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F 000	INITIAL COMMENTS A Recertification survey was conducted by the Office of Healthcare Assurance on February 11, 2025. The facility was found not to be in substantial compliance with 42 CFR §483 subpart B. No deficiencies were cited related to intakes #10916; 10920; 10928; 11427;11436; and 11461. Survey dates: 02/04/25 to 02/11/25. Survey census: 227 residents. Sample size: 35 residents.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.	F 553		

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

Electronically Signed

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

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F 553	Continued From page 1 §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure the resident's right to participate in the quarterly care planning process and development of the resident's person-centered plan of care for one Resident (R) 5 of four residents sampled for care planning. The deficient practice caused the resident to have discomfort. Findings include: Cross reference to F561: Self Determination and F825: Specialized Rehab Services. During an interview on 02/05/25 at 09:24 AM, with R5 and R5's Family Member (FM)44. Asked R5 and FM44 if they had been invited to and/or participated in a quarterly care planning meeting regarding the resident's treatment plan with the Interdisciplinary Team (IDT). R5 and FM44 confirmed they have not attended or been invited to a care plan (CP) meeting regarding the resident's treatment with the IDT. Inquired if there were any concerns regarding the resident's treatment or concerns in general. FM44 reported several concerns: staff do not shower R5 at the resident's preferred time, some staff position the	F 553		

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resident with the head of the bed below the resident's feet while sleeping which is uncomfortable to the resident, R5's roommates often have their television (TV) on late at night or at a loud volume which disrupts her sleep, the resident has been found by FM44 wearing clothes which are not the resident's but have the resident's name written on the garments, and the resident is supposed to be having a Physical Therapy (PT) assessment, but it's been a couple of weeks and no PT staff have assessed R5 or start the therapy. Asked R5 and FM44 if they would attend the care plan meeting if they were invited, and both confirmed they would attend and participate in the meeting.

On 02/06/25 at 02:13 PM, conducted a review of R5's Electronic Health Record (EHR). Review of R5's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/15/24, Section C. Cognitive Patterns documented a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident's cognition is intact. Review of R5's Plan of Care (POC) progress notes documented on 11/22/24 at 05:32 PM, "...Resident and (FM44) keep updated with plan of care." The POC progress note did not identify that R5 and FM44 were included, attended, or contributed to the care plan meeting or the resident's POC.

During an interview with Social Worker (SW)2 on 02/07/25 at 10:09 AM, inquired if R5's EHR contained documentation that R5 and FM44 were invited to or attended the resident's quarterly care plan meeting in November of 2024. SW2 reviewed R5's EHR and could not find documentation that R5 was invited to or attended the resident's IDT care plan meeting. SW2

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F 553	Continued From page 3 reported having personal notes regarding R5's CP meeting. SW2 was provided an opportunity to provide additional documentation. At approximately 01:10 PM, the surveyor followed-up with SW2 in the staff's office. SW2 confirmed an invitation to attend the care plan meeting in November of 2024 was not sent out to R5 and/or FM44. R5 and FM44 did not attend the meeting. Review of the facility's policy and procedure, Comprehensive Care Plans and Revisions, documented "The facility will ensure... that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care."	F 553		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact	F 561		

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with members of the community and participate in community activities both inside and outside the facility.

§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on interviews and record review, the facility failed to ensure the resident's right to make choices about aspects of his/her life in the facility that are significant to the resident for one (Resident(R) 5) resident sampled for choices. The deficient practice caused the resident pain and anxiety.

Findings include:

Cross reference to F656- Care Planning.

On 02/05/25 at 09:53 AM, during an interview with R5 and R5's Family Member (FM)44, inquired if the resident and FM44 can make choices about the resident's daily life and care which are important to the resident preference(s)/choice(s). R5 and FM44 agreed that the resident's wishes are not always honored. They were asked to provide specific information regarding incidents. R5 and FM44 revealed several incidents which included:

1) The resident prefers and wants to be showered after breakfast around 09:00 AM to 09:30 AM. R5 reported being asleep when staff woke the resident up by taking off the resident's incontinent brief. R5 explained, "I was asleep, and was

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woken up by staff messing with my brief. I was confused, why staff would be changing my brief. Next thing I know, I'm in the shower. I didn't know what was going on. I normally have a shower at 09:30 AM, not at 06:00 AM. I was really cold. I did not understand why staff was showering me so early." FM44 confirmed being in the facility at 06:45 AM and R5 was not in his/her assigned room. When FM44 asked staff where R5 was, staff reported the resident was in the shower. R5 and FM44 reported this is not the first time the resident was showered before 07:00 AM.

Reviewed R5's Electronic Health Record (EHR) on 02/06/25 at 02:13 PM, review of Activity of Daily Living (ADLs) task list documented R5's shower days are on Wednesday and Saturday (DAY) Question 3- Type of Bath, shower was documented at 08:47 AM. Review of R5's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/15/24, Section C. Cognitive Patterns documented a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident's cognition is intact.

During an interview with the Director of Nursing (DON) on 02/07/25 at 11:06 AM, inquired if the time reflected in the ADL task list (08:47 AM) was the time the resident was actually showered, or the time staff documented the task as completed. DON confirmed the time documented in the ADL task list is the time staff documented the shower and not the actual time of the shower and the resident should be showered at their preferred time.

2) FM44 reported the resident prefers to be dressed in his/her own clothing. However, R5's

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clothes have gone missing and R5 will be dressed in another resident's clothes. FM44 further stated that when he/she checked who's clothes the resident was wearing, it had R5's name written on the inside, but it was not the resident's clothes. FM44 reported since this happened, FM44 attempting to collect R5's clothes and wash the clothes at home before staff take the resident's clothes to be laundered. R5 reported that he/she prefers to wear the resident's own clothes and is concerned that another resident is missing their personal clothes.

On 02/11/25 at 09:34 AM, conducted an interview with Laundry Staff (LS)7. LS7 confirmed clothing coming down to the laundry room is not separated per resident. Laundry is washed in bulk and mixes with other resident clothes. The resident's name on the label identifies which resident the clothes belong to and will be delivered to that resident. LS7 reported CNA staff is responsible for identifying the resident's belongings. At 09:40 AM, conducted an interview with Certified Nurse Aide (CNA)23. CNA23 confirmed if the resident's name is on the clothes, that resident will receive that item.

3) R5 reported that while he/she is asleep, staff will change the position of the bed to where the Head of Bed (HOB) is below the resident's feet. R5 reported, "This makes all of the blood go to my head and it gives me a headache. When I fall asleep, my bed is not in that position, but when I wake up my feet are above the height of my head." FM44 confirmed there have been several mornings, including this morning, when he/she arrives at the facility at approximately 06:45 AM and observed the resident's HOB below the resident's feet. FM44 reported, R5 has voiced

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F 561	Continued From page 7 he/she does not know who or why staff placed the bed it that position, but R5 does not like it. During an interview with the Administrator and the DON on 02/07/25 at 11:06 AM, it was confirmed the resident's choices or preferences for significant aspects of the resident's life should be honored to the extent it does not interfere with care or is harmful to the resident or other residents.	F 561		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the	F 578		

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requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interview and review of policy on Advance Health Care Directives (AHCD), the facility failed to ensure that the code status was consistent with the AHCD for one Resident (R)148 of eight residents sampled and failed to falsey identify and assist in formulating an AHCD, if needed, for one (R5) of eight residents sampled. The deficient practice did not honor the residents end of life wishes.

Findings include:

1) Review of the Electronic Health Record (EHR) showed R148 was admitted on 12/13/24 with diagnosis including Knee Infection, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, and Liver Cirrhosis. A doctor's order, dated 12/13/24 read Full Code, Active which was not what R148 wanted according the AHCD.

Review of R148's Hawaii AHCD instructions for end of life decisions showed the following choice; to stop or withhold medical treatment that would

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F 578	Continued From page 9 prolong life. Review of R148's most recent AHCD, Provider Orders for Life-Sustaining Treatment (POLST) also showed the choice; No CPR, Do Not Attempt Resuscitation (DNAR). On 02/07/25 at 10:05 AM, Social Worker (SW)2 was queried about R148's current code status and acknowledged that it was not consistent with the AHCD. SW2 stated that they will follow up and make the necessary correction. A review of facility's policy on Advance Directives and Advance Care Planning read; Policy, residents have the right to self-determination regarding their medical care. This includes the right of an individual to direct his or her own medical treatment, including the right to execute or refuse to execute an advance directive. Community education and awareness efforts per the Patient Self-determination Act and state-specific laws on advance directives will be coordinated by the Social Services Director, using brochures in the facility lobby, public speaking, the Family Council, and health fairs ... Procedure ... The resident and/or family upon admission to determine the need and knowledge relative to advance directives and advanced care planning ... If the resident has an advance directive, the social worker will request a copy of the directive so that it may become part of the medical record. Documentation of such directives are placed in the Social Services progress notes. The resident's attending physician is made aware of such, and the appropriate orders are incorporated into the resident's care plan ... 2) On 02/05/25 at 02:33 PM, conducted a review	F 578		

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F 578	Continued From page 10 of R5's EHR which did not contain documentation of the resident's AHCD. Requested a copy of R5's AHCD with the Administrator on 02/06/25. At 01:30 PM, the Administrator provided a document titled, "Durable General Power of Attorney (DPOA)" as documentation of R5's AHCD. Review of the DPOA document was for financial decisions and did not include healthcare decisions. On 02/07/25 at 10:09 AM, conducted a concurrent record review and interview with SW2 regarding R5's AHCD. SW2 read R5's DPOA and confirmed the document did not pertain to the resident's healthcare decisions, only financial decisions. SW2 reviewed R5's EHR and confirmed the facility did not contain a copy of R5's AHCD or attempt to assist the resident with formulating an AHCD.	F 578		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F 584		

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F 584	Continued From page 11 the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to ensure the residents rooms were clean, quiet and home-like, making it comfortable for four of 35 Resident's (R) 119, R45, R113, and R5 in the sample. The deficient practice created an uncomfortable living environment that doesn't feel pleasant for the residents. Findings include: 1) Observation on 02/04/25 at 12:50 PM in room 333. One resident in the A bed, R119 and the other resident in the C bed, R45 were dependent on staff and being assisted to eat their lunch. In	F 584		

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between both of their beds was a brown metal hospital bed frame without a mattress or any other coverings. There was a call device sitting on top of the frame. The bed frame was pushed over close to R119's bed, which created a cramped space for the resident. There was a large amount of space next to R45's bed. The empty bed did not look home-like, and out of place in the middle of the room.

Interview with R119 and two of her family members (FM) 1 and FM2 in her room on 02/07/25 at 12:15 PM. R119 was awake and alert. The surveyor, R119 and the FM's asked what happened to the mattress, and pointed to the bed. FM2 stated, its been like that for a while now, it looks ugly in here, she doesn't have very much room pointing at the area next to the right side of the bed.

Random observations were made by the surveyor on 02/05/25 to 02/11/25. The empty bed frame remained in the middle of the room in room 333.

Interview with Maintenance Director (MD) on 02/10/25 at 01:45 PM on the first-floor North unit. The surveyor asked the MD if maintenance takes care of the beds in the resident rooms. MD said that his department will repair them if they aren't working. The surveyor explained that the mattress in room 333 on the center bedframe in the middle of the room is missing and if he knew where the mattress was. The MD said that Central supply maintains the mattresses for the beds and that he didn't know where the mattress was, but he would find out and get back to the surveyor.

Interview with Registered Nurse (RN) 33 and

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F 584	Continued From page 13 Certified Nurse Aid (CNA) 43 on the Three North unit on 02/10/25 at 02:09 PM. The surveyor asked the RN and the CNA's if they knew where the mattress for the bedframe in room 333 is? They both said they weren't sure what happened to it, and RN33 said, they must have taken it out of the room, I recall that it wasn't an air mattress or a special mattress. Interview with the Central Supply Director (CSD) at the Central Supply department on the first floor on 02/11/25 at 08:17 AM. The surveyor asked the CSD if he knew what happened to the mattress in 333 and why it was taken off of the bed. The CSD stated, it was old, and we removed it, or it might have had an unused wing mattress. After further discussion with the surveyor, the CSD said that he thinks there may have been a plan to take the bed out of the room to make more room for the two residents in the A and C beds and may have just got left in the room. The CSD said he will take the frame out of the room. 2) On 02/05/25 at 09:58 AM, conducted an observation of R113 in the resident's room. Inspection of R113's formula pump observed dried formula on the front and bottom of the pump. Also, R113's call light was placed on top and across the resident's body, the call light cord was observed to have a caked film of brown dirt/dust on it which was in contact with the resident's bed. 3) During an interview with R5 and R5's Family Member (FM)44 on 02/05/25 at 09:53 AM, inquired if there are any issues with the environment. R5 and FM44 reported that the resident's roommate near the window will watch television (TV) late at night and it keeps the	F 584		

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F 584	Continued From page 14 resident up and/or wakes the resident up. R5 explained that resident likes to sleep in the day and is up more in the evening. Throughout the interview with R5 and FM44, the resident's roommate (R2) closest to the door randomly turned on his/her TV and the volume was extremely loud. Throughout the interview with R5 and FM44, R2 turned the TV off and on, at a loud volume 8 to 9 times. The volume was loud and made it difficult to hear R5 and FM44. On one occasion, the sudden loud sound from the TV made this surveyor jump, and R5 stated, "try and sleep through that." Any reasonable person would find the randomness and volume of the TV startling and difficult to rest through. R5 and FM44 reported that their home is peaceful and quiet.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		

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F 656	Continued From page 15 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 record review, staff interview and review of policy, the facility failed to develop and implement a care plan to monitor for possible adverse reaction to Epogen medication for one resident (Resident (R)135) on dialysis and failed to implement restorative care and Physical therapy (PT) for one resident (R5). As a result of this deficient practice, R135 is at risk for more than minimal physical harm related to an adverse reaction to Epogen and R5 experienced a decline in physical mobility.	F 656		

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F 656	Continued From page 16 Findings include: 1) Review of the Electronic Health Record (EHR) revealed that R135 was admitted on 08/27/24 with a diagnosis including End Stage Renal Disease, Diabetes, Asthma, and Spondylosis. The Dialysis Communication Records on 02/03/25 and 02/05/25 showed that R135 was given Epogen (a medication that is used to treat anemia for individuals with chronic kidney disease on dialysis by helping the body to create more red blood cells) at the dialysis center. A review of the most recent comprehensive care plan showed interventions related to dialysis but did not have any interventions to monitor for possible adverse reaction to Epogen. During staff interview on 02/07/25 at 01:45 PM, Director of Nursing (DON) acknowledged that there was no monitoring for possible adverse reaction to the Epogen medication that R135 receives during dialysis. DON stated that they would make the necessary change. Review of facility's policy on Comprehensive Care Plans and Revisions read policy; the facility will ensure the timeliness of each resident's person-centered, comprehensive care plan and to ensure the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care ... Procedure, the facility should monitor the resident over time to help identify changes in the resident condition that may warrant an update to the	F 656		

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F 656	Continued From page 17 person-centered plan of care. When these changes occur, the facility should review and update the plan of care to reflect the changes to care delivery ... 2) On 02/06/25 at 02:33 PM, conducted a review of R5's EHR. Review of services received by R5 documented the resident received PT from 08/15/24 to 08/28/24. A Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/29/24, Section GG. Functional abilities and Goals- Discharge (completed upon R5's discharge from PT) documented R5 was: A. Rolling left and right: Independent (resident completes the activity by themselves with no assistance from a helper) B. Sit to lying: Independent C. Lying to sitting on side of bed- Set-up or clean-up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) D. Sit to stand: Supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) E. Chair/bed-to -chair transfer: Supervision or touching assistance F. Toilet transfer: Supervision or touching assistance Review of a quarterly MDS with an ARD of 11/15/24 documented a decline in R5's physical functional abilities, Section GG.: A. Rolling left and right: Independent (resident completes the activity by themselves with no assistance from a helper) B. Sit to lying: declined to Dependent (helper	F 656		

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F 656	Continued From page 18 does ALL of the effort) C. Lying to sitting on side of bed- declined to Dependent D. Sit to stand: declined to substantial/maximal assistance (helper does MORE THAN HALF the effort, helper lifts or holds trunk or limbs and provides more than half the effort) E. Chair/bed-to -chair transfer: declined to substantial/maximal assistance F. Toilet transfer: declined to Dependent Review of R5's care plan did not include a goal to maintain R5's physical abilities achieved upon her discharge from PT on 08/28/24. On 02/07/25 at 11:06 AM, conducted a concurrent record review and interview with the DON and Administrator. DON confirmed the facility's restorative program was available for residents when R5 was discharged from PT services, but did not receive restorative services. On 02/10/25 at 11:31 AM, conducted a concurrent record review and interview with the Director of Restorative Services (DRS) and Restorative Staff (RS) 9. Inquired how are resident identified and/or referred to receive restorative services. DRS explained residents can be directly referred for physical therapy, from discussions with the interdisciplinary team (IDT), and/or referrals from the nurses on the floor. Inquired if R5 was referred to restorative services after completing physical therapy. DRS and RS9 confirmed R5 was not referred to receive restorative services from physical therapy, the IDT, or by nursing staff. DRS confirmed R5 would have been a good candidate for restorative service had the resident been identified or referred.	F 656		

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F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and review of policy, the facility failed to timely revise the comprehensive care plan (CP) for two Residents (R)135 and R211 of a sample of four. R135's CP was not revised to correctly reflect 1) The status of his advanced health care directive after a POLST (Physician Order for Life-Sustaining Treatment) was developed, 2) A	F 657		

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F 657	Continued From page 20	F 657		

new fall intervention was added, but an incorrect one was not deleted. In addition, R211's CP was not revised after her urinary tract infection was resolved. As a result of these deficiencies, there was increased risk that R135 would receive advanced care against his wishes, and may be more vulnerable for falls due to bed positioning. In addition, there was a potential not all staff knew if R211 had an active infection or not.

Findings include:

1) Review of the Electronic Health Record (EHR) revealed that R135 was admitted 10/06/2021. His medical diagnoses include hemiplegia and hemiparesis following a cerebral infarction (stroke) affecting his dominant right side, chronic obstructive pulmonary disease, hypertension, falling, Type 2 Diabetes Mellitus, difficulty walking and dysphasia.

R135's EHR included a POLST completed by his legally authorized representative dated 03/15/2024. The POLST said that CPR (cardiopulmonary resuscitation) should not be initiated and to provide "comfort-focused treatment" only. The active physician order was DNR (do not resuscitate) with comfort measures.

A review of R135's most recent comprehensive care plan included:
Focus (initiated 05/15/2024): "POLST: CPR. Full Treatment, Long-Term Artificial Nutrition with tube."
Interventions (initiated 10/19/2021) included:
- "... Verify presence of CPR on resident's chart (POLST)"
- "Verify presence of physician's order for CPR "

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F 657	Continued From page 21 On 02/06/2025 at approximately 10:30 AM, during an interview with the Social Services Assistant (SSA) in the conference room, he said it was the Social Services responsibility to ensure the advanced healthcare directive (AD) in the EHR, and to update the CP regarding status. At that time reviewed R135's EHR and he confirmed the information in the CP was not correct and did not reflect the current POLST or Physician order. Review of R135's progress notes revealed the following entries: 02/03/2025 at 06:40 PM: "found sitting upright on floor back side against night stand. ...Prior to fall, bed was in low position, then during fall, bed was in regular position. ..." 02/04/2025 at 11:07 AM: "Fall huddle held with IDT (interdisciplinary team) for fall of 2/3. Reviewed circumstances of the fall and interventions in place. ...Spoke with direct care giving staff. Note resident with history of adjusting his bed. Root causes of fall are: ...2. Resident adjusted his bed height. Team agrees with care plan updates. Place bed control by the foot of bed. ...Staff and CP updated." Reviewed the active CP, which included R135 was at risk for falls and had multiple interventions that included but not limited to: - Date initiated 09/22/2023 (page 20): "Please keep bed remote and TV remote in resident's easy reach." - Date initiated 02/03/2025 (page 21): "Place remote control by the FOB (foot of bed) or away from resident." Although the new intervention was added, the old one was not deleted. 2) R211 is a 79 year old female admitted to the	F 657		

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F 657	Continued From page 22 facility on 11/19/2024 after a hospitalization for urinary retention and a urinary tract infection (UTI). Her diagnoses included but not limited to advanced dementia, hypertension and osteoarthritis. Review of R211's active care plan (CP) revealed two entries regarding a urinary tract infection. The entries included: - Focus: Infection. "The resident has a Urinary Tract Infection." Date initiated was 11/19/2024. Interventions included but not limited to Enhanced Barrier Precautions and "Give antibiotic therapy as ordered." - Focus: "The resident is at risk for dehydration or potential fluid deficit r/t (related to) malnutrition, recent UTI, dementia, self-care deficit, and other comorbidities." Date initiated was not documented. Reviewed R211's hospital discharge summary dated 11/19/2024, which included "DC to lifecare today, continue IV Zosyn to complete 10 day course, end date 11/24/2024." Review of R211's medication orders revealed she was no longer on medications for a UTI. On 02/05/2025 at 08:30 AM, observed there were no signs posted by R211's room indicating she was on enhanced barrier precautions. On 02/10/2025 at approximately 02:15 PM, interviewed the Assistant Director of Nursing in the nurses station. At that time, she confirmed R211 did not have an active UTI and that the CP should have been updated to reflect her current status.	F 657		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI	F 690		

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F 690	Continued From page 23 CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	F 690		

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F 690	Continued From page 24 failed to ensure resident(s) with a catheter received appropriate treatment to prevent a urinary tract infection (UTI) for one of two residents (Resident (R)73) sampled. The deficient practice caused the resident pain and discomfort. Findings include: On 02/07/25 at 12:02 PM, observed R73 seated in a wheelchair in the hallway on the second floor, approximately 15 feet from the door. Asked R73 how the resident was doing and R73 responded, "I'm tired, I am exercising." At 12:14 PM, passed by R73 and observed Staff (S)1 with the resident and the resident's catheter tubing on the floor under the resident's wheelchair. Pointed out the catheter tubing on the ground to S1 and inquired with S1 if the resident's catheter should be in contact with the ground. S1 confirmed R73's catheter tubing should not be in contact with the ground.	F 690		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.	F 726		

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F 726	Continued From page 25 §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews, document and medical record review (RR), there was a delay in notifying the physician on one Resident's (R)102 change of condition of a sample of one. After R102 was assessed to have altered mental status (AMS) and did not respond to a sternal rub (painful stimuli to test consciousness level), it took between 40- 50 minutes to notify the physician. As a result of this deficient practice, there was a delay in transfer to identify the underlying cause which would determine if it was a life-threatening condition. Findings include: 1) R102 is a 73 year old male with a medical history that included but not limited to asthma, Type 2 diabetes with chronic kidney disease, metabolic encephalopathy, history of falling, dysphasia, difficult walking, and bipolar disorder.	F 726		

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R102 has a brief interview for mental status (BIMS) of 0 (severe cognitive impairment). He is able to make simple needs known, and is alert and verbal at baseline.

2) On 02/05/2025 at 09:00 AM observed R102 self ambulating in a wheelchair. He was pleasant, alert and interacting with staff.

3) Review of medical record revealed the following entries:
12/13/2024 effective date at 09:18 AM, Plan of Care Note: "Fall Huddle held with interdisciplinary team (IDT) for fall 12/12 at 2245. Reviewed circumstances of the fall, resident found on hands and knees and reported problem with putting shoes on and off. ...Root causes of the fall is decreased functional mobility. ..." After the fall, resident was placed on the protocol for neurological checks.

12/15/2024 effective date at 02:20 AM, Health Status Note entered by the Nurse Supervisor (NS): "called by charge nurse (CN) 10 @ 0200, as unable to arouse resident (R102). In to assess resident in bed. Able to grasp weakly with both hands x 1, ...non-responsive to wet wash cloth on face, repositioning, & sternal rub. ...Color is adequate. Pupils pinpoint with very slight reaction to light @ 1-2 mm. ..."

12/15/2024 effective date at 02:24 AM, Communication with family entered by the NS: "Sister ... called & updated change of condition. Unable to arouse resident, & pupils pinpoint with slight reaction to light. ... Per sister would like resident evaluated @ ...ER (emergency room).

12/15/2024 effective date at 02:30 AM,

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F 726	Continued From page 27 Communication with Physician entered by the NS: "Situation: Alternate MD...called @0230, regarding unresponsiveness since 0150." "Background: is diabetic, Fell on 12/12/24 & 12/13/24 without head injuries." "Assessment (RN)/Appearance (LPN): ... Sister is requesting eval @ ...ER" "Recommendations: New orders received to send to ...ER for eval & Tx (treatment) regarding AMS/ unresponsiveness." 12/15/2024 effective date at 02:50 AM, Health Status Note entered by the NS: "out with 911/rescue via gurney in guarded condition @ 250. ..." 12/15/2024 effective date at 02:50 AM, Health Status Note by RN10: "Resident on health status note for unwitnessed fall 12/12/2024. Next neuro assessment to be done at 01:40. At 0110 (01:10 AM) went into residents room, resident in bed with eyes closed. ...Difficulty waking up resident. Non verbal with occasional mumbling when calling his name and asking if wanting snack. PERRLA (pupils equal, round. reactive to light and accommodation) 2 mm pinpoint and sluggish with minimal reaction. Returned back 0140 for next neuro check, resident remained in bed with eyes closed. ...Continued to have difficulty in waking up with no respond [sic] to calling out of name, no response to sternal rub, weak to minimal hand grasp x 1 and no pedal pulses. ...Nurse supervisor contacted and informed. ... Family and MD contacted by nursing supervisor. Resident picked up by 911 and transferred to ...ER for further evaluation and treatment." 12/15/2024 effective date 06:49 AM, Health	F 726		

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F 726	Continued From page 28 Status Note by NS: "Called ER ...resident being admitted with Dx (diagnoses) AMS, Hypoglycemia (low blood sugar), & UTI (urinary tract infection)..." 4) On 02/10/25 at 09:27 AM, interview conducted with the Nursing Supervisor on the telephone. She said when the RN (Registered Nurse) first checked R102 that night, he had decreased responsiveness. When she went back to check him again, his responsiveness had further decreased. The NS went on to say R102 sometimes had behaviors where he would ignore the staff, not open eyes, not respond to their commands and "shuts down." She said this may have been the reason it "took us a bit of time to assess." The NS said prior to the interview, she had checked her phone, and confirmed the RN contacted her at 02:00 AM, and asked her to evaluate R102. She said after they couldn't get him fully aroused, the family and physician were notified. The NS said she had to take extra time to review R102's chart and familiarize herself with him, because she would be communicating his condition to the "weekend MD", who was not his primary physician and may not know R102's history. On 02/10/2025 at 09:41 AM, interviewed the Registered Nurse (RN10) assigned to R102 the night of 12/15/2024. She said when she first went to assess R102 in his room, "He was not his usual self, but that he does have behaviors of not responding to staff and not following commands." She went on to say "his vitals were stable, his behavior was not." RN10 explained she went to assess him again (30 minutes later) because it was time for his next scheduled neuro (neurological) assessment because he fell a few	F 726		

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F 726	Continued From page 29 days earlier. She said at that time, she did a sternal rub and in-depth neuro check and "he was not as alert," so she went to the office to ask the Supervisor to check him. RN10 went on to say they both went back to the room and the Supervisor did an assessment, checked his glucose and did another sternal rub. After that, the physician was contacted and 911 was called to transfer him to the hospital. 5) Reviewed the facility policy titled "Changes in Resident's Condition or Status," last reviewed 09/05/2024. The policy included: - "This facity will notify the resident, his/her primary care provider, and resident/resident representative of changes in the resident's condition or status." - The Federal Regulation "F580 483.10 (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with his or her authority, the resident representative(s) when there is - ...(B) A significant change in the resident's physical, mental, or psychosocial status (that is a deterioration in health, mental, or psychosocial status is either life-threatening conditions or clinical complications);" Reviewed the facility policy titled "Neurological Checks." last reviewed 09/05/2024. The policy included "... The nurse documents and reports any pertinent changes in the resident's neurological status immediately to the physician." Reviewed the "Facility Assessment Template" dated 06/24/2024. The facility assessment included "Part 5 - Training and Competencies, ...Competent support and care for our Resident Population and During Emergencies." One of the topics listed in this section was "Identification of	F 726		

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F 726	Continued From page 30 resident changes in condition, including medical issues appropriately, how to determine if symptoms represent problems in need of intervention, ..."	F 726		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on document review and interviews, the facility failed to provide evidence they conducted a performance review at least once every 12 months on three of three Certified Nursing Assistants (CNA)11, CNA12 and CNA13 sampled. Although the CNA's had documentation of education in 2024, there was no evidence any education was based on the outcome of a performance review. Findings include: 1) CNA 11's hire date was 04/12/1991. There was no evidence a performance evaluation had been completed at least once every 12 months. CNA11's "Personal In-service Record" for the year 2024 documented a total of 18.52 hours. The total hours included 8.77 hours labeled as "General Requirements," plus 9.75 hours of additional in-services. There was no evidence any education was based on the outcome of a	F 730		

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F 730	Continued From page 31 performance review. 2) CNA 12's hire date was 04/18/1994. There was no evidence a performance evaluation had been completed at least once every 12 months. CNA12's "Personal In-service Record" for the year 2024 documented a total of 23.52 hours. The total hours included 8.77 hours labeled as "General Requirements," plus 14.75 hours of additional in-services. There was no evidence any education was based on the outcome of a performance review. 3) CNA13's hire date was 08/02/1995. There was no evidence a performance evaluation had been completed at least once every 12 months. CNA13's "Personal In-service Record" for the year 2024 documented a total of 16.02 hours. The total hours included 8.77 hours labeled as "General Requirements," plus 7.25 hours of additional in-services. There was no evidence any education was based on the outcome of a performance review. 4) On 02/19/2025, the Administrator confirmed there were no performance evaluations located in CNA11, CNA12, or CNA13's employee files.	F 730		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		

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F 761	Continued From page 32 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and review of policy, the facility failed to follow up on an out-of-range temperature recording for one medication refrigerator out of one sampled. As a result of this deficiency, there was risk of decreasing the effectiveness for the stored medications. Findings include: During an observation of the Medication Refrigerator, on 02/07/25 at 08:15 AM, several medications were being stored under temperature control. Review of the refrigerator temperature log showed an out-of-range recording that was not followed up and not reported. Staff interview on 02/07/25 at 01:40 PM, Director of Nursing (DON) acknowledged the out-of-range	F 761		

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F 761	Continued From page 33 temperature recording and that follow up should be done. Review of facility policy on Storage of Medication read; Policy, Medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations, to keep their integrity and to support safe, effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel or staff members lawfully authorized to administer medications ... Procedures ... Medications requiring "refrigeration" or "temperatures between 2'C (36'F) and 8'C (46'F)" are kept in a refrigerator with a thermometer to allow temperature monitoring. Medications requiring storage "in a cool place" may be refrigerated unless otherwise directed on the label ... A temperature log or tracking mechanism is maintained to verify that temperature has remained within accepted limits ... Medication storage conditions are monitored on a regular basis as a random quality assurance ("QA") check. As problems are identified, recommendations are made for corrective action to be taken.	F 761		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(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.	F 842		

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F 842	Continued From page 34 §483.70(h) Medical records. §483.70(h)(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(h)(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(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(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	F 842		

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F 842	Continued From page 35 there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(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 interview and record review, the facility failed to document a bowel movement for one Resident (R) 115 of three residents sampled for bladder and bowel incontinence. AS a result of this deficient practice, R115 experienced physical pain and discomfort related to constipation. Findings include: Progress notes reviewed on 02/06/25. R115 is a 78-year-old female in Hospice care. Review of the task flowsheet noted that R115 had not had a Bowel Movement (BM) for the past three days. R115 is taking multiple pain medications that cause constipation. Task flowsheet for 02/2025 reviewed on 02/07/25. Review of the indicates R115 hasn't had a BM for four days. Medication Administration Record (MAR) reviewed. Resident has been given Sennokot twice daily for constipation and has an	F 842		

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as needed (PRN) order for an additional dose of Sennokot if no BM for two days. R119 also has a PRN order for a Dulcolax suppository (a rectal laxative) if there is no BM for three days. Neither of the PRN medications for constipation were signed as given between 02/03/25 to 02/07/25.

Physician orders for R119 reviewed on 02/07/25. R119 has the following laxatives ordered:
Senokot Oral Tablet 8.6-50 MG (Sennosides-Docusate Sodium)
Give 1 tablet by mouth two times a day for constipation.
-Order Date-
01/03/2025 1513

Senokot Tablet 8.6 MG (Sennosides)
Give 1 tablet by mouth as needed for no BM after 2nd.
day daily
-Order Date-
12/24/2024 0823

Dulcolax Suppository 10 MG (Bisacodyl)
Insert 10 mg rectally as needed for constipation daily if.
no BM after 3rd day
-Order Date-
12/24/2024 0823

Progress notes reviewed on 02/07/25 12:16 PM. R119 was not documented with a bowel movement between 02/04/25 and 02/07/25.

Interview with R115 and two of her family members in her room on 02/07/25 at 12:15 PM. R115 was awake and alert. The surveyor asked her how she was feeling and if she has had any trouble moving her bowels. The FM1 said that

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R115, had a big BM last night. R115 confirmed this to be true.

Interview with Licensed Nurse (LN) 25 on 02/07/25 at 01:05 PM in the hallway outside R115's room. The Surveyor asked her to show where the bowel movement is documented in R115's Electronic Health Record (EMR). LN25 opened the EMR screen to the task flowsheet. She looked at the flowsheet and said R115's last BM was on the third of February. The surveyor then asked her if there is a protocol or bowel regimen if a resident doesn't have a BM for more than two days. LN25 looked at R115's MAR and said R115 can get a suppository after three days, then she said yesterday I offered her a suppository, but she refused. The surveyor asked her where it would be documented in the EMR. LN25 said it would be documented here (in the MAR) and confirmed that it was not documented. The surveyor asked if she has another PRN for no BM after two days? The LPN stated that she gets prn Senna (laxative) for no BM after 2 days. The surveyor looked at the MAR with LN25 and confirmed that no prn laxatives were given after the resident didn't have a BM for two days. Now the Resident hasn't had a BM for four days. LN25 said when I give her the daily senna I also give her prune juice.

The surveyor explained that during a conversation with the Resident and her family earlier that the resident said she had a large BM the previous night. The LPN said she wasn't aware of this and said, oh they didn't chart it in the EMR. The Certified Nurse Aides (CNA)s are charting if the resident had a BM when they provide care for the resident. They must have forgot to chart it.

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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 §483.71 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:	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125040	A. BUILDING _____ B. WING _____	02/11/2025

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F 880	Continued From page 39 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, document and record review, one Certified Nursing Assistant (CNA) failed to follow enhanced barrier precautions (EBP) consistent with accepted standards of practice while assisting with a wound care dressing on one Resident (R) 58 of one wound care observed. As a result of this deficient practice, there was an increased risk of transmission of infection. Findings include:	F 880		

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F 880	Continued From page 40 R58 was admitted to the facility on 11/07/2024. His medical history included, but not limited to dementia, metabolic encephalopathy and atrial fibrillation. R58 was incontinent of bowel and bladder and had a stage 4 pressure ulcer on his coccyx. On 02/05/25 at 09:04 AM, observed a laminated sign outside R58's room that indicated he was on EBP's. There was a small storage container outside the room that contained personal protective equipment, including gowns, so they are readily available to staff. On entering the room, observed a Registered Nurse (RN) getting gloves out of the wall unit. She was noted to have a gown on and preparing to put a dressing on R58's coccyx wound. At that time, she said R58's dressing had accidentally come off, so she was replacing it. CNA10 was assisting by holding R58 on his side, so the RN could access the wound. The CNA had a mask and gloves on, but was not wearing a gown. Reviewed the facility policy titled "Enhanced Barrier Precautions" with revision date 06/12/2023. The policy included: - "The facility should use Enhanced Barrier Precautions (EBP) as an additional MDRO mitigation strategy for residents that meet the following criteria, during high contact resident care activities; ...2. Wounds, ...even if the resident is not known to be infected or colonized with a MDRO. ...a. Wounds generally include chronic wounds, ...Examples of chronic wounds include, but are not limited to, pressure ulcers, ..." - "Enhanced Barrier Precautions (EBP) - refer to an infection control intervention designed to reduce transmission of multidrug-resistant	F 880		

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F 880	Continued From page 41 organisms that employs targeted gown and glove use during high contact resident care activities." - "Multi-drug resistant organism (MDRO) - an umbrella term for bacteria and other microorganisms that are resistant to antibiotics and other drugs designed to kill them." - "High contact care activities - include dressing, bathing/showering, transferring, ... and wound care." On 02/10/2025 at 12:50 PM, interviewed CNA10 in the dining area on the third floor. Informed her of the observation that she did not have a gown on when she assisted the Registered Nurse replacing the dressing on R58's pressure ulcer. CNA10 said R58's dressing had come off accidentally, so she immediately went to find the nurse to put another one. She acknowledged when she returned to the room with the RN, she did not put on a gown. On 2/10/2025 at 01:15 PM, during an interview with the Assistant Director of Nursing, inquired what the expectation was for enhanced barrier precautions. She confirmed the staff in the room assisting with wound care should have gown and gloves on.	F 880		