3. Activities Director inserviced the IDT and clinical team regarding ensuring residents activity programs/care plans are followed. Inservices will be ongoing as needed. Current residents activity programs were reviewed to ensure compliance and participation by the Activity Director. Updates were made as needed. 4. Activity Director/designee will audit activity programs participation through observation and medical record reviews weekly through medical record reviews for a minimum of 12 weeks or until compliance is achieved. The Activity Director will bring the results of these audits monthly to the Quality Assurance and Performance Improvement Committee monthly for review and recommendations for a minimum of 3 months or until compliance is achieved.	

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F 679	Continued From page 33 carry out. Observation on 02/09/23 at 08:46 AM Bed bath being done by staff member 3. Aquarium channel is on. Observation done on 02/10/23 at 08:20 AM shows resident in room in bed.	F 679		
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: Based on interview, and record review, the facility failed to manage "critical lab [laboratory]" values for one Resident (R) in the sample (R169), and failed to identify, care plan, and manage constipation for another resident (R16) in the sample. As a result of this deficient practice, R169 was discharged with an increased risk of injury and/or readmission to an acute care facility, and R16 developed potentially avoidable hemorrhoids. This deficient practice has the potential to affect all the residents at the facility admitted from an acute care facility or at risk of constipation. Findings include:	F 684	1. Resident 169 has been discharged. Resident 16 has been discharged. 2. Facility residents with critical lab values and /or constipation have the potential to be affected by the alleged practice. 3. The DON/designee inserviced the clinical team and licensed nurses regarding ensuring residents critical labs are reviewed and followed up on and care plans are developed and followed for constipation. Inservices will be ongoing as needed. Current residents labs and care plans were reviewed to ensure compliance and participation by the	5/5/23

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F 684	Continued From page 34 1) On 12/05/22, a complaint was received by the State Agency (SA) from Resident (R)169's son regarding her care, with one of the allegations being an inappropriate discharge. R169 is a 94-year-old female admitted on 10/25/22 for short-term rehabilitation (rehab) following a stroke, with diagnoses that include pancytopenia (a condition in which there is a lower-than-normal number of red and white blood cells and platelets in the blood), chronic kidney disease, high blood pressure, osteoarthritis, and osteoporosis. Per the complaint, R169 was discharged on 11/09/22 "because showed no progress [in rehab]", despite a request by R169's son that she remain "a bit longer because her house is not ready to comply with her needs." On 02/10/23 at 11:42 AM, an interview was done with Nurse Manager (NM)1 at the Nurses' Station (NS). During a concurrent review of R169's electronic health record (EHR), NM1 confirmed that R169 was discharged with "critical [laboratory] (lab) values" (related to her pancytopenia) on 11/01/22 and 11/02/22 that were not rechecked prior to her discharge. NM1 stated that R169 was admitted with the pancytopenia diagnosis and that her lab values were trending downward at admission. A review of R169's discharge summary from the acute care facility confirmed that she had been discharged on 10/25/22 with a ferrous sulfate (iron) order for her pancytopenia. A review of R169's admission orders to the skilled nursing facility (SNF) noted no ferrous sulfate order carried over. A review of R169's medication administration record (MAR) noted that ferrous sulfate was only added to her medications as a result of the second critically low lab value obtained by the SNF on 11/02/22. NM1	F 684	DON/Nurse Managers. Updates were made as needed. 4. DON/Nurse Managers/designee will audit for compliance through medical record reviews weekly for a minimum of 12 weeks or until compliance is achieved. The DON will bring the results of these audits monthly to the Quality Assurance and Performance Improvement Committee monthly for review and recommendations for a minimum of 3 months or until compliance is achieved.	

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F 684	Continued From page 35	F 684		

confirmed that the ferrous sulfate should have been carried over and could not explain how it had been missed. When asked for a copy of the provider orders for discharge from the SNF, a medical clearance for discharge from the SNF, or an SNF discharge summary completed by the provider, NM1 stated she needed to review the EHR further.

On 02/10/23 at 01:05 PM, NM1 reported to the SA that with regards to discharge orders, the facility had documentation of physical and occupational therapy discharge recommendations that were signed by the physician on the day of discharge after R169 had already left. With regards to a medical clearance for discharge, NM1 stated there was no documentation found. With regards to a discharge summary by the provider, NM1 stated that although the provider does usually complete one, she could not find one completed for R169.

2) On 02/07/23 at 11:13 AM, an interview was done with R16 at her bedside. R16 reported that she has a "doodoo problem." R16 explained that when she was admitted on 12/19/22, she was constipated and the SNF gave her medications for it, but "now they don't." Stated that for the "past couple days" her bowel movements have been hard, and she has had "to push." R16 reported that she asked for a stool softener "weeks ago, but apparently Doctor didn't OK it." As a result, R16 states she has bleeding hemorrhoids sometimes, for which the facility has been giving her hemorrhoidal cream.

On 02/09/23 at 01:18 PM, a review of R16's EHR noted the following order for a stool softener: "one capsule every day as needed for no daily bowel

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F 684	Continued From page 36 movement," ordered on 12/23/22. Also noted was an order beginning on 02/01/23 for hemorrhoidal cream: "apply ... to rectum 3x [three times] daily as needed for itch." A review of R16's comprehensive care plan noted no care plan developed to prevent or manage constipation and/or hemorrhoids. On 02/10/23 at 11:30 AM, an interview was done with NM2 at the NS. During a concurrent review of R16's MAR, NM2 confirmed that the stool softener had not been given once since admission, but the hemorrhoidal cream had been administered almost daily from 02/04/23 - 02/09/23. NM2 agreed that staff should have utilized the stool softener order in addition to the hemorrhoidal cream to prevent and treat R16's hemorrhoids.	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 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	F 688		5/5/23

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F 688	Continued From page 37 reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure for three of six sampled residents (R)4, R16 and R169 received range of motion (ROM) exercises to prevent decline and reduction in mobility. Findings include: Observation on 02/07/23 at 10:58 AM shows resident in room in bed. Splints were not applied to BUE. Observation on 02/08/23 of R4 at 09:03 AM was done in his room. Has soft wraps on both arms. Record review (RR) of interdisciplinary care plan (ICP) was done on 02/08/23 at 09:05 AM. ICP provided and dated 01/31/21 indicates "certified nurse's aide (CNA) will perform passive range of motion to bilateral lower extremities and did not address BUE or splints. RR of orders on 02/08/23 indicates ROM and up in chair three times a day. Observation on 02/08/23 of R4 at 01:48 PM was done in his room. R4 did not have his splints on. Splints were noted on bedside table. Splints looked over-worn and looked soiled. Registered nurse (RN)1 agreed and stated "we need to order new splints from physical therapy (PT) It's dirty. " RN1 attempted to put splints on and was not able to and called the certified nurse's aide (CNA)6 to assist to put splints on. Interview was done with CNA6 on 02/09/23 at 10:22 AM. Queried with CNA6 regarding ROM	F 688	1. Resident 169 has been discharged. Resident 4 had new splints obtained and are being applied as ordered. Care plan was reviewed and updated as needed. Resident 16□s care plan was reviewed and updated as needed. Resident 16 was discharged. 2. Facility residents needing splints and range of motion (ROM) assistance have the potential to be affected by the alleged practice. 3. The DON/designee inserviced the clinical team, licensed nurses and certified nurse aides (CNAs) regarding ensuring proper application/use of splints and ROM assistance. Inservices will be ongoing as needed. Current residents□ using splints and/or needing ROM assistance were reviewed to ensure compliance. Updates were made as needed. 4. DON/Nurse Managers/designee will audit for compliance through observations and medical record reviews weekly for a minimum of 12 weeks or until compliance is achieved. The DON will bring the results of these audits monthly to the Quality Assurance and Performance Improvement Committee monthly for review and recommendations for a minimum of 3 months or until compliance is achieved.	

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F 688	Continued From page 38 for BUE and or contractures. CN6 stated "I gave him a shower and the physical therapist usually does the ROM. They are good with him and what he needs. He is stiff. We try to do what we can with what we have." Interview was done on 02/09/23 at 10:52 AM with physical therapy manager (PTM). PTM stated that R4 received OT and the result of the OT eval was to try and maintain positioning and not trying to restore but maintain, with the contractures. OT Care plan is sent to nursing to carry out. "I saw R4 this morning for screening process and if R4 should be picked up by Occupational therapy (OT) for his hands. The splints don't fit him well and I don't know if they have stretched out and gotten old. Orders came today from nursing." ROM depends on if we have a long-term person, and we pick them and if we feel ROM is appropriate. PT/OT will write a care plan out and nurse's aide is to carry out. In his closet he has the pictures on how to position him and that is from last time he did therapy.	F 688		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755		5/5/23

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F 755	Continued From page 39 dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview with staff member, the facility failed to assure drug records are in order and that an account of all controlled drugs are maintained to ensure no diversion. Findings include: On 02/09/23 at 08:20 AM observation of medication cart was done with Registered Nurse (RN)8. Inquired what is the facility's process for ensuring accurate counts of controlled medications are done. RN8 explained two nurses will sign to attest to an accurate count of controlled drugs at the change of shift (oncoming and leaving). The nurse leaving and the nurse coming onto the shift. Requested to review their record. A review of the form titled,	F 755	1. Licensed nurses were re-inserviced regarding appropriate narcotic count sign off by DON/designee. 2. Facility residents have the potential to be affected by the alleged practice. 3. Nurses will not accept keys for change of shift until they have verified they have both signed off the narcotic count (oncoming and outgoing). Facility licensed nurses were inserviced regarding appropriate narcotic count sign off by DON/designee. 4. DON/Nurse Managers/designee will audit for compliance through observations and narcotic record reviews weekly for a	

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F 755	Continued From page 40 "Emergency/Controlled Substance Inventory & Kit Verification" for 02/01/23 to 02/08/23 was done. Review found missing signatures for the following days/shifts: 02/02/23, day shift of the oncoming nurse; 02/02/23, evening shift of the off-duty nurse; 02/06/23, evening shift of the on duty nurse; and 02/06/23, night shift of the off duty nurse. RN8 confirmed the missing nurse signatures. The facility provided a copy of the policy, "Medication Storage - Controlled Medication Storage" on 02/09/23 at 03:33 PM. The procedure includes, "6. At each shift change or when keys are surrendered, a physical inventory of all Schedule II, including refrigerated items, is conducted by two licensed nurses or per state regulation and is documented on the controlled substances accountability record or verification of controlled substances count report. The nursing care center may elect to count all controlled medications at shift change."	F 755	minimum of 12 weeks or until compliance is achieved. The DON will bring the results of these audits monthly to the Quality Assurance and Performance Improvement Committee monthly for review and recommendations for a minimum of 3 months or until compliance is achieved.	
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	F 761		5/5/23

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F 761	Continued From page 41 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview with staff member, the facility did not assure medications were stored under proper temperatures. Findings include: On 02/08/23 at 09:20 AM observation of the medication storage room was done with Nurse Manager (NM)1. The refrigerator contained medication for the residents and an opened box of flu vaccine vials. A review of the temperature log (Medication Refrigerator Temperature Record) for January 2023 found no documentation temperatures were checked on the 03:00 PM to 11:00 AM shift on 01/08/23, 01/28/23, and 01/29/23. NM1 confirmed there was missing documentation and reported medication refrigerator temperatures are to be taken twice a day. On 02/08/23 at 10:40 AM, the facility provided the temperature record for December 2022. Review noted no documentation for the 03:00 PM to 11:00 AM shift on 12/02/22, 12/03/22, 12/14/22, and 12/18/22. A review of the policy "Medication Storage -	F 761	1. At the time of survey, medications not held at temperature were destroyed. Licensed nurses on duty were inserviced by DON/Nurse Managers regarding importance of keeping refrigerated medications/vaccines at temperature and recording refrigerator temperatures. 2. Facility residents have the potential to be affected by the alleged practice. 3. DON/SDC/Nurse managers inserviced facility licensed nurses regarding importance of keeping refrigerated medications/vaccines at temperature and recording refrigerator temperatures. Checking refrigerator temperatures are assigned twice per day to licensed nurses as part of change of shift. 4. DON/Nurse Managers/designee will audit for compliance through observations reviews weekly for a minimum of 12 weeks or until compliance is achieved. The DON will bring the results of these	

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F 761	Continued From page 42 Storage of Medication" provided by the facility on 02/08/23 at 10:40 AM notes in the procedure for medications requiring "refrigeration" a temperature log or tracking mechanism is maintained to verify that temperature has remained within accepted limits. Also, the temperature of any refrigerator that stores vaccines should be monitored and recorded twice daily.	F 761	audits monthly to the Quality Assurance and Performance Improvement Committee monthly for review and recommendations for a minimum of 3 months or until compliance is achieved.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to store, label, monitor, and discard food in accordance with professional standards for food service safety. Specifically, the facility failed to ensure all perishable or	F 812	1. At the time of survey, the caesar dressing, coleslaw, ranch dressing and oriental dressing were discarded. The Dietary Manager inserviced the kitchen staff on duty on appropriate labeling of	5/5/23

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F 812	Continued From page 43 refrigerated food items were labeled, dated, and monitored. Residents (R) risk serious complications from foodborne illness as a result of their compromised health status. Unsafe and/or unsanitary food handling practices represent a potential source of pathogen exposure for all residents at the facility. Findings include: On 02/07/23 at 10:14 AM, during a tour of the facility kitchen with the Food Service Manager (FSM), the following observations were done: An opened gallon of Caesar (cream-based) Dressing with no date opened indicated and/or facility label. An opened gallon of Cole Slaw (cream-based) Dressing with "1/23" written in sharpie on the lid and no facility label. An opened gallon of Ranch (cream-based) Dressing with "1/23" written in sharpie on the lid and no facility label. An opened gallon of Oriental (cream-based) Dressing with two dates written in sharpie on the lid, "4/12/22" and "10/12/22." When asked how long the dressings are good for, the FSM stated cream-based dressings "should be good for three (3) months [after opening]." Neither date written on the lid made sense to the FSM as she stated that the facility uses Oriental Dressing daily. When asked about the facility policy on labeling perishable items, the FSM stated that each item should have a facility label indicating at a minimum, the name of the item, the date it was opened, and the date to discard.	F 812	food items. Inservices will be ongoing as needed. 2. Facility residents have the potential to be affected by the alleged practice. 3. Dietary Manager inserviced facility dietary staff regarding labeling of food items. Inservices will be ongoing as needed. 4. Dietary Manager/designee will audit for compliance through observations reviews weekly for a minimum of 12 weeks or until compliance is achieved. The Dietary manager will bring the results of these audits monthly to the Quality Assurance and Performance Improvement Committee monthly for review and recommendations for a minimum of 3 months or until compliance is achieved.	

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F 812	Continued From page 44 A review of the facility Labeling Guidelines, last updated on 04/30/21, noted the following: "*Items with a use by date, defer to that date UNLESS opened, then use per policy below." "30 days** (or otherwise stated as per expiration on label)* ... Salad dressings (unless otherwise stated on exp [expiration] date/label..."	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		5/5/23

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F 880	Continued From page 45 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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	125004	A. BUILDING _____ B. WING _____	02/10/2023

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F 880	Continued From page 46 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 COVID-19 and other communicable diseases and infections for three of six sampled residents (Resident (R)35, R45 and R33). This is evidenced by the facility failing to ensure staff followed transmission-based precautions (TBP) by wearing the proper personal protective equipment (PPE) and facility failing to follow their Mitigation Plan and isolating (R)45. 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 02/07/23 the State Agency (SA) was notified at Entrance that the facility had a current COVID-19 (COVID) outbreak, and as a result all staff on the affected floor (second floor) were required to wear at a minimum, eye protection and an N-95 respirator (N95) when in patient care areas. On 02/08/23 at 08:33 AM, observed Certified Nurse Aide (CNA)1 and CNA2 in Room 258 assisting Resident (R)35 with her morning hygiene. Both CNAs were wearing purple procedure masks and face shields as they helped R35 brush her teeth. On 02/08/23 at 08:47 AM, an interview was done with Charge Nurse (CN)4 outside Room 251. CN4 confirmed that the required personal protective equipment (PPE) for all staff on the second floor was an N95 and a face shield when	F 880	1. Staff were re-inserviced by the DON regarding wearing/using the appropriate PPE. Inservices will be ongoing as needed. Resident 33 and 45 were both placed in isolation in place. The Director of Staff Development/Infection Preventionist inserviced the facility SDC/ (Infection Preventionist) IP and DON regarding the Covid mitigation plan, appropriate testing and isolation of residents. Inservices will be ongoing as needed. 2. Facility residents have the potential to be affected by the alleged practice. 3. The SDC/IP or designee inserviced facility staff on wearing/using appropriate PPE. The SDC/IP inserviced facility nursing staff regarding the Covid mitigation plan, appropriate testing and isolation of residents. Inservices will be ongoing as needed. 4. DON/SDC/Nurse Managers/designee will audit for compliance through observations reviews and medical record/testing reviews weekly for a minimum of 12 weeks or until compliance is achieved. The SDC/IP will bring the results of these audits monthly to the Quality Assurance and Performance Improvement Committee monthly for review and recommendations for a minimum of 3 months or until compliance is achieved.	

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F 880	Continued From page 47	F 880		

in resident rooms, or working directly with a resident (if outside the room, for example).

On 02/08/23 at 08:49 AM, an interview was done with Nurse Manager (NM)2 at the Nurses' Station (NS). NM2 validated that all staff on the second floor should be wearing N95s and face shields. When asked how staff are informed and updated on PPE requirements, NM2 reported that PPE requirements are covered with staff during "huddles [informal staff meetings]" every day at 10:15 AM. In addition, NM2 stated that the Infection Preventionist (IC) makes compliance rounds daily and informs/reminds staff then. NM2 reported that the current PPE requirements had been in place/practice "for a while."

2) Review of the Electronic Health Record (EHR) showed R45 was admitted on 05/20/20 with diagnosis including Cerebral Infarction, Wernicke's Encephalopathy, Hypertension, Asthma, Cholelithiasis, Calculus of Bile Duct, Hemiplegia, Hemiparesis ...

On 01/25/23, R45 tested positive for COVID-19 and was immediately moved to a private room and isolated for 10 days following the facility Mitigation Plan. After the 10 days, on 02/05/23, R45 was cleared from isolation and moved back to the previous semi-private room next to roommate R33. R33 did not show any signs and/or symptoms for COVID-19 and was tested negative.

During an observation on 02/06/23 at 10:00 AM, R33 and R45 was in the same semi-private room with no transmission-based precautions and no isolation.

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F 880	Continued From page 48 On 02/09/23 at 03:00 PM, review of EHR showed that R33 tested positive for COVID-19. Review of R45's EHR (the roommate) revealed that 3 days prior, on 02/06/23, R45 again tested positive for COVID-19 but was not moved to a private room, was not isolated for 10 days, and did not follow the facility Mitigation Plan. During an interview with the Director of Nursing (DON), Infection Control Coordinator (IC) and the Administrator (Admin) on 02/10/23 at 10:20 AM, DON and IC said they were following the Mitigation plan but was not sure about the repeat positive COVID-19 test. During an interview with the Medical Director (Med Dir) on 02/10/23 at 01:00 PM, Med Dir acknowledged that the repeat COVID-19 test could remain positive and the Mitigation plan may need to address that further. Review of the Mitigation Plan read the following: Control Strategies (to be done if Person Under Investigation [PUI] is identified); 1. Isolation, a. Identify a private room that can be available immediately in the event a resident/guest is suspected of having COVID-19 or is confirmed COVID-19+, b. Immediately isolate a person suspected of having COVID-19; i. Move potentially infectious person to a private room and close the door ... ii. Post Special Droplet/Contact Precautions sign ... c. A resident with confirmed COVID-19 must be placed in a private room (red zone) ... 11. Transmission-based precautions/isolation for a PUI can be discontinued if the result from at least one molecular assay for SARS-COV-2 is negative ...	F 880		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ	F 921		5/5/23

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F 921	Continued From page 49 CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and review of policy, the facility failed to properly transport two oxygen cylinders (O2 tanks) in a safe manner. As a result of this deficient practice, the facility put the safety and well-being of the residents, staff, as well as the public at risk for accident hazards. Findings include: During an observation on 02/07/23 at 10:30 AM, Maintenance Staff (Maint1) transported two O2 tanks in an unsafe manner. The two O2 tanks were laying sideways on a hand-truck cart, rolling back and forth hitting one another. Also, the head valve of the O2 tanks were sticking out the side of the cart having the potential of being knocked off during transport. During staff interview on 02/07/23 at 10:40 AM, the Housekeeping Manager (Hskpg Mgr) acknowledged that the O2 tanks were being transported in an unsafe manner. Hskpg Mgr further stated that the facility was working on obtaining portable oxygen cylinder holders for safe transporting of the O2 tanks. Review of facility policy on Oxygen Cylinder Storage read the following: Procedure, All freestanding cylinders shall be stored in a rack, on a cart, in a portable cylinder holder, in a gas	F 921	1. Maintenance staff were inserviced regarding transporting oxygen by the SDC. Inservices will be ongoing. Oxygen transportation cart has been obtained to maintain safety. 2. Facility residents have the potential to be affected by the alleged practice. 3. The SDC/IP or designee inserviced maintenance and facility staff on appropriate transporting oxygen cylinders. Inservices will be ongoing as needed. 4. DON/SDC/Nurse Managers/designee will audit for compliance through observations reviews weekly for a minimum of 12 weeks or until compliance is achieved. The DON will bring the results of these audits monthly to the Quality Assurance and Performance Improvement Committee monthly for review and recommendations for a minimum of 3 months or until compliance is achieved.	

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F 921	Continued From page 50 cylinder storage cabinet, or secured with a chain to protect them.	F 921		