

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/23/2024
NAME OF PROVIDER OR SUPPLIER Garden Isle Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3-3420 Kuhio Highway, Suite 300 Lihue, HI 96766	
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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38870</p> <p>Based on observation, staff interview and policy review, the facility failed to ensure the resident's right to a dignified existence and treat each resident with respect and dignity for (4) residents. Resident (R)35, R67, R30, R60 residents sampled.</p> <p>Findings include:</p> <p>1) R60 was admitted to the facility on [DATE] with diagnosis which includes cancer, aphasia (the loss of the ability to understand or express speech), seizure disorder, and malnutrition. Review of R60's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/28/24, Section C. Cognitive Patterns, R60's Brief Interview for Mental Status (BIMS) was 4, indicating R60's cognition is severely impaired. Section GG. Functional Abilities and Goals documented R60 has functional limitation in range of motion for the upper and lower extremities on one side, uses a wheelchair, and requires substantial assistance (helper does more than half the effort) for toileting hygiene. A significant change MDS with an ARD of 01/01/24 documented, Section C. Cognitive Patterns, R60's Brief Interview for Mental Status (BIMS) was 00, indicating the R60 was unable to complete the assessment. Section GG. Functional Abilities and Goals documented R60 was dependent (helper does all of the effort; resident does none of the effort to complete activity) for toileting. As a result of R60's significant change, the resident was placed on hospice.</p> <p>Multiple observations were made of R60's Family Member (FM)1 at the facility visiting with the resident for times greater than 1 hour on 02/20/24 at 10:42 AM, 02/21/24 at 10:10 AM, 02/22/24 at 12:13 PM, and 02/23/24 at 10:32 AM. Due to the extended amount of time FM1 spent in the facility with R60, was interviewed on 02/21/24 at 10:10 AM. FM1 reported having to go to the nursing station often to get more water and ice for the resident (due to staff not providing it regularly for the resident), but there is no staff at the nurse's station. FM1 stated, when I do find staff, they tell me to use the call light, but staff don't come to the room to answer the call light.</p> <p>On 02/23/24 at 10:32 AM, observed FM1 at the third-floor nurse's station, speaking loudly at staff, stating, No one changed my wife all morning, she can't wait till 01:00 PM. At 12:30 PM, conducted an interview with FM1 regarding the event observed at the third-floor nurse's station. FM1 reported being upset because no one cleaned R60 all morning, the resident's brief was soiled.</p> <p>39754</p> <p>(continued on next page)</p>		

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
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2) During an observation of the second floor Activities room on 02/20/24 at 11:20AM, R35 was calling out for attention saying, excuse me, excuse me. There were two staff members close by that did not immediately respond to R35's call for attention. R35 kept saying excuse me, excuse me three more times until staff said ok, hold on. After fifteen minutes past and R35 saying excuse me, excuse me another time, staff finally attended to R35's needs.</p> <p>During staff interview on 02/22/24 at 11:30AM, Activities Manager acknowledged that the close by staff members should have responded right away to R35. Activities Manager said that they would address this with the staff.</p> <p>Review of policy on Dignity and Respect read - Policy, it is the policy of this facility that all residents/guests be treated with kindness, dignity and respect. Procedure, 1. The staff will display respect for residents/guests when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings .</p> <p>42160</p> <p>3) On 02/20/24 at 11:20 AM, conducted an interview with R67. Inquired if the resident waits long for staff to respond to call lights. R67 reported the facility staff try their best to answer the call lights, but there just is not enough staff, especially if it's around a mealtime and staff are on break.</p> <p>While walking down the second-floor hallway on 02/20/24 at 02:05 PM, observed the call light was activated for room [ROOM NUMBER]. Entered the room and R30 requested for this surveyor to assist the resident back into bed, stating I've been in my wheelchair long enough, I need to lay down and rest for a bit. R30 was unable to independently transfer from the wheelchair to the bed. Inquired with R30 as to how long the resident had been waiting for staff to respond to the call light. R30 and R67 (share a room) both confirmed they have been waiting for over an hour for staff to help them and staff has not come to the room to check on why the residents activated the call light.</p> <p>On 02/23/24 at 11:53 AM, conducted a record review of R30's and R67's EHR. Review of R30's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/26/24 Section C. Cognitive Function, Brief Interview for Mental Status score was 15, indicating the resident is cognitively intact.</p> <p>Review of R67's admission MDS with an ARD of 01/24/24, Section C. BIMS score was 14 indicating the resident's cognition is intact. Review of Section GG. Functional Abilities and Goals: R67 is dependent on staff for toileting, showers, and dressing.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>42160</p> <p>Ensure each resident receives an accurate assessment.</p> <p>Based on interviews and record review, the facility failed to ensure the resident assessment accurately reflected the resident's status for one of three (Resident (R)71) sampled for closed records. R71 was coded on the discharge Minimum Data Set (MDS) as discharged to a short-term general hospital. Staff confirmed R71 was discharged home on 01/18/24.</p> <p>Findings include:</p> <p>On 02/21/23 at 03:10 PM, conducted a review of R71's Electronic Health Record (EHR). On 01/21/24 at 03:53 PM, Minimum Data Support Staff (MDSS)6 documented in a progress note, Resident remained on skilled services for rehab services until 1/17/24 and was discharge to home on 1/18/24. Review of R71's discharge MDS with an Assessment Reference Date (ARD) of 01/18/24 documented in Section A 2105. Discharge Status- 04. Short-Term General Hospital.</p> <p>On 02/22/24 at 03:28 PM, conducted a concurrent record review of R71's EHR and interview with MDSS6 and MDSS1. After reviewing R71's progress notes and discharge MDS (ARD 01/18/24), MDSS6 confirmed R71 was discharged home and the discharge MDS did not accurately reflect the resident's discharge status.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245</p> <p>Based on observation, interview, and record review, the facility failed to ensure there was an ongoing resident-centered activities program that met the resident's needs, for 1 of 3 residents (Resident 4) sampled for activities. Specifically, the facility failed to consistently act on the resident's need for social contact and sensory stimulation and failed to develop and/or implement a person-centered activities program that the resident found meaningful. As a result of this deficient practice, Resident (R)4 was placed at risk of experiencing a decline in his psychosocial well-being and comfort. This deficient practice has the potential to affect all residents at the facility.</p> <p>Findings include:</p> <p>R4 is a [AGE] year-old male admitted to the facility on [DATE] for long-term care. His current diagnoses include, but are not limited to, cerebral palsy (a group of disorders that affect a person's ability to move and maintain balance and posture), aphasia (loss of ability to understand or express speech), intellectual disabilities, and functional quadriplegia (complete immobility due to severe disability that is not caused by injury to the brain or spinal cord). In addition, R4 has a tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea (windpipe) from outside the neck), and a gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food/nutrition).</p> <p>Multiple observations were made of R4, daily, throughout the survey period, as he lay in bed in his room with the room completely silent. No radio observed anywhere on his side of the room. R4's television (TV) was positioned on the wall opposite his bed and was always off. The TV was also positioned in a manner that the closing of his privacy curtain would obstruct its view, even if it had been on. There were minimal pictures/photos around the room. Although he does have family, there were no family photos at the bedside. Observed on the wall next to his bed were four photos of himself, one colored picture of a bird, a card with an elephant pictured, and another bird picture on his cabinet door. In addition, R4 was not observed out of his room at all throughout the survey period.</p> <p>On 02/20/24 at 10:38 AM, observations were made at his bedside. Although completely non-verbal in response to greetings, questions, and conversation, R4 was noted to track movement with his eyes as the Surveyor walked around his bed and smiled slightly when spoken to.</p> <p>A review of his comprehensive care plan for Activities noted the following primary problem:</p> <p>. [R4] is admitted for Long Term Care . with needs for social contact and sensory stimulation .</p> <p>The care plan included six interventions: 2 having to do with group activities, 1 having to do with family visits, in-person or by video, and the remaining 3 planned interventions addressing activities for when R4 is in his room.</p> <ol style="list-style-type: none"> 1. Provide . [R4] with all types of sensory stimulation . 2. Provide . [R4] with weekly or more 1:1 [one-to-one] room visits for socialization, social stimulation. <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Turn on . [R4's] TV to all types of TV shows when awake .</p> <p>On 02/22/24 at 04:04 PM, received the last 6 months of Activity Logs for R4 from the Activities Manager (AM). A review of the Activity Logs for group activities noted that R4 attended group activities once a month for the past 4 months, twice in October, and not at all in September. A review of the documentation of 1:1 room visits by activity staff noted no visits in September, December, and January; 1 visit each in October and February; and 2 visits in November; for a total of 4 visits in the last 6 months.</p> <p>On 02/23/24 at 09:46 AM, an interview was done with AM near the elevator of the second floor. AM acknowledged that after pulling the Activity Logs at the Surveyor's request the day before, it was noted the documentation made it appear that R4 was not receiving the social/sensory stimulation and 1:1 room visits reflected in his care plan. When asked, AM reported that there were radios available for residents, and agreed that R4 could benefit from consistent music therapy and/or visual stimulation that was closer to him and in his line-of-vision. AM also agreed that R4's TV is too far from his view and would like to move it closer to him, in addition to ensuring that it gets turned on. When asked, AM could not identify specific TV channels or shows that R4 enjoyed watching, nor the type of music he enjoyed.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39754</p> <p>Based on record review, review of Facility Reported Incidents (ACTS #10723, 10743), review of Complaint (ACTS #10735), complainant interview, staff interview, and review of policy, the facility did not provide timely psychiatric assessment for one Resident (R)46, out of three residents sampled, to reduce the risk through multiple falls. R46 had an increasing number of falls with recent fracture needing surgery and hospitalization .</p> <p>Findings include:</p> <p>(Cross reference F689 Accidents)</p> <p>Review of Electronic Health Record (EHR) showed R46 was admitted to the facility on [DATE] with a diagnosis including the following: Stroke, Adjustment disorder, Atrial Fibrillation, Atherosclerotic heart disease, High blood pressure, Anxiety, Restlessness, Agitation, Frequent falls .</p> <p>Initial assessment for falls using the John Hopkins Fall Risk Assessment Tool found R46 as being high risk for falls. Further fall risk assessments showed R46 continued to be high risk for falls throughout the course of stay.</p> <p>Comprehensive Care Plan problem start dated 06/23/23 identified Falls and read R46 was at risk for falls due to left frontotemporal encephalomalacia, poor safety awareness, fall history, impulsiveness, wandering behaviors, unsteady gait, and use of psychotropic meds. Approach included the following: added 07/23/23 1:1 provided prn (as needed) if resident is restless to increase supervision and safety . 08/03/23 resident will reside in close room near nurse's station, have low bed in place, fall mat in place, soft touch call bell within reach at all times . 09/02/23 Sertraline increased . 12/07/23 psych telehealth . 01/10/24 follow up psych telehealth, next psych telehealth follow up scheduled for 02/09/24 . 02/23/24 follow up psych telehealth 02/23/24 .</p> <p>EHR review showed that R46 had the following falls:</p> <p>08/03/23 Unwitnessed fall, found sitting on bedside floor mat, alone at time of fall.</p> <p>08/16/23 Unwitnessed fall, found sitting on floor, alone at time of fall.</p> <p>08/23/23 Unwitnessed fall, found on floor, alone at time of fall.</p> <p>09/05/23 Lowered to floor, lost balance.</p> <p>09/16/23 Unwitnessed fall, found sitting on floor, alone at time of fall.</p> <p>09/19/23 Witnessed fall, alone at time of fall.</p> <p>10/18/23 Unwitnessed fall, noted on floor, alone at time of fall.</p> <p>10/31/23 Unwitnessed fall, alone at time of fall.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>11/01/23 Unwitnessed fall, found on floor, alone at time of fall.</p> <p>11/09/23 Unwitnessed fall, found on bathroom floor, alone at time of fall.</p> <p>11/10/23 Unwitnessed fall, found on floor mat, alone at time of fall.</p> <p>11/19/23 Unwitnessed fall, found on floor, alone at time of fall.</p> <p>12/08/23 Witnessed fall, alone at time of fall.</p> <p>12/15/23 Unwitnessed fall, found on ground, alone at time of fall.</p> <p>12/19/23 Unwitnessed fall, found sitting on floor mat, alone at time of fall.</p> <p>12/28/23 Witnessed fall, alone at time of fall.</p> <p>01/01/24 Witnessed, slid to floor.</p> <p>01/02/24 Witnessed by other resident, alone at time of fall.</p> <p>01/07/24 Witnessed by other resident, alone at time of fall.</p> <p>01/08/24 Unwitnessed, found on floor.</p> <p>01/09/24 Unwitnessed, found on floor, sent to hospital.</p> <p>01/17/24 Witnessed, fell upon standing.</p> <p>02/06/24 Unwitnessed, found on floor, sent to ER.</p> <p>Review of Facility Reported Incidents ACTS 10723, 10743 included the following: Care plan included laser alarm applied . supervision 1:1 as needed when restless . sent out to ER and admitted for surgical procedure.</p> <p>During review of Complaint ACTS 10735 and Complainant (C) interview on 02/21/24 at 09:05AM, C said the facility did not have psychiatric services.</p> <p>Staff interview on 02/23/24 at 11:30AM, Director of Nursing (DON) said that there were no psychiatric services on the Kauai, but they found services on Oahu. DON emphasized the care coordination effort has been multi-disciplinary and efforts to include the family and/or family representative has been on-going.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility policy on Fall Prevention and Management read the following: Key elements of the fall prevention and management program . Dynamic treatment plan, role of interdisciplinary team, use of non-pharmaceutical interventions, appropriate and necessary use of devices (enablers, restraints), re-assessments, implementation, and evaluation of treatment plan . Review record of diagnoses which may contribute to increased falls risk and make sure they are addressed as needed ., most common diagnoses that may contribute to an increase in falls, Cerebrovascular accident (CVA) . Pharmacological assessment and review, review the use of off label antipsychotics, attempt dose reductions as indicated, review the use of benzodiazepines, attempt dose reductions as indicated . Quality improvement, collect falls data (including near miss data), track and trend the falls for a defined period of time to ascertain patterns or probable factors that need to be addressed .</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39754</p> <p>Based on record review, review of Facility Reported Incidents (ACTS #10723, 10743), review of Complaint (ACTS #10735), complainant interview, staff interview, and review of policy, the facility did not provide enough supervision for one Resident (R)46, out of three residents sampled, to reduce the risk through multiple falls. R46 had an increasing number of falls with recent fracture needing surgery and hospitalization .</p> <p>Cross reference F684 Quality of Care</p> <p>Findings include:</p> <p>Review of Electronic Health Record (EHR) showed R46 was admitted to the facility on [DATE] with a diagnosis including the following: Stroke, Adjustment disorder, Atrial Fibrillation, Atherosclerotic heart disease, High blood pressure, Anxiety, Restlessness, Agitation, Frequent falls .</p> <p>Initial assessment for falls using the John Hopkins Fall Risk Assessment Tool found R46 as being high risk for falls. Further fall risk assessments showed R46 continued to be high risk for falls throughout the course of stay.</p> <p>Comprehensive Care Plan problem start dated 06/23/23 identified Falls and read R46 was at risk for falls due to left frontotemporal encephalomalacia, poor safety awareness, fall history, impulsiveness, wandering behaviors, unsteady gait and use of psychotropic meds. Approach included the following: added 07/23/23 1:1 provided prn (as needed) if resident is restless to increase supervision and safety . 08/03/23 resident will reside in close room near nurse's station, have low bed in place, fall mat in place, soft touch call bell within reach at all times . 11/15/23 family to help support resident by visiting in the evenings due to resident wanting a companion . 01/09/24 sensor alarm in-house and installed at foot of bed . 01/17/24 wear posey hipster briefs (hip protectors) as tolerated .</p> <p>EHR review showed that R46 had the following falls:</p> <p>08/03/23 Unwitnessed fall, found sitting on bedside floor mat, alone at time of fall.</p> <p>08/16/23 Unwitnessed fall, found sitting on floor, alone at time of fall.</p> <p>08/23/23 Unwitnessed fall, found on floor, alone at time of fall.</p> <p>09/05/23 Lowered to floor, lost balance.</p> <p>09/16/23 Unwitnessed fall, found sitting on floor, alone at time of fall.</p> <p>09/19/23 Witnessed fall, alone at time of fall.</p> <p>10/18/23 Unwitnessed fall, noted on floor, alone at time of fall.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Staff interview on 02/23/24 at 11:30AM, Director of Nursing (DON) said that R46 needed 1:1 supervision as needed but did not present to need supervision around the clock. DON emphasized the care coordination effort has been multi-disciplinary and efforts to include the family and/or family representative has been on-going.</p> <p>Review of facility policy on Fall Prevention and Management read the following: Key elements of the fall prevention and management program . Dynamic treatment plan, role of interdisciplinary team, use of non-pharmaceutical interventions, appropriate and necessary use of devices (enablers, restraints), re-assessments, implementation, and evaluation of treatment plan . Review record of diagnoses which may contribute to increased falls risk and make sure they are addressed as needed ., most common diagnoses that may contribute to an increase in falls, Cerebrovascular accident (CVA) . Pharmacological assessment and review, review the use of off label antipsychotics, attempt dose reductions as indicated, review the use of benzodiazepines, attempt dose reductions as indicated . Quality improvement, collect falls data (including near miss data), track and trend the falls for a defined period of time to ascertain patterns or probable factors that need to be addressed .</p>

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NAME OF PROVIDER OR SUPPLIER Garden Isle Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3-3420 Kuhio Highway, Suite 300 Lihue, HI 96766	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245</p> <p>Based on interview and record review, the facility failed to identify triggers which may cause re-traumatization, and consistently use trauma-informed approaches when caring for, and planning the care for, 1 of 1 resident (Resident (R)274) sampled for Trauma-Informed Care. As a result of this deficient practice, R274 did not have his needs met, was placed at risk of re-traumatization, and was hindered from attaining his highest practicable mental and psychosocial well-being. This deficient practice has the potential to affect all the residents at the facility with a history of trauma, post-traumatic stress disorder, and/or psychosocial adjustment difficulties.</p> <p>Findings include:</p> <p>R274 is a [AGE] year-old male admitted to the facility on [DATE] for long-term care with diagnoses that include, but are not limited to, Parkinson's disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves), chronic post-traumatic stress disorder (PTSD), depression, anxiety, dementia, and insomnia.</p> <p>A review of R274's Admission Social Services assessment noted the following:</p> <p>Resident is on Prazosin for Dx [diagnosis]: Nightmares/insomnia. Resident with Chronic PTSD related to his war experience/combat nightmares. He is an Army Guard. He has hx [history] of sleeping with tent on his upper part of the body/covers his head as it helps him feel secure.</p> <p>A review of the comprehensive admission assessment and corresponding care plan found no information of potential triggers for R274's PTSD or anxiety, nor did it contain resident-specific information to help reduce re-traumatization. There was no documentation that a review of R274's pre-admission PTSD history had been done, or that the brief history documented regarding sleeping with his head covered was addressed or investigated.</p> <p>A review of the facility's Trauma Informed Care policy, last revised on 07/12/23, noted the following:</p> <p>Residents identified as history of Trauma . will have Trauma Informed Observation progress note completed . Trauma events and triggers identified through the screening will be used to develop a care plan.</p> <p>On 02/21/24 at 09:09 AM, an interview was done with R274 at his bedside. R274 confirmed that he has PTSD from Vietnam. R274 reported that he was being followed for his PTSD at the VA [Veterans Affairs] and would see someone at the Vet Center once a week for counseling for his PTSD and nightmares. When asked, R274 stated that he had not been to the Vet Center, or had counseling offered to him at the facility, since he had been admitted . R274 stated he would like to go out to the Vet Center to continue his PTSD counseling.</p> <p>(continued on next page)</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/22/24 at 07:57 AM, a review of R274's EHR revealed no documentation of a Trauma Informed Observation being completed. Documentation of the Trauma-informed assessment that was done was requested from the Administrator. At 03:24 PM, the Administrator provided a 4-question Trauma Informed Care assessment titled Screening questions for PTSD that the facility had conducted. The questions on this form were screening questions to be answered with a yes or no, asking if the resident . had any experience that was so frightening, horrible or upsetting that, in the past month, you . The Administrator confirmed that these forms/questions were not appropriate for this resident and was not in alignment with the facility policy on trauma-informed care. The Administrator provided the State Agency with a Trauma-Informed Care Observation assessment form and Progress Note conducted by Social Services with R274 on 02/22/24, after discovering they had not used the correct assessment.</p> <p>On 02/23/24 at 11:23 AM, Social Services Associate (SSA)4 provided the State Agency with a copy of R274's last Mental Health Progress Note from the Vet Center on 01/23/24, which included a detailed history of his condition. At 11:33 AM, an interview was done with SSA4 in her office. When asked, SSA4 confirmed that the progress note/history from the Vet Center had been obtained by her today, after the information had been requested by the State Agency. SSA4 agreed that R274's pre-admission history should have been looked for, obtained, and reviewed prior to conducting his trauma-informed care assessment. SSA4 stated she would review it and re-do R274's trauma-informed care assessment. SSA4 also agreed that as R274 is forgetful (with dementia) and not a reliable historian, his assessment should be conducted with his wife present.</p>

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245</p> <p>Based on interview and record review, the facility failed to provide or obtain from an outside resource, routine dental services to meet the needs of 1 of 1 resident sampled for dental concerns. This deficient practice has the potential to affect all residents currently residing in the facility.</p> <p>Findings include:</p> <p>Resident (R)48 is an [AGE] year-old male with no natural teeth, admitted to the facility on [DATE]. On 02/21/24 at 08:46 AM, an interview was done with R48 at his bedside. R48 complained of sore gums, and not being provided a textured diet that he could eat comfortably. R48 shared an example of being given dry cereal for breakfast with no milk to pour over it. R48 stated eating the dry cereal feels like it cuts into his gums, but he has no choice because he is hungry. R48 also reported that while he did have dentures, they no longer fit properly. When asked when the last time was that a dentist evaluated the state of his gums, and the fitting of his dentures, R48 replied that he had not seen a dentist in the facility, or been sent out to see a dentist, since his admission. A review of R48's electronic health record (EHR) revealed no dental consultations, and an oral exam, last completed on 09/03/23, done by a licensed practical nurse (LPN) from the facility.</p> <p>A review of the facility's Dental Services policy, effective 05/01/21, noted the following:</p> <p>The facility must:</p> <ol style="list-style-type: none"> 1. Provide or obtain from an outside resource routine and emergency dental services to meet the needs of each resident. <p>Routine dental services means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor partial or full denture adjustments, smoothing of broken teeth, and limited prosthodontic procedures, e.g., taking impressions for dentures and fitting dentures.</p> <p>It is noted from the facility's definition above of routine services, that these services are outside the scope of LPN practice.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>42160</p> <p>Based on an interview and record review, the facility failed to maintain an accurate medical record for two residents (Resident (R)24 and R225). An interview with the Director of Nursing (DON) confirmed a document for R225 was uploaded in R24's Electronic Health Record (EHR) erroneously and should not have been.</p> <p>Findings include:</p> <p>On 02/21/24 at 10:15 AM, conducted a record review of R24's EHR. A form titled, MD (physician) Response (attached on 10/12/23) for R225 filed in R24's EHR. The MD Response for documented the physician response to nursing staff regarding questionable orders for Acetaminophen, which would exceed the recommended daily dose of the medication and could potentially negatively impact R225's health status. Review of R225's EHR, Medication Administration Record (MAR), documented identified the orders nursing staff questions were present, the resident was not administered a dose which exceeded the recommended daily dose of Acetaminophen and was not impacted.</p> <p>On 02/22/24 at 12:42 PM, conducted a concurrent interview and review of R24's EHR with the Director of Nursing (DON). DON reviewed R225's MD Response form located in R24's EHR and confirmed the document was misfiled in the wrong resident's EHR. DON confirmed the Health Information Coordinator (HIC)9 was not scheduled to work today and unavailable for interview, but an in-service would be conducted with HIC9 upon returning to work.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38870</p> <p>Based on observation, interview and policy review, the facility failed to ensure that staff followed hand hygiene and contact precautions practices consistent with accepted standards of practice. Registered Nurses (RN)60 did not complete hand hygiene between glove changes during a dressing change for a Pressure Ulcer (PU) on R70's coccyx. Staff Member (SM)15 did not wear personal protective equipment while delivering lunch to R11's room, who was on contact precautions. This deficient practice places the residents in the facility at an increased risk for communicable disease.</p> <p>Findings include:</p> <p>During an observation on 02/22/24 at 2:00 PM in R70's room with RN60 and RN75 prepared to change R70's dressings. Dressing changes for R70 included the wound on his left lower leg; two PUs on the upper back, and one pressure ulcer on the coccyx. While changing the coccyx PU, RN60 removed the dressing, cleaned the site, and removed her dirty gloves. RN60 picked up the clean gloves and started to place her fingers in the glove. The surveyor prompted RN60 by pointing at the hand sanitizer that was on the over bed table to complete hand hygiene. After using the alcohol-based hand sanitizer RN60 proceeded to put the clean gloves on and completed the wound care.</p> <p>Conducted an interview with RN60 and RN75 on 02/22/24 at 3:45 PM at the nurse's station regarding observations made during the dressing change. Staff validated hand hygiene was not done after removing the dirty gloves and before putting clean gloves on.</p> <p>Review of Handwashing and Hand Hygiene policy (revised 05/23/2023) documented, Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: t. Before donning and after doffing gloves and PPE [Personal Protective Equipment]).</p> <p>2) During an observation of the lunch trays being delivered on the third-floor unit on 02/20/24 at 12:30 PM, observed SM15 enter room [ROOM NUMBER] without donning a gown or gloves. A purple stop sign posted on room [ROOM NUMBER]'s door read, stop check with nurse before entering. The surveyor asked SM15 if a resident in the room is on contact precautions. SM15 was not sure why the resident was on contact precaution but would find out and get back to the surveyor.</p> <p>Review of R11's EHR documented a 0.8 by 0.5 by 0.2 centimeter wound on her back and is currently receiving wound care. An order for contact precautions could not be found in the physician's orders or any other part of the resident's EHR.</p> <p>Interview with the Infection Preventionist (IP) and Director of Nursing (DON) on 02/23/24 at 09:40 AM on the third-floor nurse's station. The IP and DON confirmed R11 was on contact precautions for a wound on the back and an umbilical opening and all staff should be gowning and gloving before going into the room, including delivering meal trays to any resident on contact precautions.</p> <p>Review of the Infection Control policy (updated 10/01/22) documented, Contact Precautions - used to minimize the transmission of infectious organisms through contact with hands or objects, usually found in nares, wounds, urine, and stool. Apply PPE before entering a room or resident/guest. Only gloves needed if delivering meal tray .</p>		