STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125011	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hale Nani Rehabilitation and Nursing Center	1677 Pensacola Street Honolulu, HI 96822

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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 - Some	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** Based on observations, interviews, record reviews and review of policy, the facility failed to ensure the resident's right to a dignified existence for three Residents (R) 7, 14, 42 of five residents sampled for dignity and as reported by Resident Council Members. As a result of this deficiency, the residents were not promoted the right to the maintenance or enhancement of their quality of life.Findings include: 1) During resident interview on 04/30/26 at 9:00 AM, R14 said, after activities, she was sitting in her wheelchair and told staff she had to urinate but was told to wait. Staff did not return for over one hour and it was the next shift that came to help her. R14 said she was not treated with respect and/or dignity. Review of Electronic Health Record showed R14 was admitted on [DATE] with diagnosis including Diabetes, Chronic Kidney Disease, Chronic Pain, Borderline Personality, Schizoaffective Disorder. Care Plan showed the resident had a deficit in mobility and self-performance due to significant muscle weakness and debility. 2) On 04/28/26 at 09:49 AM, observed R42 in bed watching television. R42 had an indwelling urinary catheter that was connected to a drainage bag placed on the left side of the bed, facing the bedroom door, without privacy bag. Returned at 01:56 PM and 02:35 PM and observed R42 lying in bed. Observation done from the hallway facing R42's bed and observed catheter drainage bag still without privacy bag. On 04/29/26 at 01:34 PM, observed R7 in bed watching television. R7 had an indwelling urinary catheter that was connected to a drainage bag placed on the left side of the bed, facing the bedroom door, without privacy bag. On 04/30/26 at 08:15 AM, observation and interview were done with Registered Nurse (RN) 15 while passing medication in front of R42's bedroom. Asked RN15 if catheter bag should have privacy bag, and RN confirmed that all catheter drainage bags should always be covered with privacy bags On 04/20/26 at 10:25 AM, queried DON if catheter drainage bags were supposed to be covered with privacy bags, and DON acknowledged that catheter bags should always be covered with privacy bags while in use. Review of facility policy titled Catheter Care with a revision date of 03/2026 stated, . 2. Privacy bags will be available, and catheter drainage bags will be covered at all times while in use. (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy titled Promoting/Maintaining Resident Dignity with a revision date of 03/2026 stated, .1. All staff.providing care to residents.maintain resident dignity and respect resident rights. 3) On 04/30/26 at 10:09 AM, during a meeting with Resident Council Members (RCM), residents expressed concerns regarding Certified Nurse Aide (CNA) staff members CNA19 and CNA17, stating they do not consistently respond to resident care needs and do not provide care with dignity and respect. RCM reported that CNA19 may have been trained by CNA17, which residents believed contributed to ongoing care concerns. RCM stated that in the mornings, CNA19 and CNA17 do not routinely provide basic hygiene care such as wiping residents' faces and hands. Residents further reported they do not receive daily showers, therefore, morning hygiene assistance is important for feeling clean and refreshed. RCM stated that CNA19 and CNA17 often prioritize quickly moving residents out of rooms and will ignore requests for assistance with wiping down. RCM further reported that a few CNA staff frequently pass by resident rooms when call lights are activated and tell residents they are not assigned to those rooms, stating not my patient. One resident reported observing CNA 17 walk past her room multiple times while her call light was on, and when the resident called out for assistance, CNA17 responded that she was not her patient. RCM also reported that CNA17 and CNA19 will sometimes turn off call lights when they believe the request is related to incontinence care involving a bowel movement, asking residents one or two (urine or bowel movement), then turning off the call light without returning to provide assistance, leaving the care for another shift. Residents stated this results in delayed care and unmet needs. RCM further stated that oncoming staff are aware when CNA17 is working because incontinence care is often left for the next shift, resulting in increased workload for subsequent staff. R44 and R222 reported that on one occasion, they both remained in their bowel movements for approximately one and a half hours after lunch, either on Tuesday or Thursday. R44 stated she activated her call light around 01:30 PM, was asked by staff if she had a bowel movement, and staff did not return to provide care. R44 also reported observing R222's call light on at the same time. Both residents stated they were not cleaned until after 03:00 PM when the next shift arrived. R222 stated she sometimes requests staff to pull the bathroom call light because staff respond more quickly when it is activated.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure call system equipment was within reach for three Residents (R) 87, 132, 167 of eight sampled residents sampled. The deficient practice placed residents at risk of not having emergent needs met in a timely manner and had the potential to affect all residents that rely on staff for assistance with activities of daily living. Findings include:1) R87 is a long-term care resident at the facility. Her MDS (Minimum Data Set) assessment dated [DATE] revealed her medical history included but not limited to arthritis, bipolar disorder and chronic pain. She is always incontinent of bowel and bladder, and dependent on staff of Activities of Daily Living (ADL's). On 04/28/26 at 10:30 AM conducted an interview with R87. At that time observed that her call light cord appeared to be out of reach (toward the head of the bed). Asked if she could reach it and she said no and requested it to be moved within reach. 2) R132 was a long-term resident at the facility who had a medical history of stroke with impairment on one side. He is incontinent of bowel and bladder and dependent on staff for activities of daily living. On 05/01/26 at 09:30 AM, observed R132 lying comfortably in the bed and noted that he did not access to the grey call pad that was hanging on the light fixture behind the bed. Asked R132 if he was able to use the call pad and he replied yes. Located Certified Nurse Assistant (CNA)15 who placed the call pad where R132 could access it. 3) R167 was a [AGE] year-old resident admitted to the facility on [DATE] for long term care placement. Diagnoses included but are not limited to hemiplegia and hemiparesis following infarction affecting left non-dominant side. Observation and interview done with R167 at bedside. R167 was able to communicate verbally, speech unclear but is able to understand and be understood when speaking. R167 has impaired left upper extremity impairment but is able to move right upper extremity. On 04/28/26 at 09:46 AM, observed R167 comfortably lying in bed on her back with slightly head elevated. Call light was observed left hanging on the wall, above R167's bed and out of reach. Returned to R167's room at 01:51 PM and at 02:14 PM, observed call light still hanging on the wall and out of reach from R167 on both times. On 04/29/26 at 10:08 AM, observed R167 comfortably lying in bed. Call light left hanging on the wall and out of R167's reach. On 04/30/26, at 08:46 AM, interview was conducted with the Interim Director of Nursing (DON) and DON in the office. Both DON's acknowledged that call light device should not be left hanging on the wall and should be placed within easy reach of the resident. On 04/30/26, at 10:37 AM, record review was done. Minimum Date Set (MDS) 3.0 documented under Section GG – Functional Abilities, .GG0115. Functional Limitation in range of Motion- A. Upper extremity (shoulder, elbow, wrist, hand). 1. Impairment on one side. Review of facility policy titled Call Light: Accessibility and Response with an effective date of 02/2026, stated, .5. Staff will ensure the call light is within reach of the resident and secured.6. The call system will be accessible to residents while in their bed.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to maintain a homelike environment in six Resident rooms (Rm (110, 114, 115, 116, 118 and 119) on the unit Pensacola 1. An unhomelike environment could significantly affect their physical, mental and social well-being and affect any resident in the facility. Findings include:On 04/28/26, the following observations were made: Room (Rm) 110 A: Wall clock broken (large piece missing), and several white patches on the wall. RM [ROOM NUMBER] A/B: Multiple large brown marks on the wall of unknown substance, visible immediately on entry. Immediately brought to staff's attention and observed being cleaned on 04/29/26. RM [ROOM NUMBER]: Loud constant buzzing noise when light in bathroom is turned on. RM [ROOM NUMBER] A: Several visible water marks on the ceiling, electrical plug plate broken, and the wall behind the bed very damaged. RM [ROOM NUMBER] B: The light on the wall over the head of the bed had a cord attached so the Resident could pull the cord and turn it on. Observed a plastic bag attached to the end of the cord to make it longer so Resident could reach. RM [ROOM NUMBER]: Electrical Plug located on the head of bed wall was not secure and visibly coming out of the wall. RM [ROOM NUMBER]: Sink faucet dripping, and grout around sink very discolored. Reported to unit staff. RM [ROOM NUMBER]: Strong smell of urine. Reported to unit staff. RM [ROOM NUMBER]: Sink faucet constantly running. RM [ROOM NUMBER]A: Washcloth attached to light cord at head of bed to extend the cord so Resident could reach, and six large screws/hooks in the wall.On 05/01/26 at 10:50 AM, interviewed the Facilities Director (FD) in the conference room. He said the process would be that the unit staff complete a work order for any identified repairs that needed to be done and then they are prioritized and assigned to staff to complete. FD said there were no major projects scheduled for Pensacola 1 at this time.Reviewed the open work orders, which included two for Pensacola 1, #25393 Floor tile peeling off and #25388 Need to seal grout on the sink, both in RM [ROOM NUMBER]. Both of these issues were reported to staff during the survey. #25393 was not included in above observed items, as it had just occurred within the previous 24 hours. Although there is a process in place to maintain the environment in a safe, clean, comfortable and homelike environment, routine work orders had not been made by the unit staff to notify Maintenance of needed repairs so they could be prioritized and assigned for repair.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to ensure residents were informed of their right to formulate an Advanced Health Care Directive (AHCD) for three of seven residents (Resident (R) 17, R170, and R153) reviewed for AHCD. This failure placed R17, R170, and R153 at risk of not having their health care preferences known or honored, potentially resulting in care that is not consistent with their wishes. Findings Include: 1) Review of R17's Electronic Health Record (EHR) revealed that on 04/14/25, the facility discussed AHCD information with the resident. Documentation indicated that R17 did not have an AHCD at that time and requested a blank AHCD form. Further review of the EHR revealed no evidence that an AHCD was completed or that follow-up assistance was provided thereafter.,On 04/30/26 at 10:06 AM, an interview was conducted with the Social Services Assistant (SSA). The SSA confirmed there was no documentation showing the facility followed up with R17 regarding formulation or completion of an AHCD after 04/14/25. Additionally, review of R17's most recent interdisciplinary team meeting dated 02/04/26 revealed no documentation addressing AHCD follow-up.2) Review of R170's EHR revealed the facility obtained a completed Five Wishes document related to an AHCD. Further review of the document revealed it did not contain witness signatures. The form instructions stated, Make sure you sign and witness the form just the way it says in the directions. Then your Five Wishes will be legal and valid. On 04/30/26 at 10:06 AM, an interview was conducted with the SSA. The SSA confirmed the Five Wishes document did not contain witness signatures. 3) Review of R153's EHR revealed the facility last discussed AHCD information with the resident on 12/10/24. Documentation indicated that R153 did not wish to formulate an AHCD at that time. Further review of the EHR revealed no evidence the facility periodically revisited the discussion or reoffered assistance with formulating an AHCD thereafter.On 05/01/26 at 08:17 AM, an interview was conducted with R153. R153 stated the facility had not discussed an AHCD with him and reported he would .like to fill one of those out.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and staff interview the facility failed to maintain a clean environment as evidenced by a dirty lab specimen refrigerator. As a result of this deficiency, there was an increased risk for the spread of disease-causing organisms.Findings include: Observation of the lab specimen refrigerator, on 04/30/26 at 11:30 AM, showed brown stains on the door shelf and bottom shelf and multiple small dead bugs on the door shelf.During staff interview on 04/30/26 at 11:45 AM, Infection Prevention Nurse acknowledged that the lab specimen refrigerator was dirty and said they would immediately clean it and develop a cleaning schedule going forward.

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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** Based on record review and interviews, the facility failed to develop comprehensive care plans for one of five residents (Resident (R) 5) reviewed for unnecessary medications and one of three residents (R153) reviewed for pressure ulcers. Specifically, R5's care plan did not address the resident's use of an anticoagulant medication and include interventions related to dementia care. In addition, R153's care plan did not address pressure ulcer prevention measures or identify the resident's risk for pressure ulcer development. This placed residents at risk for adverse outcomes, including medication-related complications, unmanaged dementia-related behaviors, impaired skin integrity, and the development or worsening of pressure ulcers due to the lack of individualized care planning and interventions.Findings Include: 1) Review of R5's physician orders revealed R5 was prescribed Eliquis oral tablet 2.5 milligrams (mg) twice daily with instructions to monitor for adverse reactions.Review of R5's care plan revealed the care plan did not address the resident's use of anticoagulant medication.On 04/30/26 at 12:36 PM, an interview was conducted with Minimum Data Set Registered Nurse (MDSRN) 3. MDSRN3 confirmed R5's care plan did not include the use of an anticoagulant medication and stated it should have been included in the care plan.2) Review of R5's diagnoses revealed diagnoses including, but not limited to, vascular dementia with agitation.Review of R5's physician orders revealed psychotropic medications had been prescribed.On 04/30/26 at 9:42 AM, a concurrent record review and interview was conducted with MDSRN3. MDSRN3 confirmed R5's care plan did not include dementia-related care and stated dementia care should have been included in the care plan.Review of the facility's policy and procedure Treatment/Service for Dementia, number 744, revealed The facility will develop individualized care plans taking into consideration the resident's symptoms and disease progression, as well as other co-existing diseases or conditions. 3) On 04/28/26 at 10:32 AM, an interview was conducted with R153, who stated that a previously healed pressure ulcer had reopened. R153 reported the wound may have reopened because he remained in his wheelchair for prolonged periods without repositioning assistance. R153 further stated the physician recommended wound dressing changes twice daily and reported staff on his current unit do not consistently assist with repositioning every two hours. Review of R153's wound clinic note dated 04/24/26 revealed documentation that the previous site of ulcer located to left sacrum broke down due to scar tissue and MASD [moisture-associated skin damage] mechanism found last week. The note further documented the resident attributed trauma from the shower chair as a contributing factor and requested a plastic surgery evaluation due to recurrent wounds. The wound assessment documented a skin ulcer of sacrum with fat layer exposed.Review of R153's care plan on 04/29/26 revealed no documented interventions related to pressure ulcer prevention or management.Review of R153's Braden Scale for Predicting Pressure Ulcer Risk assessment dated [DATE] revealed a total score of 11, indicating the resident was at high risk for pressure ulcer development.On 04/30/26 at 01:30 PM, concurrent record review and interview were conducted with Registered Nurse (RN) 41. RN41 stated R153 was at high risk for pressure ulcer development due to diagnoses and impaired functional mobility. RN41 further confirmed the resident's care plan did not include pressure ulcer prevention interventions.On 05/01/26 at 12:44 PM, interview and record review were conducted with MDSRN4. MDSRN4 stated the resident's pressure injury care plan had previously been discontinued after the wound healed and was not reopened until 04/30/26. Prior to that date, the resident did not have an active pressure injury prevention care plan.Review of APRN visit notes dated 01/27/26 revealed the resident's left and right sacral/buttocks pressure ulcers were documented as healed; preventive interventions remained in place, including repositioning every two hours while in bed, repositioning every hour while seated in a wheelchair, use of a pressure-relieving wheelchair cushion, timely incontinence care, use of an alternating pressure pump and pad mattress, and foam dressings (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for skin protection. The APRN follow-up note dated 04/28/26 documented reopening of the prior sacral wound and included continued preventive and treatment interventions.Review of the facility's policy and procedure regarding skin integrity, number 686, dated 03/2026, revealed A resident identified as at risk of developing PU/PI [pressure ulcer/pressure injury] will have individualized interventions implemented to attempt to prevent PU/PI from developing. Interventions will be monitored for effectiveness. The resident's care plan will reflect the interventions.

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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** Based on resident interview, staff interview and record review, the facility did not update/revise the care plan for two Residents (R) 11 and 221 of thirty-five residents reviewed. As a result of the deficiency, there was an increased risk of uncoordinated delivery of care.Findings include:1) During resident interview on 04/29/26 8:20 AM, R11 said he had a pacemaker and would connect frequently to a monitoring machine which was kept at bedside. R11 showed surveyor how the connection process was done. He also said staff were aware that this procedure was being done on a frequent basis. Review Electronic Health Record showed R11 was admitted on [DATE] with diagnosis including Heart Failure, Paroxysmal Atrial Fibrillation, Cardiomyopathy, Stroke, Diabetes, Chronic Obstructive Pulmonary Disease. Review of the most recent comprehensive care plan did not identify any interventions or instructions pertaining to the monitoring machine. During staff interview on 04/30/26 at 9:10 AM, Unit Manager (UM) 28 acknowledged that the care plan was not revised to include interventions or instructions as indicated and said that they would make the necessary changes. 2) R221 has a history that includes Congestive Heart Failure (CHF), amenia, Alcohol dependence with alcohol induced dementia, carrier or suspected carrier of methicillin resistant staff aureus (MRSA), alcohol induced psychotic disorder with delusions, and other behavioral disturbance. On 04/28/26 at approximately 09:25 AM, when R221's room entered, RN13 was present. There was a strong odor of urine, and observed two large puddles on the floor, one under the bed and the other in the middle floor. At that time, interviewed RN13, who said the puddles were urine, and that R221 urinates on the floor all the time, that's why he has his own room and can't have any room mates. On 04/29/26 at 10:30 AM, observed a large puddle of urine under the bed. On 04/31/26 at 09:00 AM, observed large puddle of urine under the bed. Review of R221's CP, on 04/28/26 revealed it did not include that he urinates on the floor. The active CP 04/28/26 included: Focus: Self-care deficit: Toilet use: Offer toileting assistance after waking, and after meals. Revision 03/12/2026. Focus: Behavioral status: Resident has episodes of verbal aggression directed to others. Resident has episodes of voiding in the trash can. Date Initiated 03/04/25. On 04/30/2026, the CP was revised to include Resident has episodes of urinating on the bedroom floor daily.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, document and record review, the facility failed to ensure three Residents ((R)16, R176 and R221 of a sample size of three received the treatment and care in accordance with professional standards of practice and their person-centered comprehensive care plan (CP). This deficient practice put these residents at increased risk of not meeting their highest practicable physical, mental and psychosocial wellbeing, and could affect any resident in the facility. Findings include:1) R16 was a [AGE] year-old female long-term resident at the facility. She had a history that included but not limited to a stroke with paralysis of the right side of her body, aphasia (difficulty communicating), oropharyngeal dysphagia (swallowing disorder), behavioral disturbance, history of seizures, constipation, malnutrition, dementia and urinary tract infection. R16 was incontinent of urine and bowel. Her BIMS (Brief Interview for Mental Status) score was 99, severe cognitive impairment. On 01/22/26 she was taken to the hospital due to altered mental status. She returned to the facility after hospitalization on 02/06/26. On 04/28/26 at 10:30 AM, observed R16 resting in bed and noted a handwritten note taped on the wall at the head of the bed that read Leave binder on at all times. She was unable to communicate to conduct an interview. Reviewed R16's Nursing Notes, which revealed the following entries: 1/22/26 04:06 AM, Interact SBAR (situation, background, assessment, recommendation (a format to report change of condition) Summary for Providers that included: - O2 (oxygen saturation) 97% - Nursing observations, evaluation and recommendations are: Resident was lethargic unable to respond. Increased stimulation provided, resident was able to make sound and gran [sic] staff which is her baseline. Vital signs stable. - Primary Care Provide Feedback .A. Recommendations: 1. CBC with diff (complete blood count with differential) and BMP (basic metabolic panel) .2) D5 1/2 NS (dextrose 5 % and 1/2 Normal Saline IV fluid) 40 ml/hr (milliliters/hour) x 3 liters . Nursing Progress note 01/22/26 at 10:14 AM: CBC with diff (complete blood count with differential) and BMP (basic metabolic panel) done. IV (intravenous) fluids was unable to start. NOC (night) and AM supervisors were unsuccessful inserting IV line. At 08:04 vital sign was: BP 118/65, P 57, RR 20, Temp 97.5 F. Oxygen saturation at 2LPM (liters per minute)/nasal cannula was 75%. Resident noted to be sluggish. Oxygen increased to 4 LPM, and oxygen saturation went up to 80%. MD made aware and ordered to transfer resident to ER for further evaluation.Called 911, resident left facility at 0830. Progress note 01/22/26 at 10:39 AM: Resident was sent out to ER @ 8:30 AM; for further evaluation, per NOC (night) nurse resident had altered mental status this 4AM. Rechecked resident status, unable to hook the peripheral line and oxygen saturation 88% RA. Administered oxygen via nasal cannula at 2L and improved to 90% HOB (head of bed) elevated. MD (MD1) notified and ordered to send to ER via 911. confirmed resident will be admitted with Dx. Infection r/t (related to) UTI or pulmonary, hypernatremia.On 04/30/26 at 01:00 PM, interviewed by the Unit Manager (UM)1, who assessed R16 the morning of 01/22/26. When he arrived, he said he got report and was asked to look at R16 because they had difficulty starting the IV. UM1 said he knew the resident well, and when he saw her, she was not at her baseline. He said her veins were small and difficult to palpate. UM1 went on to say he didn't even try to get the IV because the heart rate was below 60 and her oxygen saturation rate was 75% on 20 liters. Confirmed with UM1 that it was 20L and he said yes. He said he immediately called 911 to transfer R16 to the hospital and contacted MD1 to report her status. After review of the records, UM1 confirmed there was no other neurological assessments documented after the initial change of condition of AMS, and no documentation of ongoing monitoring of vitals or oxygen saturation. UM1 agreed there should have been ongoing monitor.On 04/31/26 conducted a telephone interview with Registered Nurse (RN)25 who was assigned to R16 the night shift of 01/22/26. She said the CNA asked her to check on R16 because she was not her usual self. RN25 said R16 did not respond and had to shake her, and finally made some noise. She said, was more like lethargic. Inquired what the Increased stimulation provided was that she documented in the SBAR note. RN25 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	described it to be a sternal rub (pain stimulus techniques to check an unresponsive person can still react to pain). She said she did get some response. RN25 said she went back and forth that night to make sure R16 was OK. Inquired if additional vitals were taken or documented, and she replied, I don't think so. 2) R221 has a history that includes Congestive Heart Failure (CHF), amenia, Alcohol dependence with alcohol induced dementia, carrier or suspected carrier of methicillin resistant staff aureus (MRSA), alcohol induced psychotic disorder with delusions, and other behavioral disturbance. On 04/28/26 at 11:25 AM, RN13 was present when R221's room was entered. On entry, there was a strong odor of urine, and two large puddles were observed on the floor, one under the bed and the other in the middle of the pathway to exit the room. Asked RN13 if that was urine, and she said yes, he won't wear diapers, that's why he's in a room by himself. She went on to say they (housekeeping) just cleaned the room and are in here all the time. On 04/29/26 at 10:30 AM, observed a large puddle of urine under the bed. On 04/31/26 at 09:00 AM, observed large puddle of urine under the bed. Reviewed R221's CP, on 04/22/26 which included the following: Focus: Self-care deficit: Toilet use: Offer toileting assistance after waking, and after meals. Revision 03/12/2026. Focus: Behavioral status: Resident has episodes of verbal aggression directed to others. Resident has episodes of voiding in the trash can. Date Initiated 03/04/25. The plan was revised on 04/30/2026 to include Resident has episodes of urinating on the bedroom floor. Goal included The resident will have decrease in behavioral episodes by at least 50% by next review. Interventions included: . Minimize potential for the resident's behavior by making sure resident has urinal that he can reach or offer assistance to toilet. Provide verbal reminder not to void in the trash can. Initiated 07/19/2025. Offer/assist to use the urinal. Assist to empty after each use. Date initiated 03/24/26. Focus: Bowel/Bladder elimination: . Encourage fluids during the day to promote voiding response. Date Initiated: 08/28/2024. Ensure the resident has unobstructed path to the bathroom. Date Initiated. 08/27/2024.Reviewed Nursing Progress Notes which revealed the following entries: 04/06/2026 04:14 PM: Resident on monitoring for behaviors. Big puddle on ground of resident's room hx of urinating on ground. Redirections done but ineffective, resident is confused. Housekeeping cleaned up. 04/10/2026 02:08 PM: . On monitoring for behaviors due to GDR (gradual dose reduction) of Trazodone (antidepressant). Noted a puddle of urine on the floor. Resident has history of urinating on the floor. Encouraged resident to use bathroom when in need to urinate and defecate. Resident said yea, I know. Housekeeping cleaned room and has not had any other episode this shift. 04/11/2026 01:46 PM: . urinated on floor. 04/15/2026 11:08 AM: .Floor is urine soaked and housekeeping was made aware.Review of Documentation Survey Report v2 Apr-26 (April26) for behaviors and interventions for the period of 04/01/26 through 04/30/26 revealed no behaviors documented for the days progress notes documented urine of floor, or the days observed during survey. There is no specific behavior code for urinating on the floor, but there was a code OB- Other behaviors Not Directed At Others.Review of Documentation Survey Report v2 Apr-26 for the period of 04/01/26 through 04/30/26 for bladder continence, revealed no documented entries for the day shift on 04/28/26 and 04/29/26 when puddles of urine observed on the floor of R221's room.Review of the 30 day look back for Urinary Continence for 04/01/26 through 04/31/26 revealed R221 was documented to be sometimes incontinent and sometimes continent. Reviewed R221's NSG (nursing) Bowel and Bladder Screener- V3 documents which revealed the following: 11/22/2025 : 1. Screener included R221 was able to void appropriately without incontinence, not always, but a least daily, required 1 person assistance to the bathroom, forgetful but follows commands and usually aware of the need to toilet. 2. The screener score was 10, which indicated R221 was a Candidate for scheduled toileting (timed voiding) 3. Care Planning: The question Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence? was answered No. 02/22/2026. 1. Screener included R221 voids appropriately without incontinence, but less than daily, and that he now was incontinent of stool 1-3x/wk (three times per week) 2. Score was 8 and remained a Candidate for scheduled toileting. 3. Care Planning: The (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	question Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence? was answered No. Reviewed the facility policy titled Bowel and Bladder Program (no date). The policy included: Intent: to assess residents' level of bowel and bladder continence in order to implement interventions and programs to maintain or restore as much continence as possible. Incontinent residents will be scheduled for bowel and bladder elimination tracking. incontinent residents will be placed on a continence plan. Continence plans will be developed according to the cognitive and functional abilities of each resident. Residents receiving restorative bowel and bladder elimination retraining programs will be reviewed by the facility restorative committee monthly for progress and needed changes to their program. The following definitions will be used in developing individualized resident continence programs: a. Bladder Retraining: Requires the resident to resist the sensation of urinary urgency to postpone or delay voiding.Residents must have sufficient cognitive ability to participate. b. Prompted Voiding: Beneficial for cognitively impaired residents regardless of incontinence typed/category.Every effort will be made to tailor the program to the resident's individual elimination pattern. Assistance is typically scheduled to occur every 3-4 hours while resident is awake. c. Scheduled Voiding: Another term to describe this type of continence program is Habit Training. Scheduled voiding is most appropriate for resident who may have severe cognitive impairment and are unable to self-toilet. Section 12 of the Program provided included Bowel and Bladder Continence Course Training and Competency and included: Treatment ideas for functional incontinence: Habit training for a bladder schedule, eliminating functional inhibitors to the bathroom, schedule assistance to the toilet, behavior modification for those who are unwilling to go to the toilet, and use of the commode for urinal.Reviewed R221's MDS (Minimuml Data Set) assessment dated [DATE] Section H Bowel and Bladder which revealed the question has a trial of a toileting program (e.g. Scheduled toileting, prompted voiding, or bladder training) been attempted on admission/entry or reentry or since urinary incontinence was noted in this facility? Was answered No, and documented him to be frequently incontinent. On 04/28/26 at approximately 02:00 PM, interviewed the housekeeper of the unit, and she said R221 urinates on the floor every morning. Said she cleans it up right away at the beginning of her shift and then keeps an eye on the room to see if he urinates again as she works during the day.On 04/27/26 at approximately 09:30 AM, interviewed Certified Nurse Assistant (CNA)14. She said the CNAs are to document when R22 voids. Asked how they document when he urinates on the floor, and she said incontinent Asked if there was any specific instructions or plan on how to improve the situation and she said not that she was aware of, and they check on him when rounding.On 04/30/26 at 01:00 PM, interviewed the Unit Manager (UM)2 and conducted concurrent chart review. UM2 said R221 was continent and that his urinating on the floor was behavioral. Reviewed the April CNA task documentation for bladder, and POC Response History. She said there may be some confusion of how to document when R221 urinated on the floor, and that the documentation did show a routine voiding schedule and that the documentation was incomplete. UM2 said she was not aware of any evaluation of his voiding patterns and confirmed he was not currently on a scheduled toileting or bladder program. 3) R176 had a history that included but not limited to acute respiratory failure, muscle weakness, chronic pain syndrome, muscle spasm of back, major depressive disorder, Type 2 Diabetes with chronic kidney disease and was on hospice. She needed assistance with her activities of daily living. On 04/28/26 at conducted an interview with R176. She was lying in her bed with her head at the foot of the bed. Observed R176 had a blood-soaked dressing on her left shin and foot. When asked about the dressing, she said she had open sores due to psoriasis and that she picks at them. On 04/31/26 at 01:00 PM, observed R176 in bed sleeping. She did not have dressing on her left leg. On 05/01/25 at 10:05 AM observed R176 in bed sleeping. She did not have a dressing on her left leg. Reviewed R176's wound care orders, which revealed the current order by Physician (MD)1 dated 03/15/26 was LEFT SHIN: Cleanse with NS (normal saline). Pat dry, apply hydrogel gauze, non-adherent dressing, wrap with kerlix and secure with tape as needed for OPEN LESION AND every (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	day shift every other day for OPEN LESION. Reviewed R176's April Treatment Administration Record (TAR) which revealed her dressing was changed on 04/27/26. 04/28/26 would have been the day the dressing would not be changed unless there was need to do so (e.g. blood soaked, taken or came off). On 05/01/26 at 10:15 AM interviewed and conducted concurrent record review with assigned treatment nurse (Registered Nurse (RN))14 in the nursing station. RN14 confirmed the order for wound care and that it was to be done every other day and as needed. RN14 said she knew R176 had open wounds to her shin but did not know what caused them. She reviewed TAR for the past week and confirmed the wound care, and dressing was marked as completed every other day (04/23/26. 04/25/26, 04/27/26 and 04/29/26). There was no documentation on the TAR or nursing progress note regarding the observations noted above. RN14 could not explain why R176 did not have a dressing on the past two days.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review and interview, the facility failed to provide supervision for one Resident (R)176 of sample of one, that was consistent with her needs, goals, care plan and current professional standards of practice to eliminate the risk of a fall. As a result of lack of assistance, there was increased risk of a fall that could result in a negative outcome. This deficient practice could affect any resident in the facility. Finding includeR176 had a history that included but not limited to acute respiratory failure, muscle weakness, chronic pain syndrome, muscle spasm of back, major depressive disorder, Type 2 Diabetes with chronic kidney disease and was no palliative care. She had an unwitnessed fall on 04/12/2026, that resulted in no injury. On 04/28/2026 at 03:14 PM, observed R176 using a front wheel walker moving down the hall in a rapid pace, calling out to staff. She had a patient gown on and a jacket. The gown was open in the back, did not have any underwear on and her buttocks were exposed. R176 did not have any foot coverings on and the dressing on her left lower leg/foot was coming undone and visibly soaked in blood. The only staff in the area was the nurse at the medication cart, who turned to R176 and told her to go back to her room multiple times. R176 finally turned around and headed back to her room. RN did not stop what she was doing to help R176 to ensure she safely got back to her room. Reviewed R176's Care Plan (CP) the revealed she had limited mobility r/t (related to medical condition). One of her goals was to remain free of complications related to mobility . the interventions included: Ambulation. The resident requires assist by (1) staff to walk. uses [NAME] for mobility. On 04/29/26 at 02:30 PM, during an interview with the Unit Manager (UM)2, she confirmed R176 was a one-person assist, and that the RN should have assisted her back to the room.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to provide appropriate services to prevent urinary tract infections for one resident (Resident (R)8). The deficient practice exposed the residents to contaminants that may cause preventable urinary tract infections. This has the potential to affect all residents with a urinary catheter. Findings include:1) R8 was a [AGE] year-old resident admitted to the facility on [DATE] for short-term rehabilitation services after having a fall at home resulting in a fractured right femur (thigh bone). Diagnoses included but not limited to malignant neoplasm of the prostate (prostate cancer) and secondary malignant neoplasm of the bone (cancer that has spread to the bone). On 04/28/26 at 09:01 AM, observed R8 sitting up in a wheelchair in the hallway just outside his room. R8 had an indwelling urinary catheter connected to a urine collection bag that was hung under the seat of the wheelchair. The urine collection bag was touching the floor. Review of Treatment Administration Record (TAR) revealed that the staff documented every shift when they check to ensure the privacy bag is on and the urine collection bag is not touching the floor. On 05/01/26 at 10:06 AM, an interview was conducted with Registered Nurse (RN)17 at the nurses' station. RN17 confirmed that the urine collection bags for all residents with an indwelling urinary catheter are not to be touching the floor.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interviews, document and record review, the facility failed to report to the physician that one Resident (R)16, of a sample of one, had a trend of significantly lower intake than baseline. In addition, R16's last documented weight indicated a significant weight loss, which was not confirmed with a reweigh according to standards of care and their own policy. As a result of this deficient practice, timely medical review to determine of these signs were a part of a broader decline in health status was not done and increased the risk of a negative outcome. This deficient practice could affect any Resident in the facility and prevent them from maintaining the highest practicable level of well-being. 1) R16 was a [AGE] year-old female long-term resident at the facility. She had a history that included but not limited to a stroke with paralysis of the right side of her body, aphasia (difficulty communicating), oropharyngeal dysphagia (swallowing disorder), behavioral disturbance, history of seizures, constipation, and dementia. R16 had a BIMS (Brief Interview for Mental Status) of 99, severe cognitive impairment. She was a full code. R16 was totally dependent on staff for eating. On 01/22/26 R16 had altered mental status and was transferred to the hospital for higher level of care. R16's hospital diagnoses included but not limited to severe Hypernatremia (too much sodium and not enough water in blood). She had a Peg tube (feeding tube inserted directly into stomach to provide nutrition when oral intake is insufficient) placed on 02/02/26. 2) On 04/28/26 at 10:30 AM, observed R16 sleeping in bed. She was unable to communicate to do an interview. There was a handwritten note above her bed to keep the abdominal binder on at all times (to help keep the PEG tube in place). 3) Review of the R16's Nutrition- V7 Evaluation dated 12/03/25 revealed R16 was on a Reg/MM5/Thin diet, small portions (a dysphasia -safe food texture where food is minced or ground into very small pieces with minimal chewing required). The document included: - Food intake was approximately 75% of meals - Received 2 Cal HN 237 (high-calorie, high protein nutrition formula) 237milliliters (ml) TID (three times a day.) - Her fluid intake per meal was 120-480 ml. - Weight: 171.6 on 10/15/25.- Assessment: .continue current nutrition POC (plan of care). PO (Oral) intakes are adequate to meet daily EEN needs (Exclusive Eternal Nutrition). Monitor weight trends. Review R16's Resident at Risk Review-Nutrition and Woiunds-V2 document dated 01/17/26 included the following: - Weight: 01/07/25 was 160.4 (pounds/#) weighed using mechanical lift. - Weight history: 12/11/25 175.6, 10/15/25 171.6, 7/6: 162.2. - Significant Change was 5% in 1 month. - % of food intake was 0-25% majority of meals. - Fluid intake was 151-240 ml per meal. - R16 remained on the nutritional supplement. - Assessment: Wt loss of 15.2# 8.1 % x 1mo (month)- Discussed with UM (UN1(Unit Manager)) on 1/9 and reweigh was requested. Wt loss has not been confirmed by reweigh. Meal intakes are generally poor to fair, but r/t good acceptance of ONS (oral nutritional supplements) which is primary source of her nutritional intake. R16 was identified to be at-risk for Malnutrition. - Recommendations: Cont (continue) to recommend reweigh to confirm wt loss and will place .on weekly wt monitoring. - The document had a section for Meeting Note/Attendance. The meeting notes were: RD cont to recommend reweigh to validate ~ 15# wt loss and will place .on weekly wt monitoring. The note was electronically signed by UM1 on 01/22/26.Reviewed R16's Weights and Vitals Summary, which documented weights as follows: - 08/03/25 166.8# - 09/11/25 170.6# - 10/15/25 171.6# - 12/11/25 175.6# - 01/07/26 160.4# There was no weight documented for November 2025, and the nursing staff did not reweigh R16 as recommended by RD (registered dietitian) to confirm accuracy of wt. loss. Reviewed the hospital Discharge summary dated [DATE] which included .Patient with poor PO (oral) intake and inconsistent desire to feed prior to this event (hospitalization). PEG placement (for nutrition) 2/2/26 with general surgery. 4) On 04/17/25 at approximately 03:30 PM interviewed the Registered Dietician (RD) in the conference room and did concurrent record review, which included the Documentation Survey Report 2 for December 2025 and January 2026 that included the % of daily meal and fluid intake. RD confirmed the trend that R16's (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intake had decreased and that she made the recommendation for reweigh and weekly weights but was unsure how this would be communicated to the staff to implement.5) On 04/17/25 at approximately 09:00 AM interviewed UM1 in the office. He said that R16 was weighed monthly because she was a long-term resident. UM1 said the policy is that if a Resident has a significant weight loss, the CNAs are to do a reweigh at that time to ensure accuracy. He said the Dietician and Provider should be notified. UM1 confirmed there was no reweigh done and no documentation of Provider notification6) Reviewed the facility policy titled Weights Procedure updated 07/02/25. The policy included Residents with a 5-lb or more variance from their previous weight will be re-weighed to verify the accuracy of current weight and If a significant variance is actual after reweight, the nurse documents in the medical record, revises the careplan, refers to the Resident At Risk Review committee, and notifies the physician and resident/resident's authorized representative. These notifications are recorded in the progress notes of the medical record.

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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 observations and interview the facility failed to assure one of one resident (R) 40, sampled for respiratory care, was provided oxygen assuring the O2 tubing was connected to the O2 concentrator. This deficient practice puts all residents who are using oxygen at risk for respiratory distress and complications related to not receiving lifesustaining O2. Findings Include:On 04/28/2026 at 11:08 AM went into R40's room and observed her resting in her bed with her oxygen concentrator running at 3L with the nasal cannula placed on resident's face with tongs placed in resident's nostrils. Went to check date on oxygen (O2) tubing and noticed O2 tubing was not attached to the O2 concentrator and tubing was on the ground. Went out and got resident's nurse, Registered Nurse (RN)105, asked her to bring her pulse oximeter which she placed on the resident. First reading of R40's oxygen saturation was 85% and resident was not in any distress. Asked RN105 to look at the oxygen tubing and she noticed it was on the ground, nurse stated It's not connected. RN105 applied new tubing and put nasal cannula on resident and her O2 sats went up to 96%. Resident was upset, stated They're trying to kill me! Inquired of RN105 how this could have occurred, and she said the staff might have assisted her and dislodged the tubing. Inquired if staff should check to assure tubing is in place before leaving resident and she confirmed this.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide access site care as ordered by the physician for one of one resident (R) 138, sampled for Dialysis. The deficient practice puts all residents who receive dialysis at risk for complications related to improper care of resident's hemodialysis access site potentially putting the resident's at risk for reduced blood flow, clotting, and narrowing or stenosis of the Arteriovenous Fistula (AVF). Findings Include:On 04/29/2026 at 11:53 AM interviewed R138 in his room. Surveyor inquired about his access site which is used for hemodialysis. R138 explained it is on his right arm. Inquired of R138 when do the nurses at the facility take off the dressing on his access site after he returns to the facility from dialysis and R138 stated nurses take the dressing off the day he comes back or the next morning. On 05/01/2026 during record review of R138's Electronic Health Record (EHR) found resident has an order for the following: When back from dialysis, keep compression bandage on no longer than 4 hours. If known to have bleeding post dialysis, remove the top compression bandage and leave the bottom bandage for an additional 2-3 hours every day and evening shift every Tue, Thu, Sat for POST HD AVF PROTOCOL. Continued record review found a care plan for R138 that stated: RENAL The resident needs hemodialysis r/t renal failure The resident will have immediate intervention should any s/sx of complications from dialysis occur through the review date. The resident will have no s/sx of complications from dialysis through the review date. Check and assess dressing at access site when back from dialysis as ordered. Remove dressing on AV fistula as ordered. During record review on 05/01/2026 found a Registered Nurse (RN) had charted on 05/01/2026 at 00:19 Resident came back from HD (hemodialysis) via wheelchair at 1740. No SOB (shortness of breath) noted. Denies any pain in the AVF (Arteriovenous Fistula) site. Dressing intact clean and dry. No active bleeding noted. Can verbalized [sic.] needs. Call light within reach. On 05/01/2026 at 09:30 AM observed R138 sitting in the hallway in his wheelchair. Inquired of R138 if he still had a dressing on his access site and he confirmed it. R138 confirmed he had dialysis the day before. Inquired if the nurses had removed the dressing after he returned from dialysis and R138 said No as I pulled up his right shirt sleeve. Dressing was observed on R138's upper right arm, covering his AVF. On 05/01/2026 at 10:44 AM met with and interviewed the Director of Nursing (DON) and interim Director of Nursing (IDON) in DON's office. DON was able to confirm that R138 returned to the facility on [DATE] after his dialysis appointment in the afternoon. DON was able to confirm resident has an order for the following: When back from dialysis, keep compression bandage on no longer than 4 hours. If known to have bleeding post dialysis, remove the top compression bandage and leave the bottom bandage for an additional 2-3 hours every day and evening shift every Tue, Thu, Sat for POST HD AVF PROTOCOL and that this information is also on R138's care plan. Inquired of DON and IDON why resident would continue to have the dressing on his AVF this morning. DON and IDON were unable to explain why the dressing was still on R138's AVF and stated they would investigate this.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the attending Physician's (MD1) post hospitalization visit examination notes for one Resident (R)16 of a sample size of one, did not reflect a thorough examination of R16's current health status on return to the facility Each visit must document review of resident's current, progress and problems in maintaining or their health status. Specifically, the progress note did not include R16 had been hospitalized for sepsis, hypernatremia (high sodium and low water in blood), or that she had a Peg tube inserted (feeding tube inserted directly into the stomach to provide nutrition). This deficient practice could affect any resident in the facility and increase the risk that Residents would not meet their highest practicable physical, mental and psychosocial well-being. Findings include:1) R16 was a [AGE] year-old female long-term resident at the facility. She had a history of a stroke in 2000 with paralysis of the right side of her body, aphasia (difficulty communicating), oropharyngeal dysphagia (swallowing disorder), behavioral disturbance and history of seizures. R16 was incontinent of urine and bowel. She has a BIMS (Brief Interview for Mental Status) of 99, severe cognitive impairment. On 01/22/26 she was taken to the hospital due to altered mental status. She returned to the facility after hospitalization on 02/06/26 2) Reviewed R16's hospital Discharge summary dated [DATE] which revealed the following: Final Diagnoses included but not limited to Severe Sepsis (life threatening infection) due to complicated UTI, Severe Hypernatremia (too much sodium and not enough water in blood that leads to imbalance) likely due to poor oral intake leading to dehydration, Combative behavior, Severe constipation. An incidental Pelvic Mass was found with the recommendation for further evaluation with MRI .as an outpatient setting, and a Peg tube was placed on 02/02/26. Physical exam on discharge included: .Abdomen: +PEG w/dressing (with dressing) .3) Reviewed MD1's Progress Note for R16 dated 02/17/26 post hospitalization. The note read: Denies having a cough, No fever, No wheezing or orthopnea (shortness of breath when someone lies down). Denies hemoptysis (coughing up blood) or pleurisy (inflammation of lining of the lungs). Review of systems reviewed. As noted in the history. Ten systems reviewed. Vital signs stable. General: lying comfortably in bed in no apparent distress. Responding to commands. HEENT (head, ears, eyes, nose, throat). Eyes, pupils reactive to light. Dentition fair. Oropharynx is clear. Neck: no lymphadenopathy. Normal carotid pules. Cardiovascular. No murmurs, rubs or [NAME]. Respiratory: Fair respiratory effort. Clear to auscultation. Abdomen, Positive bowel sounds, Soft and nontender. No masses palpated. Extremities: Dorsalis pedis and radial pulses 2+. No edema. Assessment and Plan: cva (cerebral vascular accident (stroke)) Supportive care. Constipation. Bowel movements moving regularly on current regimen. Plan of care. Here for long term care. R16 was readmitted to the facility on [DATE] and MD1's examination was done on 02/17/26. The notes of that examination did not reflect R16's current health status and did not include: 1) R16 had been hospitalized , 2) the reason for hospitalization, hospital course or diagnoses or that 3) R16 had a PEG inserted surgically and would now be receiving tube feedings for nutrition.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observations, interviews, and record reviews, the facility failed to ensure sufficient nursing staff were available to provide nursing and related services necessary to meet residents' needs in a safe manner and in a manner that promoted each resident's rights and physical, mental, and psychosocial well-being for five Residents (R) 170, 187, 222, Anonymous 1, Anonymous 2 of thirty five residents sampled. These failures placed residents at risk for unmet care needs, delays in assistance, decline in hygiene and psychosocial well-being, and diminished quality of life.Findings Include: 1) On 04/28/26 at 08:51 AM, an interview was conducted with R170. R170 stated the facility was short staffed and when there were not enough staff, Certified Nurse Aides (CNAs) did not have time to provide showers and instead provided bed baths. R170 further stated it takes nursing staff longer to answer call lights when staffing is short. The resident reported there should be at least five CNAs on the unit, however, at times there were only three CNAs working. On 04/28/26, review of the daily posted nursing staff report documented five CNA staff available for the unit, observed only four CNA staff. On 04/28/26 at 01:12 PM, an anonymous nursing staff member (ANS) 1 reported the unit was short staffed that day, 04/28/26. ANS1 stated the unit initially had five CNAs assigned in the morning; however, one CNA was reassigned to another unit, leaving only four CNAs. ANS1 further reported she had not yet taken a lunch break and stated the unit has the highest census with 49 residents out of a maximum census of 50, while other units had lower census numbers of approximately 42 to 43 residents and were assigned six to seven CNAs. ANS1 expressed frustration regarding staffing assignments and stated it was difficult for staff to manage the workload when only three to four CNAs are working on the floor. On 04/29/26 at 08:24 AM, an interview was conducted with CNA20. CNA20 stated there were times staff were unable to provide resident showers and instead performed bed baths because of short staffing. CNA20 reported in order to provide showers, staff need to leave the wing and there are not enough staff available to remain on the floor and answer resident call lights. CNA20 further stated staff tended to provide bed baths to residents who required longer shower assistance because residents complained when call lights were not answered promptly. On 04/29/26 at 08:26 AM, an interview was conducted with CNA21. CNA21 reported the unit was short staffed and there were days when only three CNAs were assigned. CNA21 confirmed efforts were made to provide showers, however, when staffing was insufficient, residents received bed baths instead. CNA21 further stated that when the unit was short staffed, staff rushed care rather than providing quality care. Review of the CNA shower task documentation for R170 revealed the resident received a bed bath on 04/28/26. On 05/01/26 at 08:17 AM, R170 reported he received a bed bath on 04/28/26 because there were not enough staff available. 2) On 04/28/26 at 12:54 PM, an interview was conducted with R187. R187 reported the unit where she resides is short staffed and that although five CNAs were initially assigned to the unit that day, one CNA was reassigned to another unit, leaving only four CNAs available. R187 stated the staffing (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shortage negatively affects resident care because staff are overworked and argue amongst themselves regarding incomplete assignments, while some staff only assist within their own assigned areas. R187 further reported there was an occasion when staff did not respond to assist her after she had a bowel movement, resulting in her remaining incontinent from approximately 08:00 AM until 12:30 PM. The resident also stated that when bed baths were provided, staff rushed through the care and did not complete the hygiene task thoroughly. 3) On 04/28/26 at 12:54 PM, an interview was conducted with R222. R222 reported the unit where she resided was short staffed, with only four CNAs assigned to care for a census of 49 residents. R222 stated there should be five to six CNAs assigned to the unit to adequately meet resident care needs. R222 further stated that when the unit was short staffed, staff took longer to provide timely incontinent care. The resident expressed concern and confusion regarding why CNAs assigned to her unit were frequently reassigned to other units that had fewer residents and lower care needs. 4) On 04/28/2026 at 10:45 AM observed a resident who was in their room. An interview was conducted with the resident who stated they wished to remain anonymous. Interviewed anonymous resident (AR) 1 in their room. Inquired if they felt there was enough staff to assist them when they needed help and they stated, the unit is short staffed. AR1 stated there have been times when they had to wait almost an hour for staff to come and help them after they rang their call light resulting in AR1 sleeping in their urine. AR1 stated the unit always has staff floating to other units when the other units are short staffed and never the other way around, they stated the staff on their unit always gets floated to other units and the unit they reside on works short staffed. AR1 stated it takes staff about 45 minutes to an hour to respond to their call light, not that they don't want to help them but that they are short-staffed. 5) On 04/28/2026 at 1:44 PM an interview was conducted with a resident in their room. The resident stated they wished to remain anonymous, anonymous resident (AR) 2. Inquired if resident felt there was enough staff to assist them when they need help, when they use their call light. AR2 stated they feel there are not enough staff on the unit to help them. AR2 stated the staff want to help them but they are busy helping others and it takes them awhile to help them. AR2 stated sometimes it takes an hour for staff to help them.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure safe administration of medications in accordance with standards of nursing practice when four residents (Residents (R) 44, R170, R169, and R203) of a sample size of 38 were not directly observed taking their medications and licensed staff left them at the bedside. As a result of this deficient practice, there is a risk of hoarding, diversion, inaccurate timing of administration, and omission, which increases risk of an adverse outcome. This deficient practice could affect any resident in the facility.1) On 04/28/26 at 12:04 PM, during an interview with R44 observed Registered Nurse (RN) 42 enter R44's room, hand a cup of medication to R44 and tell her one of the medications was tums, then left the room without observing R44 take the medication. R44 then put the cup of medication on her bed without taking the medication given. Review of R44's Medication Administration Record (MAR) for 04/28/26 revealed R44 was administered Renvela Oral Tablet 800 milligrams (mg) one tablet by mouth with meals for ESRD and Tums oral chewable tablet 500 mg, 1 tablet by mouth for ESRD. On 04/30/26 at 08:33 AM, interview with the Director of Nursing (DON) confirmed there were no residents in the facility assessed or authorized to self-administer medications independently. 2) On 05/01/26 at 08:23 AM, while interviewing R170 observed a cup of multiple medications unattended and on bedside table with a cup of water. Licensed Practical Nurse (LPN) 43 later entered R170's room with another cup of water and grabbed the cup on bedside table and asked R170 which cup he preferred. R170 did not show any preference in the water cups and LPN43 proceeded to watch R170 take his medications. Review of the facility's policy and procedure Medication Storage dated 03/2006 documented all drugs and biologicals will be stored in locked compartments .during a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. 3) R169 is a [AGE] year-old male with a medical history that includes dialysis and cancer. He is receiving hospice care. R169 had a BIMS score of 14 (cognizant) and was able to carry on a conversation. On 04/28/2026 at 09:40 AM, when interviewing R169. observed a medication cup with three pills on a large cardboard box that he was using as a table at the side of his bed. When asked if that was his medication, he became upset and loudly yelled They say take it now. I don't always want to take it now. 4) R203 is a [AGE] year-old female with history that included, but not limited to high blood pressure, obesity, post-traumatic stress disorder, urinary incontinence, weakness, and severe episode of recurrent major depressive disorder, with psychotic features. On 04/28/26 at 09:30 AM, while interviewing R203, Registered Nurse (RN)13 entered the room and placed two medication cups on the bedside table and left. Asked R203 if those were her medications, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and she said Yea, she put them there because I was talking to you. Asked if that has occurred at other times, and she said yes. R203 went on to say the cup with only one pill was Tylenol and it was for her to take later, and the other cup with several pills was for now. On 04/30/26 at 10:11 AM, observed RN13 enter R203's room and leave one medication cup with one pill on the bedside table and leave the room. On 04/28/26 at 10:30 AM, interviewed RN13 in the hall of the nursing unit, and inquired why the medications were being left on R203's bedside table. She said it was the only way R203 would take her medication. RN13 went on to explain if the staff insist R203 take the pills right away and observe them, she refuses to take them at all. She said she knew it was wrong to leave them at the bedside, but it was the only way to ensure R203 got her medication. RN13 said she goes back periodically to see if R203 has taken her pills. When asked RN13 if she was aware that R203 had a history of suicidal ideation, she said yes. Reviewed R203's active care plan, which included the intervention for Mood and Behavior Monitor/document/report PRN (as needed) any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills .) . Reviewed the facility policy titled Resident Self-Administration of Medication, last reviewed/revised 03/26. The policy included: Policy: It is the policy of this facility to support each resident's right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered. Policy Explanation and Compliance guidelines: .8. All nurses and aides are required to report to the charge nurse on duty any medication found at the beside not authorized for bedside storage. On 04/30/26 at 08:33 AM, the Director of Nursing said there were no residents in the facility that were approved to self-administer medications.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interview, the facility failed to ensure the attending physician documented review of the consultant pharmacist's monthly medication regimen review (MRR) recommendations, including actions taken in response to the pharmacist's recommendations, for one of five residents (Resident (R) 5) reviewed for unnecessary medications. This deficient practice placed R5 at risk for unresolved medication-related concerns, including adverse drug reactions, medication interactions, continued use of unnecessary medications, ineffective treatment, and potential decline in health status. Findings Include: Review of R5's MRR notes from April 2025 to April 2026, revealed the pharmacist documented the MRR was complete and included Sending rec [recommendation] regarding fluid restrictions on 07/09/25. Requested from the facility the July 2025 MRR to review what the pharmacist recommended regarding fluid restrictions and physician's response. The July 2025 MRR was not provided. Review of R5's MRR notes from April 2025 through April 2026 revealed that the consultant pharmacist documented completion of the MRR and noted on 07/09/25 that a recommendation regarding fluid restriction was being sent. The July 2025 MRR containing the specific recommendation regarding fluid restriction was requested; however, the facility was unable to provide this document for review.Review of the December 2025 MRR for R5 revealed the consultant pharmacist recommended a gradual dose reduction trial for Abilify, Trazodone, and Vilazodone. There was no documentation indicating the attending physician reviewed the MRR or responded to the pharmacist's recommendations. The January 2026 MRR reflected the pharmacist repeated the same recommendation.On 04/30/26 at 12:28 PM, the Director of Nursing (DON) in training confirmed the facility was unable to locate the July 2025 MRR for R5. The DON further confirmed there was no documentation that the attending physician addressed the pharmacist's December 2025 recommendations.Review of the facility's policy and procedure Medication Regimen Review, number 756, dated 03/2026, documented The pharmacist reports any irregularities in a separate written report to the attending physician, medical director and the director of nursing. The recommendations are reviewed, and a response provided, in a timely manner, dependent upon the nature of the concern .the pharmacist recommendations are considered part of the medical record.

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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. Based on interview and record review, the facility failed to ensure that antipsychotic and antidepressant medications received adequate documented behavior monitoring for one of five residents (Resident (R) 5) reviewed for unnecessary medications. This failure placed R5 at risk for ineffective treatment monitoring and continued unnecessary medication use. Findings Include:Review of R5's physician orders revealed R5 is taking Abilify 5 milligrams (mg) one tablet in the evening for depression, trazadone 50mg one tablet at bedtime for depression/anxiety, and vilazodone 10mg two tablets at bedtime for depression. On 04/30/26 at 12:38 PM, an interview was conducted with the Director of Nursing (DON) in training. The DON stated behavior monitoring is usually documented on the treatment administration record for nursing staff to monitor. The DON was unable to locate behavior monitoring documentation related to the resident's psychotropic medications Review of the facility's policy and procedure Use of Psychotropic Medication(s) reviewed on 04/2026, documented A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior .Psychotropic medication are to be used only when a practitioner determines that the medication(s) appropriate to treat a resident's specific, diagnoses, and documented condition and the medication(s) is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s).

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure one Resident (R)52 of sixteen residents selected for review, is free of medication errors. List of wrong medications given to R52 included psychiatric medications, antihypertensive (medications to control high-blood pressure), furosemide, and blood thinner. As a result of this deficiency, R52 was at risk of experiencing potential side effects, adverse health issues and harm. Findings include:R52 is a [AGE] year-old male admitted to the facility on [DATE] and is currently receiving Intermediate Care Facility level of Care. Diagnoses included but not limited to hemiplegia (severe or complete paralysis/loss of voluntary movement on one side) and hemiparesis (mild-to-moderate weakness or reduced sensation on one side) following cerebral infarction affecting left dominant side. On 04/19/26, Office of Health Care Assurance (OHCA) received complaint report with Intake #2994297. Complainant reported that, .On 04/16/26.my father, a resident at Hale [NAME].was given another patient's medications.request that OHCA investigate. On 04/29/26 at 09:34 AM, record review of electronic R52's electronic health record (EHR) was done. EHR reflected in the Progress Note that, .Unit Manager (UM) was notified that nurse made a med error. Patient was given another patient's medication.Resident was given Tylenol, furosemide, spironolactone, olanzapine, Entresto, brillinta, metoprolol, aspirin, ticagrelor, venlafaxine, gabapentine. On 04/30/26 at 11:45 AM, an interview and record review were done with Director of Nursing (DON) in the office. When DON was queried if RN23 should ensure that resident is free of medication error by checking six rights of medication administration and proper resident is identified, DON confirmed that all registered nurses were trained and instructed to identify residents using two identifiers (name and date of birth) all the time. Review of facility policy titled Medication Administration with a revision date of 03/01/26 instructs staff to, .3. Identify resident by photo in the MAR (medication administration record.10. Review MAR to identify medication to be administered.11. Compare medication sourse.to verify resident name, medication name, form, dose, route, and time.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and staff interview, the facility did not properly secure two Medication and Treatment Carts, of six reviewed, which contained various medications and medical supplies. As a result of this deficiency, there was an increased chance of missing equipment/medications and/or accident hazards.Findings include: 1) Observation, on 04/30/26 at 08:30 AM, of the Treatment Cart on Lewalani Unit, the cart lock was broken and anyone could open the cart/drawers and have access to all the medications and medical supplies. During staff interview on 04/30/26 at 08:45 AM, Treatment Nurse acknowledged the cart was not secured and said there was a work order for it to be repaired. Treatment Nurse said they would check again to have the lock repaired as soon as possible. 2) On 04/28/26 at 08:45 AM, during initial tour of the facility, observed the medication cart in the hallways unlocked and unsecured. As Registered Nurse (RN) 25 walked out from the resident's bedroom, RN observed going back to the medication cart, but left medication cart unlocked. When RN25 was asked if medication cart should be locked when not in use, or before leaving cart to administer medication to residents, RN25 stated that it should be locked and secured. On 04/30/26 at 10:20 AM, an interview was conducted with Interim Director of Nursing (DON) and DON in the office. Shared observation of the unlocked medication cart with DON. DON confirmed that medication carts should always be locked and secured when not in use.A review of the facility policy titled, Medication Storage with a revision date of 03/2026 stated, . a. All drugs and biologicals will be stored in locked compartments.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review, the facility failed to ensure residents food preferences were honored for one of four residents (Resident (R) 187) reviewed for food services. This failure placed R187 at risk of dissatisfaction with meals and overall quality of life. Findings Include: On 04/28/26 at 12:54 PM, during a dining observation and interview, R187 stated that she was not supposed to have gravy or chicken skin but the facility continued to serve foods with gravy on her plate. Observation of R187 lunch tray revealed chicken with the skin on and gravy covering the chicken. Review of R187's meal card on the meal tray revealed R187 was ordered a No Added Salt (NAS) diet with instructions for no sauce, gravy, or chicken skin. On 04/29/26 at 07:56 AM, Resident 187 reported that her dinner plate the previous evening had a lot of gravy. When asked whether she reported the concern to staff, the resident stated she did not want to complain and instead tried to work around the food because otherwise her meal would arrive later. Review of the facility's daily dinner menu for 04/28/26 revealed crispy pork cutlet with gravy was served.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125011	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2026
NAME OF PROVIDER OR SUPPLIER Hale Nani Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1677 Pensacola Street Honolulu, HI 96822	

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to assure their sanitation solution kept in their sanitation buckets in the kitchen were maintained at the correct sanitation level. The deficient practice places the residents at risk for spread of foodborne illness. On 04/28/26 at 9:02 AM requested staff, Dietary Aide (DA) 5, check the sanitation level of the red sanitation bucket. DA5 used the Hydrion QT-40 test strip, which she dipped in the bucket. Inquired of DA5 how long the strip must be kept in the sanitation bucket and she said, 15 seconds. Showed DA5 the Hydrion QT-40 test strip container which states Dip paper in quat solution, not foam surface, for 10 seconds. Don't shake. Compare colors at once. DA5 retested the first sanitation solution in the red bucket, and the strip was compared to the test strip container and found to be out of range, not reaching the 150-400 parts per million (PPM). Surveyor requested DM5 test the second sanitation solution in the second red bucket and also found the sanitation solution to be out of range. On 04/30/2026 at 12:10 PM interviewed the Dietary Manager (DM)10 in her office. Inquired if DM10 had training and rosters of her staff that she had showing she provided training on the preparation of sanitation solution and use of the sanitation bucket and she was able to share what she had from 2024. During this interview DM10 could not provide any training material or rosters of staff who completed training on preparing sanitation solution and usage of the sanitation bucket from 2025 - 2026 prior to the survey. DM10 stated they had moved some records and might be included with those moved out of her office.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hale Nani Rehabilitation and Nursing Center	1677 Pensacola Street Honolulu, HI 96822

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews and review of policy, the facility failed to maintain an infection prevention and control program to provide a safe, sanitary environment and to prevent the transmission of communicable diseases and/or infections. This deficient practice placed the residents at risk for the potential spread of infections and communicable diseases. Findings Include:1) R58 was a [AGE] year-old resident admitted to the facility on [DATE] for short-term rehabilitation services to include physical and occupational therapy. Diagnoses included but not limited to generalized muscle weakness, bacterial pneumonia and positive for Clostridioides difficile (C. diff - bacterium that causes an infection of the colon). On 04/28/26 at 11:54 AM, observed signage outside R58's room with a heading that stated, Stop, Contact Precautions. At 11:55 AM, observed Registered Nurse (RN)31 enter R58's room after donning a gown and gloves. R31 checked R58's blood pressure and temperature, wiped the equipment, removed his gown and gloves. RN31 performed hand hygiene by using the Alcohol-Based Hand Rub (ABHR) dispenser outside the room and went to the nurses' station. Queried RN31 why R58 was on contact precautions, RN31 said it was due to the resident being positive for C. diff. Queried RN31 if using ABHR alone was acceptable to use after caring for residents with C. diff. RN31 said he will wash his hands with soap and water. On 05/01/26 at 08:44 AM, observed, Activities Assistant (AA)5 enter R58's room without wearing a gown and gloves. AA5 placed a paper copy of the activities schedule on the bedside table, exited the room and performed hand hygiene using the ABHR dispenser outside the room. Queried AA5 if she was aware R58 was on contact precautions. AA5 replied that she was told a gown and gloves are not needed if not making contact with the resident. On 05/01/26 at 08:51 AM, observed a visitor in R58's room not wearing a gown. Queried RN24 if visitors are to also wear a gown and gloves when entering R58's room. RN24 said everyone that goes into R58's room are to wear a gown and gloves, and wash their hands with soap and water before exiting since C. diff is highly contagious. On 05/01/26 at 09:32 AM, an interview was conducted with the Infection Preventionist (IP) in her office. IP confirmed that it was the facility's policy for anyone to enter a room of a resident on contact precautions to wear a gown and gloves. IP also confirmed that if a resident was positive for C. diff, staff and visitors are to use soap and water to perform hand hygiene before exiting the room. Review of facility policy titled Management of C. Difficile Infection stated, . All staff are to wear gloves and a gown upon entry into the resident's room . Hand hygiene shall be performed by handwashing with soap and water . 2) On 04/28/2026 at 12:15 PM during lunch observation observed a Certified Nursing Assistant (CNA) 8 and the Infection Preventionist (IP) nurse passing out meal trays. CNA8 was observed delivering trays to the resident's rooms. CNA8 was observed helping residents get comfortable for their lunch by assisting them in sitting up in their bed by using the bed remote to sit the head of the bed up, placing a pillow behind the resident's head and coming out of the room to deliver the next meal tray. CNA8 picked up another resident's lunch tray and delivered it to the resident, placing it on the over the bed table which CNA8 moved closer to the resident. CNA8 was observed not doing hand hygiene between meal tray delivery, resident care and delivery of straws to various resident rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/28/2026 at 12:32 PM interviewed the IP nurse in the hallway. Inquired of the IP nurse what staff are expected to do between meal tray delivery and resident care and she stated, hand hygiene. 3) On 04/30/2026 at 08:55 AM observed Registered Nurse (RN) 3 do a medication pass with Resident (R) 205. RN3 was able to give the resident their medication which was crushed up and in chocolate pudding. Afterwards RN3 took off the dirty gloves and put on clean gloves before giving R205 her eye drops. Hand hygiene was not observed after taking off the dirty gloves, before putting on clean gloves. Inquired of RN3 if she is supposed to do anything after taking off dirty gloves and she stated either wash my hands with soap and water or use a hand sanitizer. 4) On 04/28/26 at 11:29 AM, Certified Nurse Aide (CNA) 18 and CNA19 were observed in R211's room providing care. A shower chair was positioned next to the resident's bed, and both CNAs were observed handling disposable items and linen. Neither CNA was wearing a gown, despite signage posted outside the resident's room indicating the resident was under Enhanced Barrier Precautions (EBP). When interviewed, CNA18 and CNA19 stated they had provided R211 with a shower. When asked whether a gown should have been worn while providing care, CNA18 stated she forgot. CNA19 confirmed staff were required to wear a gown when providing care to R211 due to EBP status. Review of the facility's policy and procedure Infection Prevention and Control Program: Enhanced Barrier Precautions documented The facility will adopted Enhanced Barrier Precautions (EBP) to reduce the transmission of MDROs [multidrug-resistant organisms] by using personal protective equipment (PPE) during resident care activities with a high risk of transferring pathogens. These precautions will apply to residents with wounds or indwelling medical devices, even if they do not have active infections .Gowns and gloves should be worn for .high-contact resident care activities .providing hygiene assistance, including bathing and toileting. 5) On 04/28/26 at 09:00 AM, during an interview with R170, the resident expressed concerns regarding his roommate, R237, entering his area and taking his belongings. During the interview, R237 was observed taking R170's trash bin from underneath the privacy curtain separating the roommates' beds. Two portable urinals were hanging from the trash bin, one of which contained R170's urine. R170 asked R237 where he was taking the trash bin and requested it be returned. R237 removed the urinals and placed them on the floor, removed the trash bag from the bin, tied it, brought the trash outside the room, entered the soiled utility room as a staff member exited, and discarded the trash. R237 then went into the hallway to check on socks hanging from the jalousie windows and returned to his room. During this time, R170 appeared distressed about his missing trash bin and the surveyor requested staff assistance for R170. While a CNA assisted R170, concurrent observation with Licensed Practical Nurse (LPN) 43 revealed R237 picked up the urinal containing urine from the floor and carried it into the bathroom. R237 emptied the urine into the toilet, flushed the toilet, returned the urinal to R170's trash bin, and sat on his bed. LPN43 then exited the room without encouraging or ensuring R237 performed hand hygiene after handling bodily fluids and contaminated equipment. Observation of R170's door revealed signage indicating the resident was under Enhanced Barrier Precautions (EBP).