STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125061	A. BUILDING _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAUAI CARE CENTER	9611 WAENA ROAD WAIMEA, HI 96796

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA). The facility was found not to be in substantial compliance with 42 CFR 483 Subpart B. Survey Dates: 04/11/23 to 04/14/23 Survey Census: 35 Sample Size: 12	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to report the results of an investigation of alleged abuse (invasion of privacy) for two of two sampled residents (R)20	F 610	F610 Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	5/29/23

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

Electronically Signed | 06/12/2023

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F 610	Continued From page 1
	and R21.
	
	Findings include:
	
	1)The facility was asked if they could provide the results and followup of a complaint investigative report. The report was not available for R20.
	
	Observation and concurrent interview with administrator on 04/14/23 at 10:30 AM were done. A query was made with the administrator regarding missing final reports sent to the state agency. Administrator stated that "I was not here when that was happening. It was the other administrator that was here." Administrator was not able to confirm that the completed investigation was done to verify if the appropriate corrective action occurred.
	
	2) The facility reported an initial event report (#10015) on January 5, 2023. No completed report or followup was received.
	
	These deficient practices have the potential to affect all residents in the facility if alleged regulatory violations are not thoroughly investigated and reported.
		F 610	How the corrective action will be accomplished for residents affected by the deficient practice:
			
			Identified residents (R20) and (R21) affected by this practice, although thorough and completed investigation(s) were completed both timely per facility incident protocols and appropriate corrective action(s) were taken, a final and completed report was not provided to the State Survey Agency within 5 working days of the incident.
			
			For (R20) and (R21) surveyor was provided with the completed final report day of survey entrance 4/11/23.
			
			For (R13) surveyor was provided with the completed final report of allegation unsubstantiated following a thorough and completed investigation, appropriate actions were taken by the facility including an APS and DHS were both notified, report filed and documented per APS no further investigation warranted, no findings, case unsubstantiated.
			
			How the nursing facility will identify other residents having the potential to be affected by the same deficient practice:
			
			All resident(s) have the potential to be affected by this deficiency.
			
			Measures the nursing facility will put into place or systemic changes made to ensure the deficient practice will not recur:	

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F 610	Continued From page 2	F 610	Nursing management staff were educated on the State Survey Agency reporting requirements and that the final and completed report is to be provided to the State Survey Agency within 5 working days of the incident to ensure alleged regulatory violations are thoroughly investigated and reported. How the facility will monitor its performance to ensure that solutions are sustained, plan for ensuring the corrective actions are achieved and sustained, how the facility will evaluate for its effectiveness and is integrated into the quality assurance system: Executive Director and/or Designee will audit weekly x 4 weeks then monthly x 2 months to ensure compliance with state survey agency reporting requirements. Results of the audits will be reviewed by the Executive Director/designee, any issues identified will be addressed and corrected and will be reported to monthly QAPI committee x 2 months for further review and recommendation. The title of the person responsible to ensure correction: Executive Director/designee will be responsible for ongoing compliance. Dates when corrective action will be completed: Compliance will be met by May 29th, 2023	

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F 610	Continued From page 3	F 610	and on an ongoing basis.	
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (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;	F 623		5/29/23

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F 623	Continued From page 4	F 623		

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental 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

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F 623	Continued From page 5 for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of policy, the facility failed to provide written notice of discharge for two residents (R)13 and R26 out of four residents sampled. As a result of this deficiency, there was a potential for miscommunication. Findings include: Cross reference to F625. The facility did not provide written notice of bed-hold policy. Review of the Electronic Health Record (EHR) indicated that R13 was discharged to the hospital on 09/07/22. Further review did not show any written notice of discharge to the resident and/or representative.	F 623	F623 Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) See POC for F625 How the corrective action will be accomplished for residents affected by the deficient practice: Identified residents (R13) and (R26) were affected by this practice, facility provided verbal and documented notification upon transfer to the hospital however failed to provide a copy of the written notification. How the nursing facility will identify other	

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F 623	Continued From page 6 Review of the EHR indicated that R26 was discharged to the hospital on 02/25/23. Further review did not show any written notice of discharge to the resident and/or representative. During staff interview on 04/12/23 at 2:30 PM, Social Services Director acknowledged that the facility did not provide written notification of discharge for R13 and R26. Review of facility policy on Admission/Transfer/Discharge read the following: Policy, it is the policy of this facility to provide direction and guidance in accordance with state and federal regulations for admissions, transfer, and discharge of residents ... Transfer/discharge policy ... 3. Prior to a facility-initiated discharge or transfer, the facility must provide notice of transfer or discharge and reasons to the resident, resident representative, and State Long-Term Care Ombudsman. Copies of these notifications will be retained in the resident record.	F 623	residents having the potential to be affected by the same deficient practice: All resident(s) have the potential to be affected by this deficiency. Measures the nursing facility will put into place or systemic changes made to ensure the deficient practice will not recur: Social services designee and nursing staff were educated on the requirements to provide timely written notification upon transfer and as soon as practicable. How the facility will monitor its performance to ensure that solutions are sustained, plan for ensuring the corrective actions are achieved and sustained, how the facility will evaluate for its effectiveness and is integrated into the quality assurance system: Executive Director and/or Designee will audit weekly x 4 weeks then monthly x 2 months to ensure written notification of transfer. Results of the audits will be reviewed by the Executive Director/designee, any issues identified will be addressed and corrected and will be reported to monthly QAPI committee x 2 months for further review and recommendation. The title of the person responsible to ensure correction: Executive Director/designee will be responsible for ongoing compliance.	

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F 623	Continued From page 7	F 623	Dates when corrective action will be completed: Compliance will be met by May 29th, 2023 and on an ongoing basis.	
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced	F 625		5/29/23

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F 625	Continued From page 8 by: Based on record review, staff interview, and review of policy, the facility failed to provide written notice of bed-hold policy for two residents (R)13 and R26 out of four residents sampled. As a result of this deficiency, there was a potential for miscommunication of the facility's bed-hold policy. Findings include: Cross reference to F623. The facility did not provide written notice of discharge. Review of the Electronic Health Record (EHR) indicated that R13 was discharged to the hospital on 09/07/22. Further review did not show any written notice of bed-hold policy to the resident and/or representative. Review of the EHR indicated that R26 was discharged to the hospital on 02/25/23. Further review did not show any written notice of bed-hold policy to the resident and/or representative. During staff interview on 04/12/23 at 2:45 PM, Admissions Coordinator acknowledged that the facility did not provide written notification of bed-hold policy for R13 and R26. Review of Bed Hold Policy and Agreement Form provided to residents and/or representatives on admission read the following: A resident who is temporarily absent from the facility as a result of a transfer or a therapeutic/social leave may apply for a bed-hold to ensure his or her bed is preserved for the resident's anticipated return. The right to exercise a bed-hold when the resident is temporarily away from the facility is	F 625	F625 Notice of Bed Hold Policy Before/Upon Transfer CFR(s): 483.15(d)(1)(2) See POC for F623 How the corrective action will be accomplished for residents affected by the deficient practice: Identified residents (R13) and (R26) were affected by this practice, facility provided verbal and documented notification of bed hold policy upon transfer to the hospital however failed to provide a copy of the bed hold policy. How the nursing facility will identify other residents having the potential to be affected by the same deficient practice: All resident(s) have the potential to be affected by this deficiency. Measures the nursing facility will put into place or systemic changes made to ensure the deficient practice will not recur: Nursing and admissions coordinator were educated on the requirements to provide written notification of the bed hold policy upon transfer and as soon as practicable. How the facility will monitor its performance to ensure that solutions are sustained, plan for ensuring the corrective actions are achieved and sustained, how	

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F 625	Continued From page 9 applicable to all residents and may not be used as a condition for admission or re-admission ... Each resident being discharged to the hospital (or the resident's legally authorized representative) will be offered the option of holding the resident's current bed under this policy. At the time of discharge to the hospital, the discharging nurse gives the resident and representative a copy of this Bed-Hold Policy and Agreement. The resident/representative who chooses a bed-hold must sign this Agreement below acknowledging the charges for a bed-hold.	F 625	the facility will evaluate for its effectiveness and is integrated into the quality assurance system: Executive Director and/or Designee will audit weekly x 4 weeks then monthly x 2 months to ensure written notification of the bed hold policy is provided upon transfer. Results of the audits will be reviewed by the Executive Director/designee, any issues identified will be addressed and corrected and will be reported to monthly QAPI committee x 2 months for further review and recommendation. The title of the person responsible to ensure correction: Executive Director/designee will be responsible for ongoing compliance. Dates when corrective action will be completed: Compliance will be met by May 29th, 2023 and on an ongoing basis.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656		5/29/23

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F 656	Continued From page 10	F 656		

needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, and record

F656 Development/Implement

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F 656	Continued From page 11 review, the facility failed to provide non-pharmacological methods to help alleviate depression for one resident (R)11. This hinders R11's ability of attaining his highest practicable physical, mental, and psychological well-being. Finding includes: Cross reference to F740 Behavioral Health Services. The facility did not appropriately manage R11's depression. On 04/11/23 at 11:20 AM, observed R11 sitting in the dining room by himself listening to music. 04/12/23 at 09:31 AM, R11 was interviewed in his room. R11 frequently stated that he was lonely and sad. R11 stated that the activities provided by the facility were not tailored for his age group. R11 stated that he liked going out and enjoys pet therapy. R11 further stated that he was missing his two favorite cats, one of which had a birthday at the beginning of the month. On 04/13/23 at 10:41 AM, observed R11 alone in his room lying on his bed. R11 stated that he sees a psychiatrist. On 04/13/23 at 3:11 PM, observed R11's roommate and other residents were in the common area eating their afternoon snack while R11 stayed in his room. Record review of R11's "Admission Record" revealed that he is a 76 year old resident admitted to the facility on 11/08/22 for low blood sodium level, Parkinson's Disease, and recurrent major depressive disorder. R11's "Minimum Data Set (MDS)" admission assessment with assessment reference date (ARD) of 11/13/22 revealed under "Section D Mood" a PHQ-9© (Patient Health Questionnaire-9 to determine the severity of depression) score of "6" signifying mild	F 656	Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) See POC F740 How the corrective action will be accomplished for residents affected by the deficient practice: Identified resident (R11) care plan was reviewed and updated to include non-pharmacological methods to help alleviate and manage depression and activities identified that were compatible with his physical and mental capabilities were also updated. How the nursing facility will identify other residents having the potential to be affected by the same deficient practice: All resident(s) have the potential to be affected by this deficiency. Other residents who have been treated for depression, the care plans have been reviewed and updated to include non-pharmacological methods to manage depression. Measures the nursing facility will put into place or systemic changes made to ensure the deficient practice will not recur: Licensed Nurses, Social Services Designee and Activities staff educated on updating the care plan to include interventions for residents with depression in order to attain their highest practicable	

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F 656	Continued From page 12 depressive symptoms. "Section F Preferences for Customary Routine and Activities" noted under "F0500. Interview for Activity Preferences" that it was important for R11 to be around pets. Review of R11's careplan did not identify that R11 enjoyed pet therapy and did not identify specific activities that were compatible with his physical and mental capabilities.	F 656	physical, mental, and psychological and social well-being. How the facility will monitor its performance to ensure that solutions are sustained, plan for ensuring the corrective actions are achieved and sustained, how the facility will evaluate for its effectiveness and is integrated into the quality assurance system: DNS and/or Designee will audit weekly x 4 weeks then monthly x 2 months residents with new diagnosis of depression or report of depression to ensure resident care plan updated to include interventions to manage depression. Results of the audits will be reviewed by the DNS/designee, any issues identified will be addressed and corrected and will be reported to monthly QAPI committee x 2 months for further review and recommendation. The title of the person responsible to ensure correction: DNS/designee will be responsible for ongoing compliance. Dates when corrective action will be completed: Compliance will be met by May 29th, 2023 and on an ongoing basis.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		5/29/23

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F 657	Continued From page 13 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to update and revise the care plan to include interventions and treatment for a suspected hairline fracture of the left 5th proximal phalanx. The facility failed to update and revise the care plan for one of one sampled resident (R)20. Findings include: Resident(R)20 with an admission date of	F 657	F657 Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) How the corrective action will be accomplished for residents affected by the deficient practice: Identified resident (R20) care plan was updated and revised to include to include interventions and treatment for the	

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F 657	Continued From page 14 04/29/2020 with a history of falling and care planned on falling. Observation was done on 04/11/23 of R20 at 12:30 PM sitting in activity room watching TV. R20 answers occasionally appropriate answer to queries. No walker boot noted to foot. Record review(RR) done on 04/11 at 1:30 PM on nursing unit was done. RR revealed that the resident sustained a fall on 03/28/23. R20 complained of neck pain and was sent to the ER for cervical neck x-rays. R20 did not complain of foot pain at that time. Interventions were put in place for cervical pain. RR done on 04/12/23 at 11:30 AM of the falls care plan. Care plan states that resident is at risk for falls r/t poor vision, unsteady gait/balance, history of falls, poor safety awareness and impulsiveness. Fall 3/30/23 with left foot hairline fracture nondisplaced, 5th digit. Interview was done on 04/13/23 at 1:06 PM with Registered Nurse (RN)1. RN1 stated R20 started mentioning foot pain after returning from ER about her foot. Eight days later, on 04/04/2023, nursing staff noted some erythema of the foot. R20 went back to x-ray and then it was discovered that she had a hairline fracture of her left foot, 5th proximal phalanx. Further review of orders revealed that three days later, on 04/07/23, advanced practice registered nurse (APRN) ordered a walker boot to left foot to be worn when patient is out of bed. This order for a walker boot did not transcribe to the care plan. The new order stated for a walker boot when patient is out of bed.	F 657	suspected hairline fracture of the left 5th proximal phalanx, proactive measures implemented while awaiting earliest available scheduled ortho consult, rsd seen on 4.27.23 for orthopedic consult, per provider no fracture seen per imaging to left 5th toe. How the nursing facility will identify other residents having the potential to be affected by the same deficient practice: All resident(s) have the potential to be affected by this deficiency, care plans were updated and revised to include interventions to assure continuity of care. Measures the nursing facility will put into place or systemic changes made to ensure the deficient practice will not recur: Nursing staff educated on the requirement that resident care plans are updated and revised timely to the extent practicable, to include interventions and treatments as indicated by provider orders and recommendations in order to attain and maintain the resident□s highest practicable physical, mental, and psychosocial well-being. How the facility will monitor its performance to ensure that solutions are sustained, plan for ensuring the corrective actions are achieved and sustained, how the facility will evaluate for its effectiveness and is integrated into the quality assurance system:	

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F 657	Continued From page 15 Interview was done with the Rehab director (RD) on 04/13/23 at 1:23 PM. RD stated that a boot was ordered a week ago, but it has not come in. RD stated that she has been buddy taping it/gauze left foot 4th and 5th digits to protect the 5th toe hairline fracture. RD also provided another supportive orthopedic shoe until walker boot comes in. RD confirmed that this treatment was not transcribed in the care plan. This deficient practice could affect all the residents in the facility if the care plans are not updated to assure continuity of care.	F 657	DNS and/or Designee will audit weekly x 4 weeks then monthly x 2 months to ensure resident care plans are updated timely and revised accordingly to assure continuity of care. Results of the audits will be reviewed by the DNS/designee, any issues identified will be addressed and corrected and will be reported to monthly QAPI committee x 2 months for further review and recommendation. The title of the person responsible to ensure correction: DNS/designee will be responsible for ongoing compliance. Dates when corrective action will be completed: Compliance will be met by May 29th, 2023 and on an ongoing basis.	
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by:	F 740		5/29/23

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F 740	Continued From page 16 Based on observations, record review, and interviews, the facility failed to appropriately provide the necessary behavioral health care and services for one resident (R), R11, to attain his highest practicable physical, mental, and psychological well-being. The facility failed to recognize R11's depressive symptoms and provide non-pharmacological interventions to help alleviate R11's depression. Finding includes: Cross reference to F656 Develop/implement Comprehensive Care Plan. The facility failed to identify and provide individualized interventions to manage R11's depression. On 04/11/23 at 11:20 AM, observed R11 was sitting in the dining room by himself listening to music. 04/12/23 at 09:31 AM, R11 was interviewed in his room. R11 frequently stated that he was lonely and sad. R11 stated that the activities provided by the facility were not tailored for his age group. R11 stated that he liked going out and enjoys pet therapy. R11 further stated that he was missing his two favorite cats, one of which had a birthday at the beginning of the month. On 04/13/23 at 10:41 AM, observed R11 alone in his room lying on his bed. R11 stated that he sees a psychiatrist. On 04/13/23 at 3:11 PM, observed R11's roommate and other residents were in the common area eating their afternoon snack while R11 stayed in his room. Record review of R11's "Admission Record" revealed that he is a 76 year old resident admitted to the facility on 11/08/22 for low blood sodium level, Parkinson's Disease, and recurrent major depressive disorder. R11's "Minimum Data	F 740	F740 Behavioral Health Services CFR(s): 483.40 See POC F656 How the corrective action will be accomplished for residents affected by the deficient practice: Identified resident (R11) has maintained weekly scheduled provider behavioral health tele-visits since being admitted for long-term care placement, facility□s measures to obtain outside behavioral health provider visit notes and recommendations revised, goal is for timely procurement of recommendations in order for the facility to implement interventions per provider recommendations to assure continuity of care as indicated, to address behavioral health needs. Resident (R11) had just gone on a holo-holo outing the day prior and actively participates in the monthly Healing Horses pet therapy provided at the facility on a monthly basis. Immediate corrections implemented during survey to provide additional and individualized non-pharmacological interventions to help alleviate resident□s depression to address resident□s behavioral health needs: " Resident-centric pet therapy provided as resident□s preferred daily activities of his choosing integrated with his already scheduled therapies to enhance functional	

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F 740	Continued From page 17 Set (MDS)" admission assessment with assessment reference date (ARD) of 11/13/22 revealed under "Section D Mood" a PHQ-9© (Patient Health Questionnaire-9 to determine the severity of depression) score of "6" signifying mild depressive symptoms. "Section F Preferences for Customary Routine and Activities" noted under "F0500. Interview for Activity Preferences" that it was important for R11 to be around pets. Review of the progress notes revealed an "Alert Note" written on 04/09/23 at 04:06 AM stating that R11 was being monitored due to the increase of his trazadone (antidepressant medication) dosage. The "Order Summary" revealed an order for trazadone 50 mg (milligrams) written on 04/06/23 to be increased from one tablet to one and a half tablets. There was no documentation by psychiatry and the Advanced Practice Registered Nurse (APRN) found in the progress notes to explain why the dosage was increased. On 04/13/23 at 2:39 PM, queried the Social Services Director (SSD) as to why there were no psychiatry notes in R11's chart. SSD stated that the psychiatry office did not want to release them to the facility. On 04/13/23 at 4:02 PM reviewed R11's psychiatry notes that were requested from the psychiatry office on behalf of the state agency (SA). Psychiatry notes on 04/06/23 revealed that R11 was feeling more depressed during the week because he was missing his cats and remembered that April 1st was their birthday. On 04/14/23 at 08:32 AM, interview was done with the APRN. She stated that R11's trazadone was increased because he was experiencing more depressive symptoms at the beginning of this month. APRN does not know what happened to the progress note she documented in the	F 740	performance and promote participation " ROI processes □ facility implemented best effort approach in attempts to acquire timely requisition of provider visit notes and ensure follow-up on recommendations and timely updates and implementation of care plan. Attending provider also to notify nursing of updates and notifications received from outside behavioral health providers to further assist with records requisition process. How the nursing facility will identify other residents having the potential to be affected by the same deficient practice: All resident(s) have the potential to be affected by this deficiency. Other residents receiving behavioral health services were reviewed to ensure current visit notes are present in the medical record with follow-up completed as indicated and necessary according to the plan of care, care plans were also reviewed and updated to include interventions to manage depression. Measures the nursing facility will put into place or systemic changes made to ensure the deficient practice will not recur: Licensed Nurses and Social Services Designee educated that residents are to be provided the necessary behavioral health care and services to attain or maintain their highest practicable physical, mental, and psychological well-being, including recognizing depressive symptoms and providing	

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F 740	Continued From page 18 electronic health record (EHR) so all staff may not be aware of R11's current state. On 04/14/23 at 09:45 AM, SSD was interviewed. SSD stated that if she knew the outcome of R11's psychiatry visits, SSD would have followed up with him frequently. SSD stated that R11 was currently on an outing to the pet store to pick up parakeets for him to look after.	F 740	non-pharmacological interventions to help alleviate residents with depression, in accordance with their plan of care. How the facility will monitor its performance to ensure that solutions are sustained, plan for ensuring the corrective actions are achieved and sustained, how the facility will evaluate for its effectiveness and is integrated into the quality assurance system: DNS and/or Designee will audit weekly x 4 weeks then monthly x 2 months to ensure resident(s) are being provided necessary behavioral health care and services. Results of the audits will be reviewed by the DNS/designee, any issues identified will be addressed and corrected and will be reported to monthly QAPI committee x 2 months for further review and recommendation. The title of the person responsible to ensure correction: DNS/designee will be responsible for ongoing compliance. Dates when corrective action will be completed: Compliance will be met by May 29th, 2023 and on an ongoing basis.	
F 790 SS=E	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services.	F 790		5/29/23

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F 790	Continued From page 19 The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) 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 location; and §483.55(a)(5) 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. This REQUIREMENT is not met as evidenced by:	F 790		

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F 790	Continued From page 20 Based on interviews and record review, the facility failed to provide assistance in obtaining routine dental care for 2 out of 6 sampled residents (R) R16 and R20. Findings include: Interview was done on 04/12/23 at 10:11 AM with R16. R16 stated that she has not seen a dentist. Interview was done with R20 on 04/12/23 at 10:47 AM. Queried R20 if a dental exam had been done. R20 was not able to answer this question. Record Review(RR) on 04/12/23 at 2:00 PM revealed no order for a routine dental exams for R16 and R20. Interview was done on 04/12/23 at 2:48 PM with nurse manager (NM) on the unit. NM stated that seeing a dentist is on an as needed basis and if they come to us or let us know, we make arrangements with their dentist or find someone. We attack it at a holistic approach. If they complain of pain or they want to see someone, we make arrangements. This deficient practice can affect all the residents in the facility for routine dental services.	F 790	F790 □ Routine Dental Services CFR(s): 483.55(a)(1)-(5) How the corrective action will be accomplished for residents affected by the deficient practice: Resident (R16) and (R20) had the potential to be affected by this deficiency. Per facility chart review, Resident (R16) had a dental visit including procedure done this year on 3/20/2023. Residents reviewed did not have any dental concerns at the time of deficiency. How the nursing facility will identify other residents having the potential to be affected by the same deficient practice: All resident(s) have the potential to be affected by this deficiency. Other residents reviewed, residents continue to have oral assessments completed on a regular basis, dental concerns identified during assessment or as reported were assisted to obtain routine dental services to the extent covered under the State Plan. Measures the nursing facility will put into place or systemic changes made to ensure the deficient practice will not recur: Staff were educated to ensure that residents are provided assistance in obtaining routine dental care to the extent covered under the State Plan, to ensure the facility provides the assistance needed	

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F 790	Continued From page 21	F 790	or requested to obtain these services per facility processes and procedures. How the facility will monitor its performance to ensure that solutions are sustained, plan for ensuring the corrective actions are achieved and sustained, how the facility will evaluate for its effectiveness and is integrated into the quality assurance system: Executive Director/DNS and/or Designee will audit weekly audits x 4 weeks then monthly x 2 months in order to ensure assistance is provided to obtain routine dental services. Results of the audits will be reviewed by the Executive Director, DNS/designee, any issues identified will be addressed and corrected and will be reported to monthly QAPI committee x 2 months for further review and recommendation. The title of the person responsible to ensure correction: Executive Director/DNS and/or designee will be responsible for ongoing compliance. Dates when corrective action will be completed: Compliance will be met by May 29th, 2023 and on an ongoing basis.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		5/29/23

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F 880	Continued From page 22	F 880		

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions 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

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F 880	Continued From page 23 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a safe and sanitary environment which would help prevent the development and transmission of communicable disease and infections. Findings include: Observation was made on 04/11/23 at 9:54 AM of med passing at the nursing station and TV activity area. Observation was made of staff nurse 2 (SN)2 passing meds. SN2 was not using hand sanitizer (HS) between rooms when passing	F 880	F880 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) How the corrective action will be accomplished for residents affected by the deficient practice: Resident (R7) had the potential to be affected by this deficiency. Re-education and inservice on appropriate infection control practices were implemented immediately to correct.	

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F 880	Continued From page 24 meds on a nursing unit. SN2 also was pouring medications into bare hands and then into a cup. SN2 went to nursing station and opened cupboards to grab meds at nursing station, then walked to front door to grab a gown and then went back to isolation cart to gown up before entering room. Outside of the room 1A, SN2 gowned up, applied gloves without hand sanitizing, walked into room with medications she obtained initially. All this activity without handwashing or hand sanitization. Observation on 04/11/23 at 10:08 AM was done of SN2. SN2 was observed leaving Room 1A and doffing occurred outside of the room. SN2 then cleaned with hand sanitizer (HS) Observation was made on 04/11/23 at 10:44 AM. SN2 entered the resident's room with the blood pressure machine. SN2 did not HS hands or blood pressure machine. Observation was made on 04/11/23 at 10:50 AM of SN2. SN2 grabbed gloves without HS and entered room. When SN2 came out of room and did not HS. SN2 cleaned the blood pressure machine. Record review (RR) was done on 04/13/23 at 10:00 of policy of hand hygiene (HH). According to HH policy, 5th paragraph states Hand hygiene: Either soap and Water or alcohol-based hand rub: . When coming on duty . Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice) . Before and after performing any invasive procedure (finger sticks)	F 880	SN2 received 1:1 education and disciplinary counseling on infection control and prevention practices, including appropriate hand hygiene, medication handling process, equipment cleaning, and proper PPE use. How the nursing facility will identify other residents having the potential to be affected by the same deficient practice: All resident(s) have the potential to be affected by this deficiency. Measures the nursing facility will put into place or systemic changes made to ensure the deficient practice will not recur: Staff were re-educated on proper infection control practices according to professional standards in accordance with CDC and CMS guidelines and the facility□s infection control protocols. Hand hygiene, including hand washing and PPE use and competency training provided to provide a safe and sanitary environment to help prevent the development and transmission of communicable disease and infection. Additional corrective action(s) will be completed to ensure/maintain a safe and sanitary environment: " Facility further increased the amount of mounted hand sanitizer and soap dispensers for appropriate point of care access for use per IP protocols.	

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	125061	A. BUILDING _____ B. WING _____	04/14/2023

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F 880	Continued From page 25 . Before and after entering an isolation precaution area. . Before and after assisting a resident with personal care (e.g., oral care, bathing) . Upon and after coming in contact with a resident's skin (vitals, lifting) . After blowing or wiping nose . After removing gloves or aprons . After handling soiled equipment or utensils. On 04/13/23 at 1:30 PM, interview was done with Nurse Manager (NM). Observations were discussed with NM regarding hand sanitizing, hand washing, doffing, hand sanitizing and glove removal and observations. Nurse manager acknowledged that this is not best practice. This deficient practice can affect all the residents in the facility and can lead to poor outcomes with infection control spread and outbreaks.	F 880	How the facility will monitor its performance to ensure that solutions are sustained, plan for ensuring the corrective actions are achieved and sustained, how the facility will evaluate for its effectiveness and is integrated into the quality assurance system: DNS and/or Designee will audit for compliance to ensure infection prevention and control protocols are sustained with daily and weekly audits x 4 weeks then monthly x 2 months in order to ensure a safe and sanitary environment. Results of the audits will be reviewed by the Executive Director, DNS/designee, any issues identified will be addressed and corrected and will be reported to monthly QAPI committee x 2 months for further review and recommendation. The title of the person responsible to ensure correction: Executive Director/DNS and/or designee will be responsible for ongoing compliance. Dates when corrective action will be completed: Compliance will be met by May 29th, 2023 and on an ongoing basis.	
F 885 SS=E	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must—	F 885		5/29/23

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F 885	Continued From page 26 §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to inform all residents, their representatives, and families of those residing in the facility by 5:00 PM the next calendar day of a confirmed case of COVID-19 as required by regulation. Findings include: A review of the facility staff COVID-19 testing records showed a positive case on 03/20/23. During staff interview on 04/14/23 at 08:55 AM, the Infection Preventionist acknowledged that not	F 885	F885 Reporting-Residents, Representatives & Families CFR(s): 483.80(g)(3)(i)-(iii) How the corrective action will be accomplished for residents affected by the deficient practice: No specific resident(s) were identified. How the nursing facility will identify other residents having the potential to be affected by the same deficient practice:	

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F 885	Continued From page 27 all residents, their representatives, and resident families were notified of the confirmed case of COVID-19 by 5:00 PM the next calendar day as required by regulation.	F 885	All resident(s) have the potential to be affected by this deficiency. Measures the nursing facility will put into place or systemic changes made to ensure the deficient practice will not recur: IDT were educated on the requirements to provide written notification to all residents, their representatives, and families of those residing in the facility by 5:00 PM the next calendar day in accordance with covid-19 reporting regulations. How the facility will monitor its performance to ensure that solutions are sustained, plan for ensuring the corrective actions are achieved and sustained, how the facility will evaluate for its effectiveness and is integrated into the quality assurance system: Executive Director/designee will audit weekly x 4 weeks then monthly x 2 months to ensure timely notification per covid-19 reporting regulations. Results of the audits will be reviewed by the Executive Director/designee, any issues identified will be addressed and corrected and will be reported to monthly QAPI committee x 2 months for further review and recommendation. The title of the person responsible to ensure correction: Executive Director/designee will be responsible for ongoing compliance.	

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F 885	Continued From page 28	F 885	Dates when corrective action will be completed: Compliance will be met by May 29th, 2023 and on an ongoing basis.	