STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125004	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Isle Healthcare and Rehabilitation Center	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)
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. Based on observation and staff interview the facility failed to promote the dignity and self-esteem for one of nine residents sampled for dining observation. During lunch observation, Resident (R)57 was seen with staff who stood over him as they assisted him to eat. The deficient practice does not promote the resident's self-esteem and put him at risk for weight loss. Findings include: On 02/18/25 at 12:30 PM during lunch, observed Certified Nurse Aide (CNA)11 assist R57 with his meal. R57 was sitting up in his bed, and CNA11 was observed standing over R57 as she assisted him with his meal. During this time surveyor observed there was an empty chair nearby in resident's room. Inquired of CNA11 how she is to position self when feeding resident and she stated she can stand or sit when she feeds the resident. Inquired if CNA11 had training regarding feeding residents their meals and she confirmed she had training on this. During record review of R57's Electronic Health Record (EHR) found he had a three pound weight loss over the past month but has had an overall gradual increase of weight since admission. On 02/20/25 at 02:52 PM, interviewed Director of Nursing (DON) and inquired how CNAs are to position themselves when assisting resident's with their meals. DON confirmed the CNAs are expected to assist the resident with their meals at eye level for dignity and staff are educated on this upon hire and annually. Requested facility policy on assisting residents with meals which she provided. Review of facility policy titled Assistance with meals with original effective date 07/2017 stated, . Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Residents Requiring Full Assistance 1. Nursing staff will remove food trays from the food cart and deliver the trays to each resident's room. 2. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: a. Not standing over residents while assisting them with meals; .

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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to accommodate one of one Resident (R)12 in the sample with the assistance needed to put her hearing aids on during personal care. The deficient practice caused discomfort and frustration for the resident who had to wait for a trained staff that was available to assist her. This deficient practice has the potential to affect all residents that use a hearing aid. Findings include: Observation and interview with R12 on 02/19/25 at 09:29 AM in her room. When the surveyor approached R12 asking her if she has time for a few questions, she cupped her ear and motioned the surveyor to come close and speak loudly. R12 said they haven't come in to help her with her hearing aids yet. During the interview, the surveyor asked her if she is able to get the help she needs from the staff. R12 said, The availability of staff who have experience is an issue, for example putting my hearing aids in. The younger staff don't know what to do with them. If they've never used them or had a resident who wears them, they don't know how. A staff came in to answer the call light and asked R12 if she needed something. The surveyor asked her if she could help with R12s hearing aids. The staff said, I can't do that, I'm not trained yet. I'll get the nurse to help. At 09:52 AM, speech therapist and the Registered Nurse (RN)35 came in to help R12 with her hearing aids. Minimum Data Set (MDS) admission assessment dated [DATE] reviewed. R12 had a brief interview of mental status summary score of 13, cognitively intact. Hearing is coded, With moderate difficulty; the speaker has to increase volume and speak distinctly. She was not coded as having a hearing aid or other appliance used. Care plan dated 01/21/25 reviewed. No sensory problems that include the use of a hearing aid documented on R12s care plan. Observation on 02/20/25 at 08:45 AM in R12's room. The Speech Therapist (ST)15 was assisting R12 to insert her hearing aids. ST15 said, I'm having a little trouble with the right hearing aid. The surveyor confirmed that ST15 was assisting R12 to insert the hearing aids. At 09:00 AM, the surveyor spoke to ST15 in the hallway outside R12's room. The surveyor asked ST15 if she was able to insert the hearing aids for R12, she stated, Yes, we were successful, R12 is very helpful. The surveyor asked her if the Nurses are trained to insert the hearing aids for the residents. ST15 stated that all of the nurses are trained to insert the hearing aids. Interviewed the Director of Nursing (DON) on 02/21/25 at 10:09 AM. Asked when are residents with hearing aids assisted to put them in and who are trained to assist them with their hearing aids. The DON said, Our CNA's [Certified Nurse Aide] have been trained on how to insert the hearing aids and we have a policy that we follow. We try to assess the resident upon admission for self-administering of their own hearing aids. The surveyor asked the DON what time of the day the resident should have their hearing aids inserted. DON responded, I think they should upon rising in the morning, when they wake up to toilet. We put glasses and hearing aids on in the morning and remove them at night, which is the standard. DON added that it should be as soon as possible, so that they can get started on their day. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy titled, Hearing aid, use and care of dated 06/19/23 stated, Purpose: To assist the resident with use and care of a hearing aid for maximum effectiveness . To enhance psychosocial well-being .

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4) R65 was first admitted to the facility on [DATE] for long-term placement. Review of R65's EHR revealed that on 10/18/24, R65 was transferred to an acute care facility for a higher level of care. Documentation of facility sending a written notification of discharge to the LTCO was not found in the EHR. On 02/19/25 at 03:26 PM, requested a copy of written notifications of discharge for all four residents from the Director of Nursing (DON). Documents were submitted for review on 02/20/25. On 02/20/25 at 11:16 AM, review of the documents submitted revealed that the LTCO was not notified of the discharges until 02/19/25. On 02/20/25 at 02:20 PM, concurrent record review and interview was conducted with DON in her office. DON acknowledged that written notifications were not sent out to the LTCO until 02/19/25 for all four residents sampled. Facility policy titled Discharge-Transfer of the Guest/Resident was reviewed with DON and confirmed that notification of the LTCO was not included in the policy. Based on record reviews and interview, the facility failed to provide proper notification of transfer/discharge to four of four residents sampled for Hospitalization (Resident (R)26, R42, R62, and R65). The facility did not send written notification to the Office of the State LTC [long-term care] Ombudsman (LTCO) for four of the four residents that were transferred/discharged . This deficient practice has the potential to affect all residents at the facility who are discharged or transferred to the hospital. Findings Include: 1) R26 was first admitted to the facility on [DATE] for long-term placement. Review of R26's Electronic Health Record (EHR) revealed that on 09/05/24, R26 was transferred to an acute care facility for a higher level of care. Documentation of facility sending a written notification of discharge to the LTCO was not found in the EHR. 2) R42 was first admitted to the facility on [DATE] for long-term care placement. Review of R42's EHR revealed she was transferred to an acute care hospital on [DATE]. Documentation of facility sending a written notification of discharge to the LTCO was not found in the EHR. 3) R62 was admitted to the facility on [DATE] for long-term care placement. Review of R62's EHR revealed that on 04/12/24, R62 was transferred to an acute care hospital and returned to the facility on [DATE]. Documentation of facility sending written notification of the discharge to the LTCO was not found in the EHR.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3) Cross-reference to F695 Respiratory/tracheostomy Care and Suctioning for R4. Despite identifying that R4 was at risk for complications with his tracheostomy, the facility failed to develop and implement a tracheostomy care plan that included life saving interventions for an unplanned extubation. On 02/20/25 at 02:34 PM reviewed R4's care plan with Director of Nursing (DON) who confirmed there are no interventions regarding emergency care for resident if his tracheostomy became dislodged. 4) Cross-reference to F700 Bedrails for R27. Despite reviewing the facility consent form for Enabler & Restraint Rationale/Consent form with R27 and having him sign it the facility failed to completly fill out the form and develop and implement a care plan for the use of bedrails. On 02/21/25 at 09:51 AM, an interview with DON confirmed that R27 did not have a care plan for the use of the bedrails. Based on observations, record reviews and interviews, the facility did not ensure that a comprehensive person-centered care plan was developed and/or implemented for four of 21 residents (Resident (R)14, R43, R4 and R27) in the active patient sample. The facility failed to develop a comprehensive care plan for the use of bedrails and special mattress for R27, R43 and R14, and emergency care for a tracheostomy (surgically crated opening through the neck into the windpipe) for R4. As a result of this deficient practice, the residents were placed at risk for unmet care needs, decline in their quality of life, and were prevented from attaining their highest practicable physical, mental, and psychosocial well-being. Findings Include: 1) R14 is a [AGE] year-old resident admitted to the facility on [DATE] for long-term placement. Diagnoses included but not limited to hemiplegia and hemiparesis (paralysis or weakness on one side of the body) following cerebral infarction (stroke), vascular dementia with behavioral disturbance, and aphasia. On 02/18/25 at 10:47 AM during the initial screening of the residents, observed R14's bed had a concave mattress on his bed. R14 was sitting up in his wheelchair in the activities/dining area. On 02/19/25 at 08:49 AM, observed R14 in bed with head elevated and watching television. R14 was using a concave mattress and had both upper side rails up. At 09:58 AM, an interview was done with Certified Nurse Aide (CNA)23 in R14's room. Asked CNA23 what was the purpose of the concave mattress and side rails. CNA23 said the side rails are used as an enabler since he is able to turn and reposition himself in bed by pulling on them with his left arm. For the concave mattress, CNA23 said it was to prevent R14 from dangling his legs when lying in bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/19/25 at 10:46 AM, a phone interview was conducted with the R14's family member (FM)4. Asked FM4 if she participates in the care plan conferences for R14. FM4 said, Yes, the last one was in December. When FM4 was asked how long has R14 been using the concave mattress, FM4 said she was not aware they were using a concave mattress. FM4 said she knew about the side rails since they had to call her to get consent but did not know about the concave mattress. On 02/20/25, review of R14's Electronic Health Record (EHR) was conducted. Consent and assessment for the use of the side rails were scanned into the EHR. Review of care plan dated 01/17/24 revealed that the there was no intervention documented for the use of both the side rails and the concave mattress. On 02/20/25 at 02:23 PM, a concurrent interview and record review was conducted with the Director of Nursing (DON) in her office. Asked DON what was the purpose of the concave mattress for R14. DON said, It is used as a perimeter or lip for when he (R14) sits on the edge of the bed when he's eating his meals at bedside. It's like a guide so he knows where the edge of the bed is. Asked DON if R14 is able to transfer from his bed to the wheelchair by himself. DON said he requires extensive assistance and is totally dependent on staff for transfer from bed as stated in the care plan. Asked DON if there was any care plan developed for the use of the concave bed and side rails. DON reviewed the latest care plan dated 01/17/24 and acknowledged that there was no mention of the use of a concave bed and side rails. DON added that they should be included in the care plan. 2) R43 is an [AGE] year-old resident admitted to the facility on [DATE] for long-term care placement. Diagnoses included but not limited to dementia with other behavioral disturbances, aphasia (loss of ability to understand or express speech) following cerebral infarction, restlessness and agitation, and history of falls. On 02/18/24 at 10:50 AM, observed R43 in her bed that was set at its lowest position, pushed up against the wall on the right side with a fall mat on the left side, and padded side rails were in use for the upper half of the bed. On 02/20/25, review of R43's EHR was conducted. Assessment, consent and order for the use of the side rails as an enabler were found in the EHR. Review of care plan with a revision date on 01/30/25 revealed that there were no interventions documented for the use the side rails. On 02/21/25 at 09:22 AM, a concurrent interview and record review was conducted with the DON in her office. Asked DON if there was any documentation in the comprehensive care plan on the use of the side rails for R43. DON stated that they are used as an enabler when the resident is in bed. DON was not able to find a care plan for the use of the side rail in the EHR. DON confirmed that there should be a care plan developed for the use of the side rails.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to provide services to ensure one of two residents (R)52 sampled for ADL (activities of daily living) decline, maintained a level of function and the range of motion of his upper and lower extremities. The deficient practice resulted in the resident's lack of movement to get out of bed. Findings Include: Cross reference to F697 - Pain Management. On 02/18/25 at 11:10 AM, observed R52 in his bed with his eyes closed. Noted he was wearing a knee brace on his right leg. R52 is an [AGE] year-old male admitted to the facility on [DATE] for skilled nursing following a stroke. Diagnosis includes Parkinson's disease, Type two diabetes, Lewy body dementia (a vascular disease in the brain) and communication deficit. Telephone interview waS conducted with R52s family member (FM)10 on 02/19/25 at 09:10 AM. The surveyor asked if R52 has had a decline in his ability to get out of bed or exercise in the past few months. FM10 said, I think he needs more exercise. He was walking before and was able to use his walker when he first got there. After the insurance stopped paying for him to have therapy he started to decline. They restarted his therapy and worked with him for a while, but it's been a long time, and he stays in bed and now his muscles are not working. He was able to get up with a walker, but now they need to use a lift to get him out of bed. He's declining both due to his medical condition and because he's not getting any exercise. Asked if R52 is getting any restorative care and are staff doing any range of motion with him. FM10 said, Now he's so stiff that he it's really hard to move his legs, he says he's having a lot of pain when he moves his legs. Inter-Disciplinary Team (IDT) care plan dated 11/25/24 reviewed. Occupational Therapy (OT) Toolkit with exercises. Passive Range of motion (ROM) right side weakness shoulder. Elbow, forearm and wrist. Certified Nurse Aide (CNA) will perform passive ROM to bilateral lower extremities (BLE) daily as tolerated. Nursing to don (put on) right ankle splint for up to 6 hours two times per day as tolerated. Review of the attendance form documented the licensed nursing staff were present. Minimum Data Set (MDS) annual assessment dated [DATE] reviewed. R52 has a brief interview for mental status summary score of 01 and is severely cognitively impaired. He is dependent on staff for his activities of daily living (ADL) and mobility. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Rehab Services (DOR) on 02/21/25 at 9:00 AM. The surveyor asked if there is a restorative nursing program and if not, how do residents receive restorative care. DOR said, After we discharge the resident from skilled nursing, we educate the resident, family members and nursing staff on the follow up exercises. We also add it to the care plan. I send the care plan to the nurses, and we put a copy inside the room on the inside of the closet door. On the care plan it will say complete the home exercise program, (HEP) and list's the exercises to be completed. The surveyor asked the DOR where the exercises are being documented when they complete them. DOR said, she wasn't sure where nursing is documenting the range of motion exercises. The surveyor shared the telephone conversation with FM10 and the concerns about R52s decline in range his range of motion. DOR said, it was brought up during the IDT meeting. DOR said she received an email from the MDS coordinator (MDSC) on 02/19/25 that F10 is concerned that the resident is not getting enough exercise. DOR said she addressed it with the Director of Nursing (DON). The surveyor asked the DOR how they will follow up on the concerns. An IDT screening referral form will be filled out by the DOR to request for an ADL evaluation, then submitted for approval. Received and reviewed the email communication on 02/21/25 at 10:00 AM from the MDSC to the DOR dated 02/18/2024 at 11:51 AM. Documented that during the care conference dated 01/30/25, FM10 was concerned about the decline in transfers and strength after R52 got sick previously this month. DOR agreed to do the evaluation. Interview with Registered Nurse (RN)45 on 02/21/25 at 11:00 AM on the third floor. The surveyor asked when R52 is getting range of motion exercises, how often and who provides it. RN45 said usually, it is the CNAs who do the ROM when they provide the morning care, or in the afternoon. Sometimes the nurses will do it but usually it's the CNAs. Interview with CNA28 on 02/21/25 at 11:13 AM. The surveyor asked CNA28 what ROM exercises is she doing with R52 and how often? CNA28 said, I usually do his legs, in the morning when we're providing his care. Putting the lotion on then stretching his leg and bending at the knees. We stretch his arms too. When he does get up to the chair, he scoots down, he has pain to his butt. He's very stiff and complains when sitting too long. He doesn't get up to go to activities often. Observation in R52's room on 02/21/25 at his bedside. The surveyor opened his closet and viewed the exercises posted on the door. R52 was lying on the bed with his eyes closed. He was wearing a brace on his right knee. Review of facility policy titled Activities of Daily Living dated 05/01/21 stated, . The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate .Care and services will be provided for the following activities of daily living; . 2. Transfer and ambulation; Policy Explanation and compliance Guidelines: . 2. The facility will provide a maintenance and restorative program to assist the resident in achieving and maintaining the highest practicable outcome based on the comprehensive assessment .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review and interview the facility failed to assure one of one resident (R)4 sampled for respiratory/tracheostomy (surgically created opening through the neck into the windpipe) care had a care plan with interventions for an unplanned extubation and failed to assure the new tracheostomy tube was placed at bedside for such an emergency situation. The deficient practice could put R4 in a situation that could impede his breathing, causing a preventable life threatening situation. Findings Include: Cross reference to F656 Develop/Implement Comprehensive Care Plan for R4. Despite identifying R4's need for tracheostomy care and need to have a new replacement tracheostomy at his bedside the facility failed to include life saving emergency interventions in R4's care plan for an unplanned extubation. On 02/19/25 at 12:33 PM observed R4 in his room lying in his bed. R4 was observed with a tracheostomy. R4 did not appear in any distress and could be heard breathing with the use of his tracheostomy. During review of R4's Electronic Health Record (EHR), found resident had a care plan for tracheostomy care but the plan did not include interventions for emergency situations such as if/when the tracheostomy tube becomes dislodged. On 02/20/25 at 09:18 AM, interviewed Registered Nurse (RN)10 who was assigned to take care of R4 that day. Interview was conducted with RN10 in R4's room at the bedside. Inquired about emergency equipment that is kept in R4's room at the bedside. RN10 was able to show all emergency equipment needed for R4 except a new replacement tracheostomy tube. Inquired of RN10 where the new tracheostomy tube is supposed to be in his room and she pointed to the shelf below the ambu bag (a medical tool which forces air into the lungs) that is on the wall near R4's bed. The shelf was empty, no new tracheostomy tube was seen in R4's room. Inquired if RN10 knew if there was a new replacement tracheostomy tube available for R4 and she stated it is in her med cart. Asked if it is supposed to be in the med cart and not in the room. RN10 confirmed it is supposed to be left at the bedside on the shelf and she stated I will get it. and brought it and left it in the room on the shelf underneath the ambu bag. On 02/20/25 at 02:34 PM reviewed R4's care plan with Director of Nursing (DON) who confirmed there were no interventions regarding emergency care for resident if his tracheostomy became dislodged. DON confirmed the emergency tracheostomy is supposed to be in R4's room at bedside. DON stated she had holders attached to the wall where it (new replacement tracheostomy tube) can be placed.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to identify, anticipate and effectively manage pain for one of two residents (R)52 sampled for pain. The deficient practice resulted in the resident's intolerance to attend activities and participate in exercises to prevent a decline in his Activities of Daily Living (ADLs). Findings Include: Cross reference to F676. Telephone interview with R52s family member (FM)10 on 02/19/25 at 09:10 AM. F10 stated that R52 isn't participating in therapy or exercises because he has pain. He used to get up and go to activities, but now he stays in bed. When they try to move his legs and get him up, he goes ow, ow, ow. His legs are really stiff. Record review of the face sheet on 02/19/25. R52 is an [AGE] year-old male who was admitted to the facility on [DATE] for skilled nursing services. Minimum Data Set (MDS) annual assessment dated [DATE] reviewed on 02/19/25. R52 is dependent on staff for his ADLs and mobility and was coded as not having pain during the pain assessment interview. Care plan reviewed on 02/19/25. Pain. Resident is at risk for alteration of comfort due to [d/t] disease process. Resident will verbalize reduction of pain.Approach start date 06/01/23. Goal target Date: 04/30/25. Administer medications: per MAR [Medication Administration Record]. Monitor and record any non-verbal signs of pain. Interview with Certified Nurse Aide (CNA)28 on 02/21/25 at 11:13 AM. The surveyor asked CNA28 if R52 is able to participate in the Range of Motion (ROM) exercises and if he has pain. CNA28 said, Yes, he says ow, ow, and has pain with every little movement. If we can get him up to the chair, he scoots down, he has pain to his butt. He's very stiff and complains when sitting too long. He doesn't get up to go to activities often. Interview with Registered Nurse (RN)45 on 02/21/25 at 11:38 AM. The surveyor asked RN45 if R52 is having a lot of pain and if so what type of pain control is he getting. RN45 confirmed that he is having pain with movement, he says ow, ow, ow, and said, He's on Gabapentin (pain medication) 200 milligrams (mg) three times per day (TID) for leg pain. R52 also has acetaminophen (Tylenol) as needed (PRN), and acetaminophen with codeine PRN. Gabapentin is scheduled, the other two are PRN's. The surveyor asked RN45 if R52 is being given the PRN medication every day to address the pain with movement. After reviewing the medication administration record (MAR), she said, It doesn't look like he's been getting the PRNs regularly, not very much in the last month. MAR for February 2025 reviewed. Pain Monitor every (Q) shift. R52s pain level was documented zero on the following dates: 02/01/25 to 02/16/25; five on 02/17/25; zero on 02/18/25 to 02/20/25. Tylenol #3 (300 mg acetaminophen 30 mg codeine (controlled pain medication) tab. Take 1 tab Q 6 hours PRN pain 6-10/10. Not documented as given. (continued on next page)

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	125004	A. Building B. Wing	02/21/2025

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Acetaminophen 650 mg TID PRN pain 1-5 out of 10. Documented as given on the following dates: 02/01/25; 02/02/25; 02/09/25; 02/10/25; 02/12/25 to 02/17/25. Faces pain scale used to rate pain. Interview with the Director of Rehab (DOR) services on 02/21/25 at 12:00 PM. The surveyor verified that R52 should be wearing the brace, but with the pain, he doesn't want to wear it or can't tolerate it. The DOR added that his pain presence may be decreasing is ability to participate in his ROM and wearing the right knee brace. Review of the facility policy titled Pain Management Policy stated, . Nursing home residents are at high risk for having pain that may affect function, impair mobility, impair mood, or disturb sleep, and diminish quality of life. 7. Resident should be evaluated for any needed pain medication prior to, during and after treatments, (i. e wounds), care and/or therapies.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure assessment for the use of bed rails was completed and alternative interventions were attempted prior to their use for two of three residents (R)4 and R27 sampled for bed rails. This deficient practice puts R4, R27 and any resident who has bed or side rails installed at risk for harm such as entrapment. Findings Include: 1) On 02/19/25 at 01:39 PM observed R4 in his room in his bed which appeared to be like a crib, it was incased in bed rails. Review of R4's Electronic Health Record (EHR) revealed he was admitted to the facility on [DATE] and his diagnoses include, but are not limited to, cerebral palsy, unspecified (Primary, Admission), tracheostomy status, unspecified intellectual disabilities, functional quadriplegia, and unspecified lack of coordination, abnormal posture. A consent was found in the EHR signed by R4's mother on 06/01/04 for the use of bedrails. Resident had a care plan for his special mattress and full side rails. With this record review no nursing assessment or rationale for bed rail use was found, and no alternative interventions were attempted prior to using bed rails. On 02/21/25 at 10:06 AM an interview was conducted with the Director of Nursing (DON). Inquired if R4 had an assessment completed for his bedrail use and the DON confirmed resident did not have quarterly assessments of his bed rail use. Cross reference to F656 Develop/ Implement Comprehensive Care Plan for R27. Despite identifying R27's need for bed rails the facility failed to develop and implement a care plan for R27's bed rails. 2) On 02/19/25 at 10:15 AM an interview was conducted with R27 in his room at the bedside. R27 was observed lying in his bed with upper half bed rails positioned up. Inquired of R27 if he is able to use the control to lower and lift his bed and the back of the bed. R27 confirmed he could. Inquired if he needs assistance getting in and out of his bed and R27 stated he is unable to get out of bed on his own. Record review of R27's EHR found R27 signed a consent form to use the half bedrails and risks and benefits were explained to resident. Review of this consent form found it was not completed by the nurse, it did not include Nursing Assessment/Rationale, Alternative Interventions Attempted But Unsuccessful, and Bed Rail Assessment on the consent form. During this record review, did not find a care plan for resident's bed rails and there are no assessments completed for bed rails for R27. On 02/21/25 at 09:51 AM interviewed DON who confirmed the consent form that R27 signed was not completely filled out and that it should have been. Confirmed nurses are trained on how to fill out the form upon hire and stated it is pretty self explanatory. Inquired about R27's care plan and DON confirmed R27 does not have a care plan for the use of side rails. DON confirmed this should have been included in R27's care plan.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation and interview the facility failed to assure the controlled drugs were accounted for each shift by having licensed staff document a count each shift. The deficient practice puts the facility at risk for diversion of narcotic medications which could make medications unavailable for residents who might need it. Findings Include: On 02/20/25 at 08:30 AM after observing medication pass with RN10, reviewed narcotics log and narcotic count. Review of the narcotic log form found missing nurses signatures. Review of the narcotic log dated 02/09/25-02/16/25 found four entries out of the 48 entries missing nurses' signatures. Inquired of RN10 if this should have been filled out and RN10 confirmed narcotic count sheet had some blanks and confirmed this is supposed to be signed at the time of the count by the nurses. On 02/20/25 at 09:08 AM interviewed Resident Care Manager (RCM)1. Inquired of RCM1 if nurses who do the narcotic count have to sign the narcotic log and RCM1 confirmed nurses are to sign when they do the narcotic count on the narcotic count sheet. Requested a copy of policy regarding narcotic count. Inquired if nurses are trained on this and RCM1 confirmed nurses are trained on this. Review of policy titled 4.2 Controlled Medication Storage dated 01/24 stated, . medications included in the Drug Enforcement Administration (DEA) or state classification as controlled substances are subject to special handling, storage, disposal and record keeping in the nursing care center in accordance with federal, state and other applicable laws and regulations. Procedures . 6. At each shift change or when keys are surrendered, a physical inventory of all controlled substances, including refrigerated items, is conducted by two licensed nurses or approved individuals per state regulation and is documented on the controlled substances count report.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review the facility failed to assure medication errors with residents receiving medications, during medication pass observation, were less than five percent (%). One of five residents (R)29 sampled for medication pass, received medication in an altered form that was not ordered by the physician. The deficient practice has the potential to put all residents who receive medications at risk for a medication error when given their medication. Findings Include: On 02/20/25 at 08:13 AM, observed Registered Nurse (RN)10 prepare medications for R29. RN10 crushed R29's acetaminophen 325 mg (milligrams) tablet two tablets which is given BID (twice a day) for pain and RN10 opened R29's omeprazole DR (delayed release) 20 mg capsule which is given by mouth twice a day. Inquired of RN10 if R29 has an order to crush medication and RN10 stated R29 is not able to swallow pills and the lady said it was ok. RN 10 placed each medication separately into a medication cup with pudding and fed this to R29 at her bedside. Review of R29's Electronic Health Record (EHR) did not find a physician order that R29's medication can be crushed and given with pudding and no physician order stating it was ok to open R29's omeprazole delayed release capsule and give with pudding. On 02/21/25 at 10:10 AM interviewed Director of Nursing (DON) and inquired if nurses need a physician order to crush medication or open an extended release capsule before giving to resident and DON confirmed nurses are to get the physicians orders before giving medications this way. Review of facility medication error for the survey was 7.14% with two medication errors out of 28 observed medications administered to residents.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and record review, the facility failed to provide routine dental services for one of one resident (R)4 sampled for dental care. The deficient practice puts R4 at risk for developing cavities and other mouth infections. Findings Include: On 02/19/25 at 11:49 AM observed R4 in his bed. R4 had his mouth open and surveyor noted R4 had a thick orange-colored build up on his front teeth. Review of R4's Electronic Health Record (EHR) found he was admitted to the facility on [DATE] and his diagnoses include, but are not limited to, cerebral palsy (disorder that affects ability to move, balance and maintain posture), tracheostomy status, unspecified intellectual disabilities, functional quadriplegia, and unspecified lack of coordination, abnormal posture. Review of R4's Minimum Data Set (MDS) quarterly assessment dated [DATE] and and annual assessment dated [DATE] found he is dependent upon staff for all of his care. Review of R4's EHR did not find any consultation notes or progress notes regarding a dental visit from the past year. On 02/20/25 at 10:15 AM, interviewed Certified Nurse Aide (CNA)6 and inquired about R4's morning care and CNA6 was able to explain what she does for R4 during his morning care which includes oral care. CNA6 stated if R4 is drooling she will clean around his mouth with the wipes or pink swab. CNA6 explained R4 is NPO (nothing by mouth), and stated she uses the dry brush to wipe his teeth. CNA6 stated she was not sure if they can use toothpaste since R4 is NPO. During this interview, inquired with Registered Nurse (RN)10 if resident sees the dentist and she stated he has a standing order to see one if he needs to. RN10 stated she will check about the dentist appointment regarding his teeth with the plaque and tartar build up. On 02/20/25 at 12:06 PM, interviewed RN10 who stated she left a note for resident's doctor and asked about a dentist appointment and she discussed this with resident's mother. RN10 suggested a one time dose of Ativan if he goes to the dentist. Inquired with RN10 when she does mouth assessment and she stated quarterly and as needed. On 02/20/25 at 02:44 PM, interviewed the Director of Nursing (DON) regarding resident's mouth assessment and dental visits. DON confirmed oral assessment is done annually by the nurse. Reviewed R4's last dental assessment with DON that was filled out on 08/21/24 which the nurse noted plaque build up. Inquired about R4 going to the dentist and the DON stated it is hard for resident to fit into the dentist chair because of his size and diagnosis (Cerebral Palsy). DON confirmed R4 has not seen the dentist within the past year. DON will inquire with other dentist office to see if they can accommodate resident and his custom wheelchair.