

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125003	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Kula Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Keokea Place Kula, HI 96790	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47783 Based on interviews and record review, the facility failed to assure two residents (Resident (R) 27 and R46) were treated with dignity and respect and provided care in an environment that enhances their quality of life. This deficient practice has a negative effect on maintaining and enhancing both resident's self-esteem and self-worth and has the potential to cause psychosocial harm. Findings include: 1) On 06/03/24 at 11:33 AM, an interview was conducted with R27 in her room. R27 stated that the only concern she had with the facility was the long wait to get assistance from the staff. R27 said sometimes she waits for up to three hours to be changed when her incontinent pads are wet. R27 stated that there was an instance in the morning when she wanted to use the toilet, so she called for assistance using her call light. By the time someone came to assist her, she had already soiled her incontinence pads and the evening shift staff had to clean her as they were making change-of-shift rounds. On 06/05/24 at 01:51 PM, review of medical records for R27 was conducted. R27 is an [AGE] year-old resident first admitted to the facility on [DATE]. Review of current care plan with a review date of 03/01/24 stated R27 has, Functional mobility and self-care deficits r/t (related to) lower extremity weakness, morbid obesity, and osteoarthritis. Interventions included, TOILETING: Sit to stand lift assistance for commode transfers. I use briefs for B/B (bowel and bladder) incontinence . It is important to me to be assisted from bed to commode and then to the w/c (wheelchair). On 06/06/24 at 09:19 AM, a follow up interview was conducted with R27 in her room. Asked R27 if the long wait for assistance to go to the toilet still happens. R27 said it still does and said, I recently had to go in the bed. I'd rather go in the toilet, but I couldn't wait. When asked if she ever brought her concern to the nursing supervisor, R27 said, I did bring it to their attention but not much you can do if the staff are busy. 48351 2) Observation was conducted on 06/03/24 at 12:27 PM on the third-floor dining room. Hospital Aide (HA) 1 was heard stating, Who is the feeder? as she entered the dining room. One of the other staff members directed HA1 to R46. R46 was sitting in his wheelchair waiting for a staff member to assist him with eating his lunch. (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 125003	Facility ID: 125003 If continuation sheet Page 1 of 13

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview was conducted with HA1 on 06/03/24 at 12:30 PM. HA1 was asked if it was proper to call the facility residents feeders. HA1 apologized and stated that she should have said, who needs assistance? instead. A review of the facility document titled, Resident Rights, was conducted. The facility document noted, Dignity-The facility will treat you with dignity and respect in full recognition of your individuality.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48351 Based on interviews and record review, the facility failed to promote the participation for one of the sampled residents (R) 9 and her representative for the development and review of the resident's care plan. This failed practice has the potential to affect all the residents in the facility. Findings Include: R9 is a [AGE] year-old female admitted on [DATE]. Interview was conducted with R9 in her room on 06/04/24 at 08:33 AM. R9 stated that she has not attended a care conference meeting for months. She does recall having meetings in the past but does not recall having one this past year. R9 also added that if a notification was sent to her son, he would have been present at the conference. Record review was done of R9's medical records. Documentation was found on a care conference meeting that was held on 02/22/24. A list of the staff present for the meeting was noted in the document. No documentation was found on the presence of the resident or the resident's representative. On 06/05/24 at 09:24 AM Minimum Data Set Coordinator (MDSC) 1 assisted in searching for documentation that should have been sent out to R9's representative. MDSC1 stated that the normal process would be the social worker notifying the representative of the conference date and time. MDSC1 also added that the social worker will document on the resident's record of the representative's response to the invitation. MDSC1 was unable to find documentation that R9's representative was notified of the care conference held on 02/22/24. On 06/05/24 at 11:58 AM Director of Nursing (DON) confirmed that documentation could not be found that R9's representative was given notification of the care conference held on 02/22/24. A review was conducted of the facility document titled, [NAME] Hospital IDT Process. The document noted, Social Service to invite residents on the schedule for IDT Care Plan Conference. Please document resident's response if they accept or refuse invitation.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47783 Based on observations, record review and interviews, the facility failed to ensure interventions to prevent or improve pressure ulcers or injuries were implemented for one of the three residents (Resident (R) 50) sampled. Staff did not ensure R50's left heel was offloaded and documented in the medical record every shift. This deficient practice has the potential to affect all residents that are dependent on staff for repositioning in bed. Findings include: On 06/03/24 at 11:05 AM, observed R50 in bed while Registered Nurse (RN) 2 was providing care. R50 had contractures to both lower extremities and was using an air mattress. RN2 stated that R50 still had a wound to his left heel but the pressure ulcer on his coccyx was already healed. On 06/05/24 at 08:30 AM, observed R50 lying in bed with head elevated and turned slightly to his right side. At 10:05 AM, review of medical records for R50 conducted. R50 was admitted to the facility on [DATE]. Diagnosis included osteomyelitis (inflammation of the bone caused by infection) to left foot and colon cancer. Further review revealed that a significant change assessment was completed on 07/24/23 due to the development of a left heel pressure injury. On 11/16/23, progress notes stated the left heel pressure injury was resolved, however it reopened on 12/04/24. Interventions in the care plan also stated to check and reposition the resident at least every two hours and to make sure feet/heels are floated at all times. Asked RN2 where the staff documented to ensure R50 is being turned every two hours and left foot is floated. RN2 said the every-two hours turning should be in the daily logs completed by the hospital aides and the floating of the feet/heels should be in the Treatment Administration Record (TAR). Reviewed TAR that was in the medical record for March, April, and May 2024 with RN2 and Nursing Supervisor (NS) 1. For March and April 2024, only the day shift staff were completing the log with three and nine missed entries respectively. For May 2024, night shift, day shift and evening shift staff completed the logs but had a total of 30 missed entries. NS1 confirmed that the expectation from the staff was to complete the log every shift to document that they were floating R50's feet/heel. NS1 stated, Staff should document it if they did it.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47783 Based on observations and staff interview, the facility failed to secure storage rooms located on the second and fourth floors where hazardous chemicals were kept. As a result of this deficient practice, the residents of the facility were placed at risk for accident hazards. 1) On 06/05/24 at 01:06 PM, observed the door to the clean utility room on the second floor was not locked. On the wall outside the clean utility room door was a small keypad lock container. Asked Registered Nurse (RN) 1 what was being kept in the room. RN3 said they keep some of the enteral feeding supplies and nourishments for the residents in the room. Inspected contents of the cabinets with RN3. An opened container of liquid bleach and liquid dish soap were found in one of the cabinets. RN3 notified Nurse Supervisor (NS) 1 who checked the small keypad lock container outside the clean utility room. NS1 said they usually keep the keys to the door in there, but no keys were found when she opened it. NS1 confirmed that the door to the clean utility room was supposed to be locked since they also had hazardous chemicals in there. On 06/06/24 at 10:30 AM, an interview was conducted with the Director of Nursing (DON) in the second-floor conference room. DON confirmed that all hazardous chemicals need to be stored in a locked cabinet or room. 39754 2) During an observation on 06/03/24 at 11:15 AM, the Soiled Utility Room located on 4th floor nursing unit was not locked/secured and there was no staff in the immediate vicinity to prevent unauthorized entry to the room. The room contained a bottle of cleaning solution with a label that said, Caution, eye irritant, harmful if swallowed . On 06/03/24 at 11:20 AM, Charge Nurse (CN) 4, acknowledged that the Soiled Utility room should have been locked/secured and stated that they would immediately have it secured.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 43245 Based on observation, interview, and record review, the facility failed to ensure nurse competency in medication administration as evidenced by Registered Nurse (RN)5 administering a laxative/stool softener to Resident (R)36 despite documentation of a large loose bowel movement that morning. In addition, medications were not documented as administered in a timely manner. This deficient practice places residents at risk for avoidable declines in health status and has the potential to affect all residents at the facility receiving staff-administered medications. Findings include: On 06/05/24 at 08:08 AM, medication pass observations were done with Registered Nurse (RN)5 as she prepared and administered medications for Resident (R)36. RN5 prepared a total of thirteen oral medications for R36, one of which was Stimulant Laxative Plus [with stool softener]. The medications were administered at 08:15 AM. Review of R36's medical record revealed the following physician order from 10/03/23: Stimulant Laxative Plus Tablet, one tablet orally twice a day, *HOLD FOR LOOSE STOOL. On 06/05/24 at 08:18 AM, in front of the third-floor medication cart, asked RN5 when was R36's last bowel movement (BM). RN5 responded that she did not know. RN5 then proceeded to lead Surveyor to a large spreadsheet on the bathroom door in the employee break room listing the BMs of all the residents on the floor. Under the 5 column (for 06/05/24) and N row (for the shift that just got off that morning) for R36, was an L6. RN5 explained that meant before the night shift finished that morning, R36 had a large watery BM. Review of the documentation legend on the bottom of the spreadsheet revealed the following: Type 6 Watery, no solid pieces (entirely liquid). Asked RN5 if she checked the spreadsheet prior to giving medications. Initially, RN5 answered that she checks the spreadsheet daily before she passes medications. When asked why she administered a laxative to R36 when she had been documented as having a large, watery BM that morning, RN5 responded that she made a mistake, she does NOT check the spreadsheet before giving medications. RN5 stated that the Certified Nurse Aides (CNAs) are supposed to report it [BMs], but she received no report and so she gave the stimulant laxative plus. On 06/05/24 at 08:29 AM, an interview was done with Charge Nurse (CN)1 at the third-floor nurses' station. When asked what the process is for documenting and reporting off BMs, CN1 stated that the CNAs should let the nurse know immediately if there are loose BMs, then they should document it in the ADL [activities of daily living] book, and on the Master List [spreadsheet on the bathroom door]. When asked what the expectation is as far as who should be looking at the spreadsheet and when, CN1 agreed that the nurses should be checking the spreadsheet before giving any laxative medications. Review of the Medication Administration policy, last revised 07/2021, revealed the following: Medications are administered as prescribed. (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/05/24 at 08:39 AM, while RN5 was off administering medications to a different resident, a reconciliation review of R36's Medication Administration Record (MAR) with the medication pass observations was done. During the review, noted that none of the thirteen medications given to R36 that morning had been documented as administered yet. In addition, the Stimulant Laxative Plus was also not signed off as administered the previous morning either. At 08:41 AM, an interview was done with RN5 in front of the medication cart. When asked when she signs off on the MAR that medications were administered, RN5 reported that after she has given all medications due to all the residents, then she goes back to their MARs and signs off on all of them at the same time. RN5 acknowledged that she did not sign off on the Stimulant Laxative Plus the previous day, stating, I missed it. RN5 confirmed that she did administer the medication but forgot to document that. On 06/05/24 at 08:43 AM, interviewed CN1 at the nurses' station again. When asked about the process of signing off on the MAR, CN1 stated that nurses should be documenting medications as administered on the MAR immediately after administration. If held or refused, nurses should document an empty circle in the space where they would normally put their initials. Then they would document the reason the medication was held or refused on the back of the MAR. Review of the Medication Administration Record policy, last revised 07/2023, revealed the following: All medications administered to the patient shall be recorded on the Medication Administration Record promptly after they are given.		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 43245 Based on interview and record review, the facility failed to provide a Director of Nursing (DON) on a full-time basis. The same staff member covers the long-term care (LTC), the Critical Access Hospital (CAH), and the Intermediate Care Facility for the Intellectually Disabled (ICF/IID) facilities as the DON. Findings include: On 06/03/24 at 11:04 AM, an entrance interview for the Critical Access Hospital (CAH) recertification was done in the first-floor conference room with the DON and the Administrator. The DON confirmed that she was employed full-time, and was the DON for the CAH, the LTC facility, and the ICF/IID facility, each with their own facility-specific certification and licensing requirements. The DON and Administrator confirmed that they did not have a waiver for a full-time DON. A review of the Office of Health Care Assurance (OHCA) Licensed Beds and Location form noted that as of 06/03/24, there were 9 beds (4 occupied) in the CAH, 105 beds (89 occupied) in the LTC facility, and 9 beds (all occupied) in the ICF/IID facility.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47783 Based on record review and interviews, the facility failed to ensure adequate monitoring was done for one resident (Resident (R) 27) sampled for anticoagulant (medication to treat and prevent blood clots) use. The facility was not documenting if R27 was being monitored for signs and symptoms of bleeding. As a result of this deficient practice, R27 was put at risk for avoidable adverse health complications related to her health condition and the use of anticoagulants. This has the potential to affect all residents in the facility taking anticoagulants. Findings include: R27 is an [AGE] year-old resident first admitted to the facility on [DATE]. Diagnosis included but not limited to atrial fibrillation (irregular heart rhythm that can lead to blood clots increasing the risk of stroke). Record review revealed that R27 was on Apixaban (anticoagulant) 5 mg (milligrams) twice a day. Interventions noted in plan of care dated 01/16/24 stated, . Assess/record/report signs of bleeding problems to MD (medical doctor) . Please monitor me for possible side effects on Eliquis (Apixaban) TX (treatment) (see attached) . The document that was attached to the plan of care was titled Patient Education and stated. side effects . Signs of bleeding like throwing up or coughing up blood; vomit that looks like coffee grounds; blood in the urine; black, red, or tarry stools; bleeding from the gums; abnormal vaginal bleeding; bruises without a cause or that get bigger; or bleeding you can not stop. Documentation of staff monitoring for the signs and symptoms of bleeding was not found in the in R27's chart. On 06/05/24 at 01:51 PM, a concurrent interview and record review was conducted with Registered Nurse (RN) 2 and Nurse Supervisor (NS) 1 at the second-floor nurses' station. Asked RN2 how often do they monitor R27 for signs and symptoms of bleeding. RN2 responded, Every shift. When asked where do the staff document it, RN2 said, It should be in the MAR (medication administration record). RN2 opened R27's chart and looked in the section where the MARs were kept but was not able to locate documentation of monitoring. NS1 said to also look in the progress notes but when RN2 checked, no documentation was found. NS1 added that they will get an order for the monitoring of signs and symptoms of bleeding so it will be transcribed onto the MAR, that way it will remind the nurses to document it when it is done. On 06/06/24 at 10:30 AM, an interview was conducted with the Director of Nursing (DON) in the second-floor conference room. DON confirmed that the monitoring for signs and symptoms of bleeding for R27 should have been documented in the MAR every shift.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards for food service safety. Residents (R) risk serious complications from foodborne illness as a result of their compromised health status. Unsafe and/or unsanitary food storage/handling practices represent a potential source of pathogen exposure for all residents at the facility who consume food or drink prepared at the facility. Findings include: 1) On [DATE] at 10:00 AM, while conducting an initial tour of the kitchen with the Food Service Manager (FSM), observed a standing freezer next to the ice machine containing a small metal pan of approximately ten (10) poorly covered beef patties. The metal pan had been covered with plastic wrap that was not sticking to the pan, labeled Beef [DATE], and the beef patties within were visibly freezer burned (discolored in appearance and covered in ice crystals). The FSM acknowledged the patties were not stored properly, explaining that they should have been either individually bagged in plastic bags, or individually wrapped in plastic wrap. The FSM confirmed that the patties were intended for resident consumption, but since the improper storage compromised the integrity and quality of the patties, the FSM removed them from the freezer for disposal. 2) On [DATE] at 10:22 AM, observations were done with the FSM in the walk-in refrigerator. On the bottom shelf normally reserved for raw meats, observed a large metal pan of sweet yams dated [DATE]. Directly next to the sweet yams was a large metal pan of raw meat that was completely thawed. Both metal pans were loosely covered with plastic wrap. On the shelf directly above the sweet yams was a small metal pan of pureed sausage. When asked about the sweet yams, the FSM stated he would like to see only meats on the bottom [shelf], but I'm OK with it because it's only . sausage above it. Review of the facility's Food Storage policy, last revised ,d+[DATE], revealed the following: Raw meats will be stored separately, and when thawing in drip proof containers, and stored in a manner to prevent cross contamination, below fruits, vegetables, and ready to eat foods. On [DATE] at 01:40 PM, an interview was done with the FSM in the first-floor Conference Room. The FSM stated that the yams were taken straight from the can, placed in the metal pan, and refrigerated. The FSM continued explaining that the yams would be reheated before serving, so were OK to be stored next to a pan of raw meat since they were both in non-drip pans. After further discussion, the FSM acknowledged that the yams were fully cooked straight out of the can, did not require reheating to be safely consumed, and therefore met the definition of a ready to eat food. 48351 (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3) Observation was conducted on the third-floor nutrition room on [DATE] at 09:04 AM. The fridge contained a strawberry banana flavored yogurt labeled, best by [DATE]. The freezer contained an English muffin breakfast sandwich, removed from the box, without an expiration date. The freezer also contained a pineapple coconut ice cream labeled, best by [DATE]. Lastly, observation was made of an opened package of pizza rolls labeled, Best if used by [DATE]. An interview was conducted with Charge Nurse (CN) 1 on the third-floor nutrition room on [DATE] at 09:12 AM. CN1 stated that the nursing staff usually checks the fridge/freezer for expired food items. CN1 agreed that the four food items observed in the fridge/freezer should have been discarded because they were either unlabeled with an expiration date or were already past the expiration date. A review of the facility's document titled, Food Brought to Residents by Family and Visitors, dated ,d+[DATE] was conducted. The document noted, All foods brought into the facility will be checked by a staff member and labeled and dated .Nursing will monitor the resident's room, unit pantry, and refrigeration units for expiration dates. 39754 4) Observation of the 4th floor small kitchen room on [DATE] at 11:30 AM, six packets of tea bags had use by [DATE] labeled. During staff interview on [DATE] at 11:35 AM, the Dietitian acknowledged that the six tea bags previously mentioned were expired and should have been discarded. Dietitian stated that they would immediately remove the expired items.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47783 Based on observation, interviews and record review, the facility failed to ensure the staff followed the proper use gloves and performed hand hygiene procedures during wound dressing change for Resident (R) 50. This deficient practice placed the residents at risk for the potential spread of infectious and communicable diseases. Findings include: On 06/04/24 at 02:52 PM, conducted an observation of Registered Nurse (RN) 3 changing the dressing of R50's left foot wound. RN3 gathered supplies from the treatment cart and placed them on R50's bedside table. RN3 then performed hand hygiene and donned a gown and gloves by the door before proceeding with the dressing change. After removing the old dressing to R50's left foot wound, RN3 discarded the old dressing and removed her gloves. Observed another pair of gloves were under the gloves RN3 just removed. RN3 then cleaned the wound with a gauze soaked with normal saline, dried it with a clean gauze and applied an ointment as ordered. RN3 then removed her gloves and donned a new pair without performing hand hygiene and applied a new dressing. After repositioning R50 in his bed, RN3 removed gown and gloves and washed her hands in the sink with soap and water. Asked RN3 if she was initially wearing two pairs of gloves on each hand when she removed the dressing. RN3 confirmed that she had two gloves on each hand. On 06/06/24 at 10:30 AM, an interview was conducted with the Infection Preventionist (IP) and Director of Nursing (DON) in the second-floor conference room. Asked IP if the facility allowed staff to wear two gloves on each hand when performing tasks like dressing changes. IP confirmed that the staff are supposed to just wear one glove in each hand and to also perform hand hygiene between glove changes. Asked IP and DON for the facility policy on dressing changes and hand hygiene, IP said they have one for hand hygiene but not for dressing change. IP said he will provide a copy of the guidelines the facility uses for dressing changes and the policy for hand hygiene. Review of document provided titled Wound Dressing Application stated, . Perform hand hygiene. put on gloves . Remove the old dressing . Discard the soiled dressing . Remove and discard your soiled gloves . Perform hand hygiene . Put on new gloves . Clean the wound . Remove and discard your soiled gloves . Perform hand hygiene . Put on new gloves . Pat the surrounding skin dry . Apply topical wound treatment . Apply the prescribed primary dressing.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125003	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Kula Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Keokea Place Kula, HI 96790	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 39754 Based on observation, staff interview, record review, and review of equipment service manual, the facility failed to follow routine maintenance cleaning of the cabinet filter, based on the manufacturer's recommendation. This deficient practice put one Resident (R) 8 at risk for the development and transmission of communicable diseases and infections. Findings include: During resident observation on 06/03/24 at 11:45 AM, R8 was receiving oxygen via a Perfecto2 V Oxygen Concentrator. The cabinet filter of that oxygen concentrator appeared to have lint and/or dirt on the cabinet filter. During staff query on 06/05/23 at 01:50 PM, Director of Nursing (DON) said that they clean the cabinet filter once a month. Informed DON that according to the service manual, for this equipment, the recommendation for cleaning is at least once a week. DON acknowledged and revealed that there was a previous change in oxygen concentrator equipment. Review of the Service manual for the Perfecto2 V Oxygen Concentrator, Section 6 - Preventive Maintenance read the following: Cleaning the cabinet filter. There is one cabinet filter located on the back of the cabinet. 1. Remove the filter and clean at least once a week depending on environmental conditions. Note: Environmental conditions that may require more frequent cleaning of the filters include but are not limited to; high dust, air pollutants, etc. 2. Clean the cabinet filter with a vacuum cleaner or wash in warm soapy water and rinse thoroughly. 3. Dry the filter thoroughly before reinstallation.		