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

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance on 02/20/24 to 02/23/24. The facility was found not to be in substantial compliance with 42 CFR 483, Subpart B. A complaint and a Facility Reported Incidents (FRI) #10723 and #10743 were investigated, Aspen Complaint and Incident Tracking (ACTS) #10735. Deficient practice related to accidents and quality of care were identified for FRI #10723, #10743, and ACTS #10735. Survey Census: 76 Sample Size: 18	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		4/5/24

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

Electronically Signed | 03/22/2024

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F 550	Continued From page 1 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, staff interview and policy review, the facility failed to ensure the resident's right to a dignified existence and treat each resident with respect and dignity for (4) residents. Resident (R)35, R67, R30, R60 residents sampled. Findings include: 1) R60 was admitted to the facility on 11/27/23 with diagnosis which includes cancer, aphasia (the loss of the ability to understand or express speech), seizure disorder, and malnutrition. Review of R60's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/28/24, Section C. Cognitive Patterns, R60's Brief Interview for Mental Status (BIMS) was 4, indicating R60's cognition is severely impaired. Section GG. Functional Abilities and	F 550	1. Resident 30 and Resident 67 have been discharged. Resident 60 was provided with appropriate care on 2/23/24. Resident 35's behavioral care plan was reviewed and updated. Activity staff involved was re-inserviced to promptly respond to resident when calling out to assess for unmet need and/or provide redirection. 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) and facility staff were inserviced regarding answering call lights timely by the Director of Nursing (DON)/designee. Facility direct care staff were inserviced regarding regular toileting/changing of residents by the	

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F 550	Continued From page 2 Goals documented R60 has functional limitation in range of motion for the upper and lower extremities on one side, uses a wheelchair, and requires substantial assistance (helper does more than half the effort) for toileting hygiene. A significant change MDS with an ARD of 01/01/24 documented, Section C. Cognitive Patterns, R60's Brief Interview for Mental Status (BIMS) was 00, indicating the R60 was unable to complete the assessment. Section GG. Functional Abilities and Goals documented R60 was dependent (helper does all of the effort; resident does none of the effort to complete activity) for toileting. As a result of R60's significant change, the resident was placed on hospice. Multiple observations were made of R60's Family Member (FM)1 at the facility visiting with the resident for times greater than 1 hour on 02/20/24 at 10:42 AM, 02/21/24 at 10:10 AM, 02/22/24 at 12:13 PM, and 02/23/24 at 10:32 AM. Due to the extended amount of time FM1 spent in the facility with R60, was interviewed on 02/21/24 at 10:10 AM. FM1 reported having to go to the nursing station often to get more water and ice for the resident (due to staff not providing it regularly for the resident), but there is no staff at the nurse's station. FM1 stated, when I do find staff, they tell me to use the call light, but staff don't come to the room to answer the call light. On 02/23/24 at 10:32 AM, observed FM1 at the third-floor nurse's station, speaking loudly at staff, stating, "No one changed my wife all morning, she can't wait till 01:00 PM." At 12:30 PM, conducted an interview with FM1 regarding the event observed at the third-floor nurse's station. FM1 reported being upset because no one	F 550	DON/designee. Inservices will be ongoing as needed. 4. The DON/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 to the Quality Assurance and Performance Improvement Committee monthly for review and recommendations for a minimum of 3 months or until compliance is achieved. The Activities Manager/designee will audit group activities to ensure resident needs are met timely weekly for a minimum of 12 weeks or until compliance is achieved. The Activities Manager will bring the results of these audits 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 550	Continued From page 3	F 550		

cleaned R60 all morning, the resident's brief was soiled.

2) During an observation of the second floor Activities room on 02/20/24 at 11:20AM, R35 was calling out for attention saying, "excuse me, excuse me". There were two staff members close by that did not immediately respond to R35's call for attention. R35 kept saying "excuse me, excuse me" three more times until staff said ok, hold on. After fifteen minutes past and R35 saying "excuse me, excuse me" another time, staff finally attended to R35's needs.

During staff interview on 02/22/24 at 11:30AM, Activities Manager acknowledged that the close by staff members should have responded right away to R35. Activities Manager said that they would address this with the staff.

Review of policy on Dignity and Respect read - Policy, it is the policy of this facility that all residents/guests be treated with kindness, dignity and respect. Procedure, 1. The staff will display respect for residents/guests when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings ...

3) On 02/20/24 at 11:20 AM, conducted an interview with R67. Inquired if the resident waits long for staff to respond to call lights. R67 reported the facility staff try their best to answer the call lights, but there just is not enough staff, especially if it's around a mealtime and staff are on break.

While walking down the second-floor hallway on

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F 550	Continued From page 4 02/20/24 at 02:05 PM, observed the call light was activated for room 256. Entered the room and R30 requested for this surveyor to assist the resident back into bed, stating "I've been in my wheelchair long enough, I need to lay down and rest for a bit." R30 was unable to independently transfer from the wheelchair to the bed. Inquired with R30 as to how long the resident had been waiting for staff to respond to the call light. R30 and R67 (share a room) both confirmed they have been waiting for over an hour for staff to help them and staff has not come to the room to check on why the residents activated the call light. On 02/23/24 at 11:53 AM, conducted a record review of R30's and R67's EHR. Review of R30's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/26/24 Section C. Cognitive Function, Brief Interview for Mental Status score was 15, indicating the resident is cognitively intact. Review of R67's admission MDS with an ARD of 01/24/24, Section C. BIMS score was 14 indicating the resident's cognition is intact. Review of Section GG. Functional Abilities and Goals: R67 is dependent on staff for toileting, showers, and dressing.	F 550		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the	F 641	1. R71's discharge location was	4/5/24

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F 641	Continued From page 5 facility failed to ensure the resident assessment accurately reflected the resident's status for one of three (Resident (R)71) sampled for closed records. R71 was coded on the discharge Minimum Data Set (MDS) as discharged to a short-term general hospital. Staff confirmed R71 was discharged home on 01/18/24. Findings include: On 02/21/23 at 03:10 PM, conducted a review of R71's Electronic Health Record (EHR). On 01/21/24 at 03:53 PM, Minimum Data Support Staff (MDSS)6 documented in a progress note, "Resident remained on skilled services for rehab services until 1/17/24 and was discharge to home on 1/18/24". Review of R71's discharge MDS with an Assessment Reference Date (ARD) of 01/18/24 documented in Section A 2105. Discharge Status- 04. Short-Term General Hospital. On 02/22/24 at 03:28 PM, conducted a concurrent record review of R71's EHR and interview with MDSS6 and MDSS1. After reviewing R71's progress notes and discharge MDS (ARD 01/18/24), MDSS6 confirmed R71 was discharged home and the discharge MDS did not accurately reflect the resident's discharge status.	F 641	modified by Minimum Data Set (MDS) Coordinator on 2/22/24. MDS Coordinator was inserviced on 2/22/24 regarding appropriate discharge location coding by Clinical Reimbursement Director. 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 MDS Coordinator will bring the results of these audits 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	F 679		4/5/24

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F 679	Continued From page 6 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, interview, and record review, the facility failed to ensure there was an ongoing resident-centered activities program that met the resident's needs, for 1 of 3 residents (Resident 4) sampled for activities. Specifically, the facility failed to consistently act on the resident's need for social contact and sensory stimulation and failed to develop and/or implement a person-centered activities program that the resident found meaningful. As a result of this deficient practice, Resident (R)4 was placed at risk of experiencing a decline in his psychosocial well-being and comfort. This deficient practice has the potential to affect all residents at the facility. Findings include: R4 is a 52-year-old male admitted to the facility on 01/12/11 for long-term care. His current diagnoses include, but are not limited to, cerebral palsy (a group of disorders that affect a person's ability to move and maintain balance and posture), aphasia (loss of ability to understand or express speech), intellectual disabilities, and functional quadriplegia (complete immobility due to severe disability that is not caused by injury to the brain or spinal cord). In addition, R4 has a tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea (windpipe) from outside the neck), and a	F 679	1. Resident 4's activity care plan was reviewed on 3/8/24 and updated as needed. R4 is being included in various social and sensory stimulating group activities as tolerated. Television was remounted to be within view on 3/21/24. Adult bird mobile was purchased on 3/18/24 to honor residents' interest in nature and to provide increased sensory stimulation. Radio provided for music. 2. Facility residents have the potential to be affected by the alleged practice. 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 and sensory stimulation through observation and medical record reviews weekly for a minimum of 12 weeks or until compliance is achieved. The Activity Director will bring the results of these audits to the Quality Assurance and Performance Improvement Committee monthly for review and recommendations for a	

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F 679	Continued From page 7 gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food/nutrition). Multiple observations were made of R4, daily, throughout the survey period, as he lay in bed in his room with the room completely silent. No radio observed anywhere on his side of the room. R4's television (TV) was positioned on the wall opposite his bed and was always off. The TV was also positioned in a manner that the closing of his privacy curtain would obstruct its view, even if it had been on. There were minimal pictures/photos around the room. Although he does have family, there were no family photos at the bedside. Observed on the wall next to his bed were four photos of himself, one colored picture of a bird, a card with an elephant pictured, and another bird picture on his cabinet door. In addition, R4 was not observed out of his room at all throughout the survey period. On 02/20/24 at 10:38 AM, observations were made at his bedside. Although completely non-verbal in response to greetings, questions, and conversation, R4 was noted to track movement with his eyes as the Surveyor walked around his bed and smiled slightly when spoken to. A review of his comprehensive care plan for Activities noted the following primary problem: " ...[R4] is admitted for Long Term Care ... with needs for social contact and sensory stimulation ..." The care plan included six interventions: 2 having to do with group activities, 1 having to do with	F 679	minimum of 3 months or until compliance is achieved.	

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F 679	Continued From page 8	F 679		

family visits, in-person or by video, and the remaining 3 planned interventions addressing activities for when R4 is in his room.

1. "Provide ... [R4] with all types of sensory stimulation ..."

2. "Provide ... [R4] with weekly or more 1:1 [one-to-one] room visits for socialization, social stimulation."

3. "Turn on ... [R4's] TV to all types of TV shows when awake ..."

On 02/22/24 at 04:04 PM, received the last 6 months of Activity Logs for R4 from the Activities Manager (AM). A review of the Activity Logs for group activities noted that R4 attended group activities once a month for the past 4 months, twice in October, and not at all in September. A review of the documentation of 1:1 room visits by activity staff noted no visits in September, December, and January; 1 visit each in October and February; and 2 visits in November; for a total of 4 visits in the last 6 months.

On 02/23/24 at 09:46 AM, an interview was done with AM near the elevator of the second floor. AM acknowledged that after pulling the Activity Logs at the Surveyor's request the day before, it was noted the documentation made it appear that R4 was not receiving the social/sensory stimulation and 1:1 room visits reflected in his care plan. When asked, AM reported that there were radios available for residents, and agreed that R4 could benefit from consistent music therapy and/or visual stimulation that was closer to him and in his line-of-vision. AM also agreed that R4's TV is too far from his view and would

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F 679	Continued From page 9 like to move it closer to him, in addition to ensuring that it gets turned on. When asked, AM could not identify specific TV channels or shows that R4 enjoyed watching, nor the type of music he enjoyed.	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 record review, review of Facility Reported Incidents (ACTS #10723, 10743), review of Complaint (ACTS #10735), complainant interview, staff interview, and review of policy, the facility did not provide timely psychiatric assessment for one Resident (R)46, out of three residents sampled, to reduce the risk through multiple falls. R46 had an increasing number of falls with recent fracture needing surgery and hospitalization. Findings include: (Cross reference F689 Accidents) Review of Electronic Health Record (EHR) showed R46 was admitted to the facility on 06/22/23 with a diagnosis including the following: Stroke, Adjustment disorder, Atrial Fibrillation, Atherosclerotic heart disease, High blood	F 684	1. Resident 46's psychiatric services were established on 12/7/23 and are ongoing. 2. Facility residents with psychiatric needs have the potential to be affected by the alleged practice. 3. The DON/designee inserviced the IDT and licensed nurses regarding diagnoses that warrant mental health support/treatment as well as warning signs that a resident may need mental health support/treatment. Inservices will be ongoing as needed. Current residents□ diagnoses and care plans were reviewed to ensure compliance by DON/IDT. Updates were made as needed. 4. DON/designee will audit for compliance through medical record	4/5/24

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F 684	Continued From page 10 pressure, Anxiety, Restlessness, Agitation, Frequent falls ... Initial assessment for falls using the Johns Hopkins Fall Risk Assessment Tool found R46 as being high risk for falls. Further fall risk assessments showed R46 continued to be high risk for falls throughout the course of stay. Comprehensive Care Plan problem start dated 06/23/23 identified Falls and read R46 was at risk for falls due to left frontotemporal encephalomalacia, poor safety awareness, fall history, impulsiveness, wandering behaviors, unsteady gait, and use of psychotropic meds. Approach included the following: added 07/23/23 1:1 provided prn (as needed) if resident is restless to increase supervision and safety ... 08/03/23 resident will reside in close room near nurse's station, have low bed in place, fall mat in place, soft touch call bell within reach at all times ... 09/02/23 Sertraline increased ... 12/07/23 psych telehealth ... 01/10/24 follow up psych telehealth, next psych telehealth follow up scheduled for 02/09/24 ... 02/23/24 follow up psych telehealth 02/23/24... EHR review showed that R46 had the following falls: 08/03/23 Unwitnessed fall, found sitting on bedside floor mat, alone at time of fall. 08/16/23 Unwitnessed fall, found sitting on floor, alone at time of fall. 08/23/23 Unwitnessed fall, found on floor, alone at time of fall. 09/05/23 Lowered to floor, lost balance. 09/16/23 Unwitnessed fall, found sitting on floor, alone at time of fall.	F 684	reviews to ensure proper referrals were made weekly for a minimum of 12 weeks or until compliance is achieved. The DON will bring the results of these audits 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 11 09/19/23 Witnessed fall, alone at time of fall. 10/18/23 Unwitnessed fall, noted on floor, alone at time of fall. 10/31/23 Unwitnessed fall, alone at time of fall. 11/01/23 Unwitnessed fall, found on floor, alone at time of fall. 11/09/23 Unwitnessed fall, found on bathroom floor, alone at time of fall. 11/10/23 Unwitnessed fall, found on floor mat, alone at time of fall. 11/19/23 Unwitnessed fall, found on floor, alone at time of fall. 12/08/23 Witnessed fall, alone at time of fall. 12/15/23 Unwitnessed fall, found on ground, alone at time of fall. 12/19/23 Unwitnessed fall, found sitting on floor mat, alone at time of fall. 12/28/23 Witnessed fall, alone at time of fall. 01/01/24 Witnessed, slid to floor. 01/02/24 Witnessed by other resident, alone at time of fall. 01/07/24 Witnessed by other resident, alone at time of fall. 01/08/24 Unwitnessed, found on floor. 01/09/24 Unwitnessed, found on floor, sent to hospital. 01/17/24 Witnessed, fell upon standing. 02/06/24 Unwitnessed, found on floor, sent to ER. Review of Facility Reported Incidents ACTS 10723, 10743 included the following: Care plan included laser alarm applied ... supervision 1:1 as needed when restless ... sent out to ER and admitted for surgical procedure. During review of Complaint ACTS 10735 and Complainant (C) interview on 02/21/24 at 09:05AM, C said the facility did not have psychiatric services.	F 684		

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	125004	A. BUILDING _____ B. WING _____	02/23/2024

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F 684	Continued From page 12 Staff interview on 02/23/24 at 11:30AM, Director of Nursing (DON) said that there were no psychiatric services on the Kauai, but they found services on Oahu. DON emphasized the care coordination effort has been multi-disciplinary and efforts to include the family and/or family representative has been on-going. Review of facility policy on Fall Prevention and Management read the following: Key elements of the fall prevention and management program ... Dynamic treatment plan, role of interdisciplinary team, use of non-pharmaceutical interventions, appropriate and necessary use of devices (enablers, restraints), re-assessments, implementation, and evaluation of treatment plan ... Review record of diagnoses which may contribute to increased falls risk and make sure they are addressed as needed ..., most common diagnoses that may contribute to an increase in falls, Cerebrovascular accident (CVA) ... Pharmacological assessment and review, review the use of off label antipsychotics, attempt dose reductions as indicated, review the use of benzodiazepines, attempt dose reductions as indicated ... Quality improvement, collect falls data (including near miss data), track and trend the falls for a defined period of time to ascertain patterns or probable factors that need to be addressed ...	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		4/5/24

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F 689	Continued From page 13 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, review of Facility Reported Incidents (ACTS #10723, 10743), review of Complaint (ACTS #10735), complainant interview, staff interview, and review of policy, the facility did not provide enough supervision for one Resident (R)46, out of three residents sampled, to reduce the risk through multiple falls. R46 had an increasing number of falls with recent fracture needing surgery and hospitalization. Cross reference F684 Quality of Care Findings include: Review of Electronic Health Record (EHR) showed R46 was admitted to the facility on 06/22/23 with a diagnosis including the following: Stroke, Adjustment disorder, Atrial Fibrillation, Atherosclerotic heart disease, High blood pressure, Anxiety, Restlessness, Agitation, Frequent falls ... Initial assessment for falls using the Johns Hopkins Fall Risk Assessment Tool found R46 as being high risk for falls. Further fall risk assessments showed R46 continued to be high risk for falls throughout the course of stay. Comprehensive Care Plan problem start dated 06/23/23 identified Falls and read R46 was at risk for falls due to left frontotemporal encephalomalacia, poor safety awareness, fall history, impulsiveness, wandering behaviors,	F 689	1. Resident 46's fall care plan was reviewed and updated to reflect increasing resident's participation in out of bed (OOB) activities as tolerated as resident becomes less reclusive. 2. Facility residents at risk for falls have the potential to be affected by the alleged practice. 3. The DON/designee inserviced the IDT, licensed nurses, certified nurse aides (cnas) and ancillary staff regarding fall prevention and management. Inservices will be ongoing as needed. Care plans for current residents at high risk for falls were reviewed to ensure compliance of adequate supervision to prevent falls. Updates were made as needed. 4. DON/designee will audit for compliance of adequate supervision in relation to fall prevention 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 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 689	Continued From page 14	F 689		

unsteady gait and use of psychotropic meds. Approach included the following: added 07/23/23 1:1 provided prn (as needed) if resident is restless to increase supervision and safety ... 08/03/23 resident will reside in close room near nurse's station, have low bed in place, fall mat in place, soft touch call bell within reach at all times ... 11/15/23 family to help support resident by visiting in the evenings due to resident wanting a companion ... 01/09/24 sensor alarm in-house and installed at foot of bed ... 01/17/24 wear posey hipster briefs (hip protectors) as tolerated ...

EHR review showed that R46 had the following falls:
08/03/23 Unwitnessed fall, found sitting on bedside floor mat, alone at time of fall.
08/16/23 Unwitnessed fall, found sitting on floor, alone at time of fall.
08/23/23 Unwitnessed fall, found on floor, alone at time of fall.
09/05/23 Lowered to floor, lost balance.
09/16/23 Unwitnessed fall, found sitting on floor, alone at time of fall.
09/19/23 Witnessed fall, alone at time of fall.
10/18/23 Unwitnessed fall, noted on floor, alone at time of fall.
10/31/23 Unwitnessed fall, alone at time of fall.
11/01/23 Unwitnessed fall, found on floor, alone at time of fall.
11/09/23 Unwitnessed fall, found on bathroom floor, alone at time of fall.
11/10/23 Unwitnessed fall, found on floor mat, alone at time of fall.
11/19/23 Unwitnessed fall, found on floor, alone at time of fall.
12/08/23 Witnessed fall, alone at time of fall.
12/15/23 Unwitnessed fall, found on ground,

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F 689	Continued From page 15	F 689		

alone at time of fall.
12/19/23 Unwitnessed fall, found sitting on floor mat, alone at time of fall.
12/28/23 Witnessed fall, alone at time of fall.
01/01/24 Witnessed, slid to floor.
01/02/24 Witnessed by other resident, alone at time of fall.
01/07/24 Witnessed by other resident, alone at time of fall.
01/08/24 Unwitnessed, found on floor.
01/09/24 Unwitnessed, found on floor, sent to hospital.
01/17/24 Witnessed, fell upon standing.
02/06/24 Unwitnessed, found on floor, sent to ER.

Review of Facility Reported Incidents ACTS 10723, 10743 included the following: Care plan included laser alarm applied ... supervision 1:1 as needed when restless ... sent out to ER and admitted for surgical procedure.

During review of Complaint ACTS 10735 and Complainant (C) Interview on 02/21/24 at 09:05AM, C said the facility did not have enough staff to watch R46 and was told that C needed to help watch or hire somebody to be with the resident. C met with the facility and felt that communication has improved.

Staff interview on 02/22/24 at 03:25PM, Resident Care Manager 4 said that R46 needed 1:1 supervision at times but would not need it throughout the shift.

Staff interview on 02/23/24 at 08:50AM, Registered Nurse 51 said he/she felt that there was not enough staff overall and not enough staff to do 1:1 with the residents.

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F 689	Continued From page 16 Staff interview on 02/23/24 at 11:30AM, Director of Nursing (DON) said that R46 needed 1:1 supervision as needed but did not present to need supervision around the clock. DON emphasized the care coordination effort has been multi-disciplinary and efforts to include the family and/or family representative has been on-going. Review of facility policy on Fall Prevention and Management read the following: Key elements of the fall prevention and management program ... Dynamic treatment plan, role of interdisciplinary team, use of non-pharmaceutical interventions, appropriate and necessary use of devices (enablers, restraints), re-assessments, implementation, and evaluation of treatment plan ... Review record of diagnoses which may contribute to increased falls risk and make sure they are addressed as needed ..., most common diagnoses that may contribute to an increase in falls, Cerebrovascular accident (CVA) ... Pharmacological assessment and review, review the use of off label antipsychotics, attempt dose reductions as indicated, review the use of benzodiazepines, attempt dose reductions as indicated ... Quality improvement, collect falls data (including near miss data), track and trend the falls for a defined period of time to ascertain patterns or probable factors that need to be addressed ...	F 689		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting	F 699		4/5/24

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F 699	Continued From page 17 for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to identify triggers which may cause re-traumatization, and consistently use trauma-informed approaches when caring for, and planning the care for, 1 of 1 resident (Resident (R)274) sampled for Trauma-Informed Care. As a result of this deficient practice, R274 did not have his needs met, was placed at risk of re-traumatization, and was hindered from attaining his highest practicable mental and psychosocial well-being. This deficient practice has the potential to affect all the residents at the facility with a history of trauma, post-traumatic stress disorder, and/or psychosocial adjustment difficulties. Findings include: R274 is a 75-year-old male admitted to the facility on 02/01/2024 for long-term care with diagnoses that include, but are not limited to, Parkinson's disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves), chronic post-traumatic stress disorder (PTSD), depression, anxiety, dementia, and insomnia. A review of R274's Admission Social Services assessment noted the following: "Resident is on Prazosin for Dx [diagnosis]: Nightmares/insomnia. Resident with Chronic PTSD related to his war experience/combat nightmares. He is an Army Guard. He has hx	F 699	1. Resident 274's trauma-informed care observation was re-done on 2/22/24 and trauma-informed care assessment was completed with Wife/Power of Attorney (POA) on 2/23/24. Care plan was reviewed and updated as needed. 2. Facility residents with a history of trauma have the potential to be affected by the alleged practice. 3. The DON/designee inserviced the IDT and Social Services department regarding trauma-informed care. Inservices will be ongoing as needed. Current residents triggering on the trauma-informed care observation were reviewed to ensure compliance. Updates were made as needed. 4. Social Services/designee will audit residents that have an identified history of trauma have appropriate progress notes and care plans weekly for a minimum of 12 weeks or until compliance is achieved. Social Services will bring the results of these audits 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 699	Continued From page 18	F 699		

[history] of sleeping with tent on his upper part of the body/covers his head as it helps him feel secure."

A review of the comprehensive admission assessment and corresponding care plan found no information of potential triggers for R274's PTSD or anxiety, nor did it contain resident-specific information to help reduce re-traumatization. There was no documentation that a review of R274's pre-admission PTSD history had been done, or that the brief history documented regarding sleeping with his head covered was addressed or investigated.

A review of the facility's Trauma Informed Care policy, last revised on 07/12/23, noted the following:

"Residents identified as history of Trauma ... will have Trauma Informed Observation progress note completed ... Trauma events and triggers identified through the screening will be used to develop a care plan."

On 02/21/24 at 09:09 AM, an interview was done with R274 at his bedside. R274 confirmed that he has PTSD "from Vietnam." R274 reported that he was being followed for his PTSD "at the VA [Veterans Affairs]" and would see someone at the Vet Center once a week for "counseling" for his PTSD and nightmares. When asked, R274 stated that he had not been to the Vet Center, or had counseling offered to him at the facility, since he had been admitted. R274 stated he would like to go out to the Vet Center to continue his PTSD counseling.

On 02/22/24 at 07:57 AM, a review of R274's

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EHR revealed no documentation of a Trauma Informed Observation being completed. Documentation of the Trauma-informed assessment that was done was requested from the Administrator. At 03:24 PM, the Administrator provided a 4-question Trauma Informed Care assessment titled "Screening questions for PTSD" that the facility had conducted. The questions on this form were screening questions to be answered with a yes or no, asking if the resident " ... had any experience that was so frightening, horrible or upsetting that, in the past month, you ..." The Administrator confirmed that these forms/questions were not appropriate for this resident and was not in alignment with the facility policy on trauma-informed care. The Administrator provided the State Agency with a Trauma-Informed Care Observation assessment form and Progress Note conducted by Social Services with R274 on 02/22/24, after discovering they had not used the correct assessment.

On 02/23/24 at 11:23 AM, Social Services Associate (SSA)4 provided the State Agency with a copy of R274's last Mental Health Progress Note from the Vet Center on 01/23/24, which included a detailed history of his condition. At 11:33 AM, an interview was done with SSA4 in her office. When asked, SSA4 confirmed that the progress note/history from the Vet Center had been obtained by her today, after the information had been requested by the State Agency. SSA4 agreed that R274's pre-admission history should have been looked for, obtained, and reviewed prior to conducting his trauma-informed care assessment. SSA4 stated she would review it and re-do R274's trauma-informed care assessment. SSA4 also agreed that as R274 is forgetful (with dementia) and not a reliable

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F 699	Continued From page 20 historian, his assessment should be conducted with his wife present.	F 699		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not	F 791		4/5/24

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F 791	Continued From page 21 charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide or obtain from an outside resource, routine dental services to meet the needs of 1 of 1 resident sampled for dental concerns. This deficient practice has the potential to affect all residents currently residing in the facility. Findings include: Resident (R)48 is an 82-year-old male with no natural teeth, admitted to the facility on 09/02/22. On 02/21/24 at 08:46 AM, an interview was done with R48 at his bedside. R48 complained of sore gums, and not being provided a textured diet that he could eat comfortably. R48 shared an example of being given dry cereal for breakfast with no milk to pour over it. R48 stated eating the dry cereal feels like it cuts into his gums, but he has no choice because he is hungry. R48 also reported that while he did have dentures, they no longer fit properly. When asked when the last time was that a dentist evaluated the state of his gums, and the fitting of his dentures, R48 replied that he had not seen a dentist in the facility, or been sent out to see a dentist, since his admission. A review of R48's electronic health record (EHR) revealed no dental consultations, and an oral exam, last completed on 09/03/23,	F 791	1. Resident 48 had a dental consult completed on 3/21/24. 2. Facility residents have the potential to be affected by the alleged practice. 3. IDT and facility licensed nurses were inserviced regarding routine dental services by DON/designee. Last annual oral cavity observation was reviewed for current residents and Dentist referrals offered as needed and/or per request. 4. DON/designee will audit for compliance through observations and oral cavity assessments, done by a Registered Nurse (RN). Audits will be completed weekly for a minimum of 12 weeks or until compliance is achieved. The DON will bring the results of these audits 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 791	Continued From page 22 done by a licensed practical nurse (LPN) from the facility. A review of the facility's Dental Services policy, effective 05/01/21, noted the following: The facility must: 1. Provide or obtain from an outside resource routine and emergency dental services to meet the needs of each resident. "Routine dental services" means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor partial or full denture adjustments, smoothing of broken teeth, and limited prosthodontic procedures, e.g., taking impressions for dentures and fitting dentures. It is noted from the facility's definition above of routine services, that these services are outside the scope of LPN practice.	F 791		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records.	F 842		4/5/24

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 23 §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches	F 842		

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	125004	A. BUILDING _____ B. WING _____	02/23/2024

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F 842	Continued From page 24 legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on an interview and record review, the facility failed to maintain an accurate medical record for two residents (Resident (R)24 and R225). An interview with the Director of Nursing (DON) confirmed a document for R225 was uploaded in R24's Electronic Health Record (EHR) erroneously and should not have been. Findings include: On 02/21/24 at 10:15 AM, conducted a record review of R24's EHR. A form titled, "MD (physician) Response" (attached on 10/12/23) for R225 filed in R24's EHR. The MD Response for documented the physician response to nursing staff regarding questionable orders for Acetaminophen, which would exceed the recommended daily dose of the medication and could potentially negatively impact R225's health status. Review of R225's EHR, Medication Administration Record (MAR), documented identified the orders nursing staff questions were present, the resident was not administered a	F 842	1. At the time of survey, Resident 225 had already been discharged. The misfiled MD Response record was immediately removed from Resident 24's chart on 2/22/24. It was confirmed that Resident 225's medical record did have the MD Response record uploaded as well. 2. Facility residents have the potential to be affected by the alleged practice. 3. DON inserviced Health Information Manager (HIM) regarding the importance of maintaining an accurate medical record on 2/26/24. Inservices will be ongoing as needed. The last 30 days of MD Response records were reviewed for accuracy for current residents and updated as needed. 4. HIM/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	

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F 842	Continued From page 25 dose which exceeded the recommended daily dose of Acetaminophen and was not impacted. On 02/22/24 at 12:42 PM, conducted a concurrent interview and review of R24's EHR with the Director of Nursing (DON). DON reviewed R225's MD Response form located in R24's EHR and confirmed the document was misfiled in the wrong resident's EHR. DON confirmed the Health Information Coordinator (HIC)9 was not scheduled to work today and unavailable for interview, but an in-service would be conducted with HIC9 upon returning to work.	F 842	results of these audits 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 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;	F 880		4/5/24

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F 880	Continued From page 26 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 27 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review, the facility failed to ensure that staff followed hand hygiene and contact precautions practices consistent with accepted standards of practice. Registered Nurses (RN)60 did not complete hand hygiene between glove changes during a dressing change for a Pressure Ulcer (PU) on R70's coccyx. Staff Member (SM)15 did not wear personal protective equipment while delivering lunch to R11's room, who was on contact precautions. This deficient practice places the residents in the facility at an increased risk for communicable disease. Findings include: During an observation on 02/22/24 at 2:00 PM in R70's room with RN60 and RN75 prepared to change R70's dressings. Dressing changes for R70 included the wound on his left lower leg; two PUs on the upper back, and one pressure ulcer on the coccyx. While changing the coccyx PU, RN60 removed the dressing, cleaned the site, and removed her dirty gloves. RN60 picked up the clean gloves and started to place her fingers in the glove. The surveyor prompted RN60 by pointing at the hand sanitizer that was on the over bed table to complete hand hygiene. After using the alcohol-based hand sanitizer RN60 proceeded to put the clean gloves on and completed the wound care. Conducted an interview with RN60 and RN75 on 02/22/24 at 3:45 PM at the nurse's station	F 880	1. RN60 was re-inserviced by the DON on 2/22/24 regarding proper hand hygiene between glove changes. Resident 11 is no longer on contact precautions. Facility staff was re-inserviced by the DON regarding wearing/using the appropriate PPE and checking in with the nurse prior to entering if unsure about signage or precautions. 2. Facility residents have the potential to be affected by the alleged practice. 3. Infection Preventionist/Staff Educator (IP/SE)/designee inserviced facility staff on glove use, hand hygiene between glove changes and wearing/using appropriate personal protective equipment (PPE) for transmission based precautions (TBP) and checking in with the nurse prior to entering if unsure about signage or precautions. Inservices will be ongoing as needed. 4. DON/designee will audit for compliance through observation reviews and medical record reviews weekly for a minimum of 12 weeks or until compliance is achieved. The IP/SE will bring the results of these audits 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 28	F 880		

regarding observations made during the dressing change. Staff validated hand hygiene was not done after removing the dirty gloves and before putting clean gloves on.

Review of Handwashing and Hand Hygiene policy (revised 05/23/2023) documented, "Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: t. Before donning and after doffing gloves and PPE [Personal Protective Equipment])."

2) During an observation of the lunch trays being delivered on the third-floor unit on 02/20/24 at 12:30 PM, observed SM15 enter room 365 without donning a gown or gloves. A purple stop sign posted on room 365's door read, "stop check with nurse before entering." The surveyor asked SM15 if a resident in the room is on contact precautions. SM15 was not sure why the resident was on contact precaution but would find out and get back to the surveyor.

Review of R11's EHR documented a 0.8 by 0.5 by 0.2 centimeter wound on her back and is currently receiving wound care. An order for contact precautions could not be found in the physician's orders or any other part of the resident's EHR.

Interview with the Infection Preventionist (IP) and Director of Nursing (DON) on 02/23/24 at 09:40 AM on the third-floor nurse's station. The IP and DON confirmed R11 was on contact precautions for a wound on the back and an umbilical opening and all staff should be gowning and gloving before going into the room, including delivering meal trays to any resident on contact precautions.

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F 880	Continued From page 29 Review of the Infection Control policy (updated 10/01/22) documented, "Contact Precautions - used to minimize the transmission of infectious organisms through contact with hands or objects, usually found in nares, wounds, urine, and stool. Apply PPE before entering a room or resident/guest. Only gloves needed if delivering meal tray..."	F 880		