STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125019	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Care Center of Honolulu	1900 Bachelot Street Honolulu, HI 96817

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 48351 Based on observation, interview, and record review, the facility failed to provide privacy for one of the sampled residents (Resident (R) 415). This failed practice had a negative affect on R415's psychosocial well being and has the potential to affect all the residents in the facility. Findings include: Interview was conducted with R415 on 08/12/24 at 09:22 AM in R415's room. R415 stated that on multiple occasions, the staff would pull the privacy curtains from around her bed while providing personal care to her roommate. R415 stated that pulling the curtain from her side to provide privacy to her roommate ends up exposing her to individuals passing in the hallway. Interview was conducted with R415 on 08/13/24 at 09:04 AM in R415's room. R415 stated that on 08/12/24, she was exposed to the other resident in the room as well as individuals passing in the hallway. Observation was made on 08/13/24 at 09:16 AM in R415's room. While R415 was talking to State Agency (SA), Certified Nurse Aide (CNA) 62 was observed pulling one of the privacy curtains near the entrance of the room/R415's bed and pulling it towards the window to provide privacy to the resident near the window. In doing so, CNA62 exposed R415 to the hallway, since R415's bed was next to the door. R415 was exposed to staff, residents, and visitors walking in the hallway. R415 had her legs elevated and was wearing a gown and adult briefs. Her legs were open, therefore exposing her adult briefs. R415 stated, you see what I mean, pointing at the door. R415 remained exposed for 20 minutes, until CNA62 was informed by SA. Interview with CNA62 was conducted on 08/13/24 at 09:36 AM in R415's room. CNA62 agreed that she should have adjusted the curtains to provide privacy for R415. Interview was conducted with the Director of Nursing (DON) on 08/13/24 at 03:30 PM in her office. DON was informed of the observation made by SA. DON stated that normally the staff closes the door when providing personal care to a resident in the room. DON confirmed that CNA62 should have closed the door. A review of the facility policy titled, Resident Rights, with a revised date of 02/2021 was conducted. The policy documented, Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 42160 Based on observation, interview, and record review, the facility failed to ensure a homelike environment. The facility did not remove any of the resident meal trays (an institutional characteristic) after serving residents in the dining room. This deficient practice affects all residents dining in the dining areas. Findings include: On 08/12/24 at 11:55 AM, conducted a dining observation of twelve (12) residents eating lunch in the main dining room on the 1st floor. All 12 residents' meals remained on the meal trays. Inquired with Resident (R)138 and the resident's Family Member (FM)1 if it was their preference for the resident's meal to remain directly on the tray for the entirety of the meal. FM1 reported that they were not given the option to have the food taken off the cafeteria style trays, staff just always leave it on the trays. Inquired with Dining Staff (DS)3 regarding residents' meals being served and remaining on the cafeteria style tray throughout the meal service. DS3 confirmed all the residents dining in the 1st floor dining room have their meals on the tray. Asked if the residents' preference is to have the meal remain on the cafeteria style tray. DS3 confirmed he/she is unaware of the residents' preference if they want their food to remain on the trays or not and stated, This is just how we always do it. Review of R138's care plan (last reviewed 05/01/24) did not contain documentation that the resident preferred to have his meal plate remain on the cafeteria like trays while eating in the 1st floor dining room. 43414 2) On 08/12/24 at 12:19 PM, observed five residents in a common dining room area eating lunch with their meals on top of a meal tray that was not removed when the meal was served. A second observation was done on 08/14/24 at 08:10 AM, observed three residents in a common dining room area eating breakfast with meals on top of a meal tray that was not removed when the meal was served. On 08/15/24 at 11:27 AM, an interview with Registered Nurse (RN) 40 was done. Inquired if RN40 eats on meal trays when at home, he stated he does not but uses a place mat. Further inquired if he does not use meal trays when eating at home, would it be a homelike environment for residents in the dining room to eat with meal trays, RN40 stated, .it would seem it would not. On 08/15/24 at 11:29 AM, an interview with Assistant Administrator (AADM) was done. AADM reported he does not eat his meals with meal trays at home. Inquired if it would be homelike for residents to use meal trays when eating their meals in the dining room at the facility, AADM stated it depends on the resident and if they prefer to eat with meal trays. Further inquired if this would be in resident care plans, AADM reported it should be in their care plan.

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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 0585 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42160 Based on interview and record review, the facility failed to support the resident's right to voice a complaint without the fear of reprisal or retaliation for one resident (Resident (R) 31) sampled. R31 reported an allegation of mistreatment by the Alleged Perpetrator (AP) to the Assistant Administrator (AADM). Initially, R31 reported he did not want to file a formal grievance due to being fearful what AP's reaction would be, and that R31 would not receive assistance from staff, or care would be withheld. During the facility's investigation, the facility informed R31 and AP that there should not be any form of contact between the two individuals. R31 informed AADM that despite this instruction, AP went into the resident's room and confronted him in a manner which made him feel fearful, intimidated, and unsafe. During an interview, R31 stated he did not feel that the facility could keep him safe from retaliation by the AP. As a result, R31 felt anxious, fearful, unsafe, hypervigilant causing loss of sleep, and experienced a new onset of nightmares in which he was violently defending himself from AP. R31 confirmed he does not usually have nightmares. AADM did not identify R31's allegations as potential abuse and did not investigate R31's allegations or report the incident to the appropriate state and federal agencies. As a result of this deficient practice, R31 experienced psychosocial harm as evidenced by new onset of nightmares, hypervigilance, anxiousness, and being fearful of retaliation by AP which interrupted the resident's sleep patterns. All residents receiving care by AP have the potential for harm. Findings include: (Cross Reference to F600, F609, and F610) Review of the facility's policy and procedure, Grievance/Complaints: Recording and Investigating documented 9. The Grievance Officer will coordinate actions with the appropriate state and federal agencies, depending on the nature of the allegation. All alleged violations of neglect, abuse, and/or misappropriation of property will be reported and investigated under guidelines for reporting abuse, neglect, and misappropriation of property, as per state law. R31 is a [AGE] year-old resident, who was admitted to the facility on [DATE] for physical and occupational therapy to improve the resident's level of functioning. R31's diagnoses include sepsis, cellulitis (skin infection that appears red and swollen) of upper limb, hypertension, a history of falling, and a need for assistance with personal care, weakness, and unsteadiness on feet. Review of R31's Electronic Health Records (EHR) documented a Minimum Data Set (MDS) admission assessment with an Assessment Refence Date (ARD) of 07/18/24, Section C. Cognitive Patterns the resident scored a 15 out of 15 on the Brief Interview for Mental Status, indicating the resident's cognition is intact, and that he is a reliable source of information. Section GG- Functional Abilities and Goals documented the resident is dependent (helper does ALL the effort) on staff for oral hygiene, toileting, upper and lower body dressing, putting on footwear, and personal hygiene (combing hair, shaving, washing and drying face and hands). (continued on next page)

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F 0585 Level of Harm - Actual harm Residents Affected - Few	During an interview with R31 on 08/12/24 at 10:06 AM, the resident stated he did not feel safe in the facility. Asked R31 why he did not feel safe, R31 explained he reported an incident to AADM of AP's treatment of the resident when the resident requested assistance with the air conditioner on one occasion, and pain medication on another. R31 reported, I didn't want to cause a problem with staff (AP), I just wanted him to treat me better. I felt like staff [AP] was already kind of aggressive towards me. R31 stated AP told the resident, What the fuck do you want now, when he answered my call light. Then he [AP] told me if I kept pressing the call light, he was going to take it away from me. He [AP] was irritable and snappy with me, but I was new to the facility, and I thought that's what the call light was for. If I needed something, I call for staff, instead of getting out of bed by myself. I'm not sure how long I have to be here, and if he [AP] treated me bad before I complained, I could only imagine how he would treat me if I filed a grievance. The resident explained after he complained to AADM about how AP treated him, AADM assured him that AP would not be taking care of him any longer and should not have any contact with him. Despite instructions not to have contact with the resident, R31 reported AP went into his and confronted him about reporting AP to management, stating, You got a problem with me? in an intimidating tone while the resident was alone in the room, laying on the bed. R31 informed AADM that AP came into his room and confronted him about complaining to management. R31 reported to AADM that he did not feel safe and elaborated that he cannot defend himself against AP should the staff member decide to do something to him. R31 stated that he was scared of AP and requested to move rooms to get away from him. Surveyor inquired if R31 knew, or if AADM updated him on the outcome of an investigation into AP confronting him after he complained to the facility. R31 confirmed he did not know of, and was not informed of an investigation into AP confronting him. R31 stated, After I moved [rooms], I started having nightmares and I feel anxious that AP could just come into my room when I'm sleeping or by myself and do something to me. Asked R31 about the nightmares he was having. R31 reported the nightmares were violent dreams about the resident having to defend himself or fighting AP, and that he would wake up because he was yelling and upset in his dream. R31 reported it is unusual for him to have nightmares or violent dreams, but he started having them after AP entered his room and confronted him about complaining. While speaking with this surveyor, R31 was visibly upset. His eyes welled-up with tears, and he required pauses in the interview to regain his composure. The tone and rate of his voice was shaky, and he cried at one point of the interview. R31 expressed he was spontaneously waking up throughout the night with a feeling of AP's presence in his room. Inquired if he informed the facility about how he was feeling and about the nightmares he was having. R31 responded he did not tell the facility because they (facility management) could not keep him safe the first time he reported AP's behaviors, and he feared AP could retaliate again and/or harm him. (continued on next page)

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F 0585 Level of Harm - Actual harm Residents Affected - Few	On 08/14/24 at 11:10 AM, conducted an interview with AADM and the Administrator regarding R31's incident(s) with AP. Informed AADM and Administrator of R31's interview with this surveyor, and asked for the facility's account of the incident(s) between AP and R31. AADM confirmed that during a meeting which included AP and the Director of Nursing (DON), AP was informed of the initial complaint, and told that he was not allowed to have any contact with R31. The Administrator stated she was not aware that AP had confronted R31 after being instructed to not have contact with him. AADM reported he followed up on the initial complaint with R31, and that R31 did inform him that AP confronted him in his room after being instructed not to have contact with him. Inquired if the facility investigated R31's report of AP confronting and intimidating him for the potential of abuse. AADM confirmed no other investigation was initiated following R31's report of AP confronting him. AADM also confirmed he had not identified the incident as potential verbal abuse, retaliation, and/or intimidation. AADM stated it was not identified as potential verbal abuse, retaliation, and/or intimidation because R31 did not file an official grievance when the resident first reported AP. Inquired if AADM asked R31 why he did not want to file an official grievance. AADM responded he did not ask R31 why he did not want to file an official grievance, but he [AADM] filled out the grievance form as a complaint on the resident's behalf. On 08/14/24 at 01:48 PM, conducted an interview with Social Service Director (SSD) regarding R31's allegations. SSD stated she normally handles the resident's complaints and grievances; however, she was on leave during this time and had not been informed of R31's allegations. SSD confirmed no investigation was conducted into the resident's report of AP confronting the resident after complaining about staff's treatment of the resident and it was not reported to the state agencies. SSD stated at the time of the incident, AADM was acting as the Grievance Officer. After SSD was informed of R31's allegations, she confirmed AP should have been placed on leave after R31 reported he confronted the resident, while a formal investigation was completed to ensure the resident's safety. At 03:00 PM, SSD reported R31 was interviewed regarding the incident, and her interview with the resident was consistent with this surveyor's resident interview. SSD stated she would be conducting a formal investigation of R31's allegation of verbal abuse and intimidation by AP. On 08/14/24 at 01:49 PM, conducted an interview with the DON regarding AP confronting R31 regarding the his complaint of AP's treatment of him. During the interview, DON stated an investigation was conducted into R31's allegations. Requested to review the DON's full investigation complete with witness statements. DON initially stated the investigation was in the Human Resource office and did not provide any documentation on 08/14/24. On 08/15/24, the DON submitted typed, Timeline of Events 7/31/24 which documented Resident had a care concern for the attitude of a night shift CNA [Certified Nurse Aide (AP)] and gave him [R31] attitude about turning up the temperature . Union Meeting held . on 08/02, and included an unidentified staff member (no ledger on form) reporting that CNA48, CNA2, and Registered Nurse (RN)11 did not report anything related to the incident on 07/31/24. The investigation notes did not address AP confronting R31, and intimidating him after finding out the resident had filed a complaint.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42160 Based on interview and record review, the facility failed to ensure the resident's right to be free from verbal abuse for one resident (Resident (R)31) sampled. After filing a complaint with the facility regarding the Alleged Perpetrator's (AP) treatment of R31, AP was informed not to have any form of contact with the resident. Following this instruction, R31 reported to the Assistant Administrator (AADM) that AP had verbally confronted and intimidated him while he was alone in his room. AADM confirmed that he did not identify AP's confrontation and intimidation of R31 as potential abuse, and did not initiate an investigation into the incident. As a result of AP confronting R31 about the initial complaint, R31 reported feeling unsafe, fearful of additional retaliation from AP, increased anxiousness, hypervigilance with loss of sleep, and violent nightmares of having to defend himself from AP. As a result of this deficient practice, the resident was not kept safe while allegations were thoroughly investigated. Findings include: (Cross reference to F585, F609, and F610) R31 is a [AGE] year-old resident, who was admitted to the facility on [DATE] for physical and occupational therapy to improve the resident's level of functioning. R31's diagnoses include sepsis, cellulitis (skin infection that appears red and swollen) of upper limb, hypertension, a history of falling, and a need for assistance with personal care, weakness, and unsteadiness on feet. Review of R31's Electronic Health Records (EHR) documented a Minimum Data Set (MDS) admission assessment with an Assessment Refence Date (ARD) of 07/18/24, Section C. Cognitive Patterns the resident scored a 15 out of 15 on the Brief Interview for Mental Status, indicating the resident's cognition is intact, and that he is a reliable source of information. Section GG- Functional Abilities and Goals documented the resident is dependent (helper does ALL the effort) on staff for oral hygiene, toileting, upper and lower body dressing, putting on footwear, and personal hygiene (combing hair, shaving, washing and drying face and hands). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/12/24 at 10:06 AM, R31 reported he made a complaint to the facility regarding how AP treated him when he requested assistance with the temperature of the air conditioner. R31 stated when AP answered his call light, he told the resident What the fuck do you want now! and told the resident if he keeps pressing his call light that he was going to take the call light away from the resident. R31 stated he was afraid to file a formal complaint out of fear of what AP might do after he heard about R31's complaint. R31 reported the initial incident to AADM, and after looking into it, AADM informed R31 that AP would not be assigned to him any longer and had been instructed to not have any contact with him. R31 stated that after AP was informed of R31's complaint, AP confronted him while he was alone in his room and stated, You got a problem with me? in an intimidating tone and manner. R31 reported that he was afraid of AP and did not feel safe. R31 stated he informed AADM that AP came into his room and confronted him for making the initial complaint. R31 reported he did not feel safe and elaborated that he cannot defend himself against AP should the staff member decide to do something to him and requested to move rooms to get away from AP. Surveyor inquired if R31 knew, or if AADM had updated him, on the outcome of an investigation into AP confronting the resident after the initial complaint to the facility. R31 confirmed he did not know of, and was not informed, of an investigation into AP confronting him. R31 stated, After I moved, I started having nightmares and I feel anxious that AP could just come into my room when I'm sleeping or by myself and do something to me. Asked R31 about the nightmares he was having. R31 reported the nightmares were violent dreams about him having to defend himself or fighting AP, and that he would wake up because he was yelling and upset in his dream. R31 reported it is unusual for him to have nightmares or violent dreams, but he started having them after AP entered his room and confronted him. While speaking with this surveyor, R31 was visibly upset. His eyes welled-up with tears, he required pauses in the interview to regain his composure, the tone and rate of his voice was shaky, and he cried at one point of the interview. R31 expressed he was also spontaneously waking up throughout the night with a feeling of AP's presence in his room. Inquired if he informed the facility about how he was feeling and about the nightmares he was having. R31 confirmed he did not tell the facility because they (facility management) did not keep him safe the first time he reported AP's behaviors. R31 stated that he could not trust the facility to keep him safe and feared that AP would retaliate further and/or harm him. On 08/14/24 at 11:10 AM, conducted an interview with AADM and the Administrator regarding R31's report of AP confronting him about the initial complaint. The Administrator stated she was not aware that AP had confronted R31 after being instructed not to have any contact with him, and if she were aware of the incident, AP would have been placed on leave immediately until an investigation had been completed. If the allegation was substantiated, then AP would be relieved of his duty at the facility, and if the allegation was not substantiated, AP would not be assigned to R31, nor would he be allowed to provide any assigned care to him. If AP needed to interact with R31, the facility would ensure AP was escorted and not left alone with the resident. Inquired with AADM of R31's report that he informed AADM of the confrontation. AADM confirmed that R31 did inform him that AP confronted him in his room after being instructed not to have contact with him. Inquired if the facility investigated R31's report of AP confronting and intimidating him for the potential of abuse. AADM confirmed no other investigation was initiated following R31's report of AP confronting him. AADM also confirmed he had not identified the incident as potential verbal abuse, retaliation, and/or intimidation. As a result of AADM not identifying the incident as potential abuse, AP remained working in the building which exposed R31 to further potential situation(s) for verbal or some other form of abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/14/24 at 01:48 PM, conducted an interview with Social Service Director (SSD) regarding R31's allegations. SSD stated she normally handles the resident's complaints and grievances; however, she was on leave during this time and had not been informed of R31's allegations. SSD confirmed no investigation was conducted into R31's report of AP confronting him following his initial complaint, and it was not reported to the state agencies. SSD stated at the time of the incident, AADM was acting as the Grievance Officer. After SSD was informed of R31's allegations regarding the confrontation, she confirmed AP should have been placed on leave while a formal investigation was completed to ensure the resident's safety. At 03:00 PM, SSD reported R31 was interviewed regarding the incident, and her interview with the resident was consistent with this surveyor's resident interview. SSD stated she would be conducting a formal investigation of R31's allegation of verbal abuse and intimidation by AP. Review of a progress note written by SSD on 08/14/24 at 03:14 PM revealed that Social Service Assistant (SSA)5 and SSD had met with R31 in the social service office, where R31 verbalized, I am not feeling safe unless you transfer me to another facility or let him (AP) go. Resident agreed to be transferred to another floor in the facility.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42160 Based on interview and record review, the facility failed to report an allegation of potential abuse to the Administrator of the facility, the State Agency (SA), and Adult Protective Services in accordance with State law through established procedures. R31 reported to the Assistant Administrator (AADM) that a staff member [alleged perpetrator (AP)] confronted him about an initial complaint he had made about AP. AADM confirmed the incident was not identified as potential abuse, and because of not identifying it as possible abuse, it was not reported accordingly. Findings include: (Cross reference to F585, F600, F610) R31 is a [AGE] year-old resident, who was admitted to the facility on [DATE] for physical and occupational therapy to improve his level of functioning. R31's diagnoses include sepsis, cellulitis (skin infection that appears red and swollen) of upper limb, hypertension, a history of falling, and a need for assistance with personal care, weakness, and unsteadiness on feet. Review of R31's Electronic Health Records (EHR) documented a Minimum Data Set (MDS) admission assessment with an Assessment Refence Date (ARD) of 07/18/24, Section C. Cognitive Patterns the resident scored a 15 out of 15 on the Brief Interview for Mental Status, indicating the resident's cognition is intact, and that he is a reliable source of information. Section GG- Functional Abilities and Goals documented the resident is dependent (helper does ALL the effort) on staff for oral hygiene, toileting, upper and lower body dressing, putting on footwear, and personal hygiene (combing hair, shaving, washing and drying face and hands). During an interview on 08/12/24 at 10:06 AM, R31 reported he made a complaint to the facility regarding how AP treated him when he requested assistance with the temperature of the air conditioner. After filing the initial complaint with the facility, R31 was assured that AP had been instructed not to have any form of contact with him. Following this assurance, R31 reported AP verbally confronted and intimidated him while he was alone in his room, causing him to be fearful of staff, feel afraid and anxious, and he began having violent nightmares of physically defending himself from AP. R31 stated he informed AADM that AP came into his room and confronted him for making the initial complaint. During an interview on 08/14/24 at 11:10 AM with the Administrator and AADM, the Administrator confirmed she was not informed that R31 reported to AADM that AP had confronted and intimidated him following the initial complaint. AADM confirmed although he was informed, he did not identify AP confronting R31 about the initial complaint as having the potential for abuse. As a result of not conducting an investigation and following up with R31, the facility was unaware of R31's nightmares and new feelings of anxiousness and feeling unsafe. Review of SA's Aspen Complaints/Incidents Tracking System did not include a report from the facility of AP confronting R31 after the resident filed a complaint of AP's treatment of him.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42160 Based on interview and record review, the facility failed to thoroughly investigate an allegation of potential abuse for one resident (Resident (R)31) sampled. R31 reported to the Assistant Administrator (AADM) that a staff member confronted and intimidated him about a complaint he made about the staff member. AADM confirmed the incident was not identified as potential abuse and an investigation into the incident was not initiated. Findings include: (Cross reference to F585, F600, F609) R31 is a [AGE] year-old resident, who was admitted to the facility on [DATE] for physical and occupational therapy to improve the resident's level of functioning. R31's diagnoses include sepsis, cellulitis (skin infection that appears red and swollen) of upper limb, hypertension, a history of falling, and a need for assistance with personal care, weakness, and unsteadiness on feet. Review of R31's Electronic Health Records (EHR) documented a Minimum Data Set (MDS) admission assessment with an Assessment Refence Date (ARD) of 07/18/24, Section C. Cognitive Patterns the resident scored a 15 out of 15 on the Brief Interview for Mental Status, indicating the resident's cognition is intact, and that he is a reliable source of information. Section GG- Functional Abilities and Goals documented the resident is dependent (helper does ALL the effort) on staff for oral hygiene, toileting, upper and lower body dressing, putting on footwear, and personal hygiene (combing hair, shaving, washing and drying face and hands). After filing a complaint with the facility regarding the Alleged Perpetrator's (AP) treatment of R31, AP was informed not to have any form of contact with the resident. R31 reported AP verbally confronted and intimidated the resident causing the resident to be fearful of staff, feel afraid and anxious, and started having violent nightmares of physically defending himself from AP. During an interview on 08/14/24 at 11:10 AM with the Administrator and AADM, the Administrator confirmed she was not informed that R31 reported to AADM that AP confronted and intimidated the resident after the resident complained to the facility's management of the staff. AADM confirmed he did not identify AP confronting the resident about his complaints as having the potential for abuse. As a result of not conducting and following up with R31, the facility was unaware of R31's nightmares and new feeling of anxiousness and feeling unsafe. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/14/24 at 01:48 PM, conducted an interview with Social Service Director (SSD) regarding R31's allegations. SSD stated she normally handles the resident's complaints and grievances; however, she was on leave during this time and had not been informed of R31's allegations. SSD confirmed no investigation was conducted into the resident's report of AP confronting the resident after complaining about staff's treatment of the resident and it was not reported to the state agencies. SSD stated at the time of the incident, AADM was acting as the Grievance Officer. After SSD was informed of R31's allegations, she confirmed AP should have been placed on leave after R31 reported he confronted the resident while a formal investigation was completed to ensure the resident's safety. At 03:00 PM, SSD reported R31 was interviewed regarding the incident and her interview with the resident was consistent with this surveyor's resident interview and would be conducting a formal investigation of R31's allegation of verbal abuse and intimidation by AP. Review of a progress note written by SSD on 08/14/24 at 03:14 PM, Social Service Assistant (SSA)5 and SSD met resident in the social service office, R3 1 verbalized I am not feeling safe unless you transfer me to another facility or let him (AP) go. Resident agreed to a lateral transfer. Review of SA's Aspen Complaints/Incidents Tracking System did not include a report from the facility of AP confronting R31 after the resident filed a complaint of AP's treatment of the resident.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38870 Based on record review and interview, the facility failed to correctly document the presence of a stage three pressure ulcer in the Resident Assessment Instrument (RAI) for one Resident (R) 56 of 32 in the sample. As a result of this deficient practice, R56 was not properly coded which could affect the resident's care plan and potential outcomes. All residents have the potential to be affected. Findings include: R56 is a [AGE] year-old male admitted to the facility on [DATE] with a diagnoses that include anoxic brain damage, muscle weakness, contractures of left and right forearm muscle, stage three pressure injury to the sacrum . per record review (RR) of face sheet. RR of a skin & wound evaluation, dated 08/12/2024, noted the following documentation: Stage three to sacrum. present on admission. 0.3 centimeters (cm) long 0.2 cm wide no undermining or depth. No tunneling. Wound healing is slow or stalled but stable, little/no deterioration. Generic wound cleanser with foam dressing . Minimum Data Set (MDS) quarterly assessment, dated 07/18/24, reviewed. R56 was not coded with an unhealed pressure ulcer. Prior discharge assessment, dated 04/24/24, reviewed. R56 was coded with a stage three pressure ulcer which was not present on admission. Interview with Minimum Data Set Coordinator (MDSC)1 in the MDS office on 08/15/24 at 12:30 PM. The surveyor confirmed with MDSC1 that R56 was not coded with a stage 3 pressure ulcer on the 07/18/24 quarterly assessment and that R56 was diagnosed with a stage 3 pressure ulcer at the time of the look back period. MDSC2 joined the interview stating, we will correct the error on the MDS assessment.

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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** 38870 Based on observation and record review, the facility failed to implement the care plan for two Residents, (R)126 and R218, of 32 residents in the sample. R126 was not repositioned at least every two hours to promote healing of his pressure ulcer and R218 was not routinely repositioned or transferred to a wheelchair. The deficient practice placed the residents at risk for a decline in their functional and physical health status. All residents who are dependent on staff have the potential to be affected. Findings include: Cross reference to F686. R126 is a [AGE] year-old male admitted to the facility on [DATE] with a primary diagnosis that includes heart failure; septicemia; wound infection and an unhealed stage four pressure ulcer of the sacral region, per Record Review (RR) of the face sheet. During random observations of Resident (R)126 in his room on the following days and times: 08/12/24 at 09:07 AM and 2:00 PM; 08/13/24 at 09:15 AM; 11:30 AM; 2:00 PM and 3:45 PM; 08/14/24 at 08:45 AM, 11:38 AM, 1:45 PM, and 3:14 PM, noted R126 laying on his back with the head of the bed elevated, watching television. Record Review (RR) of R126's Care plan (CP), started 07/15/2023, noted the following: R126 has limited physical mobility related to pain, wounds, deconditioning secondary to sepsis. Stage four to sacrum. Will show signs of healing without complications through the next review date. The resident will not develop any further complications related to immobility . 2) R218 is a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis that includes depression, hemiplegia, and hemiparesis (weakness) per Record Review (RR) of face sheet. Cross reference to F688. Care plan (CP) 02/19/24 reviewed: The resident has impaired mobility related to (r/t) medical comorbidities. The resident will remain free of complications related to immobility, including contractures, thrombus formation, skin-breakdown, fall related injury through the next review date. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident has impaired mobility r/t medical comorbidities. Date Initiated: 02/19/24 Resident to be up in wheelchair (w/c) at 1030. Revision on: 03/05/24 Restorative Nurse Aide (RNA) to Monitor/document/report as needed (PRN) signs and symptoms (s/sx) of immobility: contractures forming or worsening, thrombus formation, skin-breakdown, fall related injury. RR of Plan Of Care (POC) dated 08/02/24 to 08/14/24. Turn and reposition (right side, left side, back, chair. R218 was up in the chair on 08/03/24 at 2:13 PM and 08/10/24 at 12:19 PM. The rest of the days documented R218 was laying in bed.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38870 Based on observation, interview and record review, the facility failed to provide treatment consistent with professional standards of practice to promote the healing and prevent infection of an existing stage four pressure ulcer for one Resident (R) 126. R126 required maximum assistance and was not repositioned off of the wound at least every two hours. The deficient practice places placed the resident at risk of worsening a stage four pressure injury. All residents who require maximum assistance from staff have the potential to be affected. Findings include: R126 is a [AGE] year-old male admitted to the facility on [DATE] with a primary diagnosis that includes heart failure; septicemia; wound infection and an unhealed stage four pressure ulcer of the sacral region, per Record Review (RR) of the face sheet. Observation and interview with R126 in his room on 08/12/24 at 09:04 AM. R126 was in his bed on his back with the head of bed up 45 degrees. R126 said that he used to walk pretty well before but now I'm in bed all the time. The surveyor asked R126 if he is able to get the help he needs from the staff? R126 said, I have a sore on my back that's infected and pretty deep. I'm supposed to be turned every two hours but there isn't always enough staff available. It takes two Certified Nurse Aides (CNA)'s to do it, and one CNA can't do it by themself. I take antibiotics because I have an infected sore. I wish I could turn or get a pillow. When they came in to change the bed, they moved the extra pillows and I didn't get them back, they must be in short supply. Record Review (RR) of the Minimum Data Set (MDS) annual review 07/09/24. R126 is cognitively intact. Dependent on staff for toileting, bathing and dressing and requires partial to moderate assistance to roll left and right and dependent on staff for bed to chair transfer. R126 has a stage four pressure ulcer present on admission. RR of Care plan 07/15/23 cross reference to F656. RR of Infection note 8/10/24. Wound noted to have deteriorated on 8/2 where last week resident was in his wheelchair exceeding four hours. Noted with green drainage and foul odor . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with the wound Nurse Practitioner (NP) from the wound clinic on 08/14/24 at 08:45 AM. The surveyor asked the NP how R126's the pressure ulcer is healing. He stated R126 has medically complex issues, and he is declining, his Chronic Obstructive Pulmonary disease (COPD) (a lung disease) has gotten a lot worse, and he's not able to do too much outside of his bed. When he came in a year ago, he was able to actually get up and walk a bit. His wounds were all completely closed then, 126 had a pretty bad skin tear that reopened the wound. He went to acute care for a cardiac procedure and was laying on a hard table for a long period of time, when he came back the wound had opened and progressed to a stage four wound on his sacrum. It's getting a little better, today were going to take a sample for a culture after we clean the wound. The surveyor asked the NP if the resident is able to reposition himself off of the wound. The NP stated, no, he needs help to turn and reposition. The wound was observed to be deep with yellow slough. After the NP removed the dressings and cleaned away the dead tissue. He said to R126 it's really important to keep the pressure off of the wound. The surveyor asked the NP for clarification, turning the resident every two hours is really important, he said yes, it's very important to keep the pressure off of the wound.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38870 Based on observations, interview and record review, the facility failed to provide the care to maintain or improve the highest level of range of motion and mobility for one Resident (R) 218 of 32 in the sample. The resident was not routinely repositioned and placed up in the chair daily as ordered by the physician. The deficient practice placed the resident at an increase risk of a decline in functional status. Findings include: R218 is a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis that includes depression, hemiplegia, and hemiparesis (weakness) per Record Review (RR) of face sheet. Observation of R218 in her room on 08/12/24 at 10:15 AM. R218's laying on her back with her bed flat, her right leg started shaking. Facial grimacing noted and an adhesive patch on her left knee. Observation of R218 on 08/12/24 at 2:33 PM. The resident was observed on her back in bed, with a contracture of her left arm, non-verbal, moaning and grimacing, and when asked if she was having pain, she moaned with her eyes wide open. Trapeze in place over the bed, when asked if she can use this, she moaned and shook her head no. The surveyor asked Registered Nurse (RN) 7 if R218 can use the trapeze bar, RN7 said we encourage her to reposition herself. (RR) of the Minimum Data Set (MDS) quarterly review 05/23/24: Resident is moderately cognitively impaired, has an impairment on one side of her upper body (left side). Resident has an impairment on her lower part of her body on both sides. Dependent in toileting, showering and mobility. Care plan (CP) 02/19/24 reviewed. Cross reference to F656. RR of physician orders: Up to wheelchair daily at 10:30 am and have patient up in wheelchair until lunch time use HOYER (a mechanical lift to assist with transfer) one time a day 4/4/2024. RR of plan of care (POC) dated 08/02/24 to 08/14/24. Turn and reposition (right side, left side, back, chair. R218 was documented up in the chair on 08/03/24 at 2:13 PM and 08/10/24 at 12:19 PM. The rest of the days document R218 was laying in bed. Interview with Restorative Nurse Aide (RNA) 4 on 08/15/24 at 12:29 PM the surveyor asked RNA4 if R218 was receiving restorative care. RNA4 stated that R218 is working with an outside rehabilitation agency.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 42160 Based on observation and interview, the facility failed to ensure that staff implemented specific competencies necessary for resident safety. This deficient practice has the potential for harm. Findings include: On 08/14/24 at 09:00 AM, while waiting to check a medication cart on Unit 4, observed Registered Nurse (RN)10 dispose of a medication tablet in the trash bin (unlocked, unsecure) located on the side of the medication cart. The medication landed on the top of other trash which was visible and accessible to anyone passing the medication cart. Inquired if it was okay to dispose of the medication tablet in the trash bin at the side of the medication cart which was unsecured and unable to be locked. RN10 stated she would have to check on how she was supposed to dispose of that medication. RN10 confirmed she disposed of a tablet of Aspirin 81 mg (milligrams) on the side of the medication cart and remained unsure of how to properly dispose of the medication. As RN10 and this surveyor were discussing RN10 disposing of the medication in an unsecure/unlocked trash bin, and the potential opportunity for a resident to retrieve the medication from the cart, Resident (R)140 independently and unsupervised, wheeled himself past the medication cart with the Aspirin 81 mg tablet exposed. On 08/15/24 at 12:20 PM, conducted an interview with Unit Manager (UM)8 and informed her of an observation of staff disposing a tablet of Aspirin 81 mg in the trash bin on the medication cart. UM8 confirmed disposal of non-controlled medication should be in the sharps or another closed system and should have not been disposed of in the trash on the medication cart.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42160 Based on observations and interviews, the facility failed to ensure posted nurse staffing information was in clear and in an identifiable and prominent place. As a result of this deficient practice, residents and resident representatives are not informed of the number of staff available for resident care. Findings include: 1) On 08/13/24 at 10:55 AM, conducted observations of daily staff posting at the entrance of the building and on all four (4) units. Near the entrance of the building, after the screener's station, Daily Staff Posting is posted on a bulletin board along with the employee clock in/out system, a Stay up to Date with your Covid Vaccine poster, Cover your Cough poster, August 2024 Employee Calendar, Mandatory CNA (Certified Nurse Aide) Meeting, and a list of employees who need to see the Director of Nursing (DON) prior to starting the shift. The 24-hour-Daily Staff Posting form was printed on what appeared to be an 11-inch (in) x 13 in paper. The print was small, and this surveyor was unable to clearly read the form until standing approximately two (2) feet away from the form. There was no larger sign clearly indicating the form was the 24-Hour-Daily Staff Posting. A visitor approached the main exit doors and this surveyor inquired if she knew where the daily staff posting was located. The visitor confirmed she did not know where it was despite standing approximately 3-4 feet away from the posted form. On each of the four units, the names of the staff working are written on a dry erase board which is set in the back of the nurses' station, over 10 feet from the entrance to the nurses' station. The entrance of the nurses' station is noted by a high counter/desktop, which is where any resident or visitor would be stopped prior to entering the nurses' station. The dry erase board was difficult to identify the location the units were listing, or the individual staffing census. On 08/14/24 at approximately 02:10 PM, inquired with the Director of nursing where the daily staffing information was posted. DON confirmed daily staffing is written on the whiteboards on each unit and at the entrance of the building. Informed DON on initial observation, the listing was not identifiable or highly visible when entering into the building due to the form being posted on the employee notification board, it appears like information for staff. On 08/15/24 at 11:37 AM, observed Resident (R)315 and multiple family members (FM), walk past the nursing station at a slow rate, then into the resident's room. Inquired with FM99, who was a young adult male (25-[AGE] years old), confirmed he does not need or use glasses and has great eyesight, if he was aware where the daily staffing was posted for the unit and for the facility. FM99 confirmed he has never seen any daily staffing form or information, and stated, Nope, I don't know where it is, and staff never told me where it was at. At 11:40 AM, inquired with R138's FM if she knew where the facility's daily staffing information for R138's unit and for the entire facility was located. FM confirmed she did not know where that information was and has never seen the form. 43414 (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) On 08/12/24 at 08:24 AM, during an initial observation of Unit 3, the daily nursing staffing posting with total number and actual hours worked per shift for nursing staff responsible for resident care was not found.

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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. 48351 Based on observation, interview, and record review, the facility failed to determine that drug records are in order and that an account of all controlled drugs is maintained and reconciled on 1 of 4 units in the facility. This deficient practice increases the risk for diversion of resident medications. Findings include: Observation was conducted on 08/14/24 at 07:38 AM at the nurses' station on the second floor. Registered Nurse (RN)24 was observed preparing medications for a resident. The medication cart she was using was unlocked and RN24 was accessing the medications contained in the medication cart. A review of the facility's document titled, Controlled Item Checklist, dated August, was conducted on 08/14/24 at 07:49 AM. The sheet did not contain the outgoing night shift nurse and the incoming day shift nurses' signatures for August 14, 2024, in the 07:00 AM boxes. RN24 was informed of the missing signatures. RN24 stated that it should have been signed earlier with the outgoing night shift nurse. On 08/14/24 at 07:57 AM, RN24 and RN20 were both observed signing the facility's, Controlled Item Checklist, form. Interview was conducted with RN20 on 08/14/24 at approximately 08:20 AM. RN20 stated that she was the only nurse on the unit on night shift and after performing the narcotic count with RN24, she did not sign off on the controlled item sheet. Instead, RN20 stated that she did her final rounds and used the restroom. She didn't want RN24 to wait on her to start her morning medication administration, so she handed off the medication cart prior to signing the narcotic count sheet. RN20 confirmed that the normal process is to count the narcotics and once verified, the outgoing and incoming nurses sign the sheet.

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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. 43414 Based on record review and interview, the facility failed to ensure the physician, the facility's medical director, and/or director of nursing acted upon irregularities the pharmacist reported during the monthly medication regimen review (MRR) for two of five residents sampled (Resident (R) 67 and R110). The attending physician did not document in the medical record that the identified irregularities had been reviewed, nor did he/she document the rationale for the no change in medications. Findings include: Review of the facility's policy and procedure Medication Regimen Reviews, revised in May 2019, documented The attending physician documents in the medical record that the irregularity has been reviewed and what (if any) action was taken to address it .Copies of medication regimen review reports, including physician responses, are maintained as part of the permanent medical record. 1) During review of R67's Electronic Health Record (EHR), under the pharmacist note in progress notes, the pharmacist documented for MRR 07/31/24 to see report. Review of documented MRRs uploaded in the resident's EHR found the MRR for 07/31/24 was not uploaded in the EHR. Review of hard chart at the nurse's station found the MRR 07/31/24 was not in the file. On 08/14/24 at 08:57 AM, an interview with Director of Medical Records (DMR) was done. Inquired where the facility keeps residents' MRRs. DMR reported it would be uploaded in the EHR or put in a binder. DMR was observed to look for the binder at the nurses' station but was not able to locate it. DMR further stated she will have to look for it in the medical records office. On 08/15/24 at 09:25 AM, an interview and concurrent record review was done with DMR. Review of R67's MRR dated 07/31/24 from the pharmacist to the attending physician documented: To help optimize pain management for this resident, please consider adding: . For severe pain not managed by PRN [as needed] APAP [Acetaminophen] to the PRN oxycodone order. Under physician's response, a handwritten note on the signature line documented: No new order. The note was dated 07/31/24, and was not signed. The bottom of the MRR form was noted to have a print date of 08/05/24. Inquired why the physician did not sign the document. DMR reported the physician was called, and the response was not to change the order. Requested for DMR to provide documentation the physician was called and notified, as well as documentation of the physician's rationale for not making the recommended change in the order. Review of R67's progress notes found no documentation the physician was notified of the recommendation and the physician's response or rationale. The documentation requested on 08/15/24 was not provided by the facility or DMR. 2) During review of R110's EHR under the pharmacist note in progress notes, the pharmacist documented for MRR between 09/01/23 and 09/30/23 to see report. Review of documented MRRs uploaded in the resident's EHR found the MRR was not uploaded in the EHR. Review of hard chart at the nurse's station found the MRR was not in the file. (continued on next page)

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	125019	A. Building B. Wing	08/15/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided a copy of R110's MRR between 09/01/23 and 09/30/23 after it was not found in a binder of residents' MRRs provided by the DMR. The MRR documented on 09/11/23, the pharmacist's recommendation to nursing staff, Please clarify medication administration directions for this resident using a feeding tube (APAP sorbitol Instaglucose Iron see MAR [Medication Administration Record]. There was no documentation found for either the physician or nursing staff regarding the recommendation and their response. On 08/15/24 at 11:48 AM, an interview and concurrent record review with License Practical Nurse (LPN) 2 was done. Inquired if R110 had a feeding tube, LPN2 confirmed she did, and that medications would be administered through the feeding tube. Concurrent review of the MAR for APAP, sorbitol, insta-glucose, and iron found the order for APAP: Give 650 mg by mouth .; insta-glucose (discontinued on 08/14/24, 11 months after the recommendation): Give 24 gram by mouth .; and for iron: Give 1 tablet by mouth . LPN2 reported the medication orders should not say by mouth and should have been changed to administer via G-Tube. The orders for APAP, insta-glucose, and iron routes of administration were not changed to feeding tube or by G-Tube despite the pharmacist recommending the facility clarify the administration directions on 09/11/23.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 43414 Based on observation, interview, and record review, the facility failed to ensure a resident's food preference/request was followed for one of four residents sampled (Resident (R) 106). R106 requested white bread for every meal and did not get white bread for every meal. Findings include: On 08/12/24 at 10:45 AM, during an interview with R106 at the bedside, resident reported she spoke with the facility's dietician and requested to have milk every morning and plain white bread every meal but has not been getting her request. R106 did not understand why she needed to ask for milk and white bread every day. On 08/12/24 at 12:36 PM, observed R106's lunch tray to not have plain white bread. R106 stated no bread again and brought out a half a slice of white bread from the top of her nightstand kept in a cup that she saved from the morning and said, good thing I kept one. Reviewed R106's meal card for lunch on her meal tray which documented + 2 SLICES BREAD DAILY (untoasted). On 08/13/24 at 08:24 AM and 08/14/24 at 08:44 AM, observed R106 eating breakfast with bread and milk on her plate, she reported she received them without asking for breakfast but did not receive white bread for lunch and dinner on 08/12/24 and 08/13/24. On 08/15/24 at 10:12 AM, an interview with Dietary Director (DD) was done. DD reported if the meal card documented a specific preference for that mealtime, whether it be breakfast, lunch, or dinner the resident should be getting their request despite the word daily for that mealtime. Reviewed R106's meal card for breakfast, lunch, and dinner, all meal cards document + 2 SLICES BREAD DAILY (untoasted). Review of the facility's policy and procedure, Food and Nutrition Services revised in October 2017 documented Meals and/or nutritional supplements will be provided per scheduled meal time or by request, and in accordance with the resident's medication requirements .Reasonable efforts will be made to accommodate resident choices and preferences.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48351 Based on observations, interview, and record review, the facility failed to store and serve food in accordance with professional standard for food service safety. This deficient practice has the potential to place facility residents at risk for food-borne illness. Findings include: 1) A concurrent observation and interview were conducted on 08/12/24 at 08:27 AM in the facility kitchen. One of the refrigerators contained a container of rice porridge with a discard date of 08/11/24. Dietary Director (DD) stated that it should have been discarded since the kitchen staff performs audits twice a day. Review of the facility policy titled, Food Receiving and Storage, with a revised date of 10/2017, was conducted. The facility policy documented, Food shall be received and stored in a manner that complies with safe food handling practices. 2) Concurrent observation and interview were conducted with the Dietary Aide (DA) 1 on 08/12/24 at 08:53 AM. DA1 was observed checking the dishwasher sanitizer with a quality assurance strip. When asked if she logs the results, DA1 stated that kitchen staff only logs the temperature for the dishwasher and there was no log for checking the dishwasher sanitizer. Interview was conducted on 08/12/24 at 01:28 PM with DD. DD confirmed that the facility did not have a log for the dishwasher sanitizer quality assurance checks. A review of the facility policy titled, Dishwashing Machine Use, with a revised date of 03/2010, was conducted. The facility policy documented, A supervisor will check the dishwashing machine for proper concentrations of sanitizer solution after filling the dishwashing machine and once a week thereafter. Concentrations will be recorded in a facility approved log.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on interview and record review, the facility failed to maintain medical records on 1 of 32 residents sampled, that were accurately documented. As a result of this deficient practice, Resident (R)313 was placed at risk for a decrease in quality and competency of care. In addition, based on observation, interview, and record review, the facility failed to keep a resident's Electronic Health Record (EHR) confidential. This deficient practice places residents' EHRs at risk for violations of the Health Insurance Portability and Accountability Act (HIPAA). Findings include: 1) Resident (R)313 is a [AGE] year-old male admitted to the facility on [DATE] for short-term rehabilitation. R313's admitting diagnoses include, but are not limited to, acute respiratory failure with hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions), epilepsy, and esophageal (tube that runs from the throat to the stomach) obstruction. As a result of his admitting diagnoses, R313 was admitted with a tracheostomy (a surgically created hole in your windpipe (trachea) that provides an alternative airway for breathing) and a gastrostomy tube (feeding tube). A review of R313's electronic health record (EHR) on 08/13/24 noted the following active provider order: NPO diet, NPO texture, to mean nothing by mouth. On 08/15/24, further review of R313's EHR noted the following in the nurse progress notes, documented word-for-word, on 08/12/24 10:28 AM; 08/11/24 06:17 PM; 08/11/24 10:13 AM; 08/10/24 10:40 PM; 08/10/24 03:40 PM; and 08/10/24 05:05 AM: Nutrition: Taking nutrition and hydration orally. No complaints of thirst. No signs/symptoms of a swallowing disorder. Mucous membranes moist. On 08/15/24 at 11:40 AM, an interview was done with Unit Manager (UM)8 in her office. After a concurrent review of the nurse progress notes/skilled nursing assessments listed above, UM8 agreed there should not be any documentation indicating that R313 was taking any food or liquids by mouth as that would be incorrect. UM8 also agreed that the documentation appeared repeatedly copied and pasted. UM8 stated that copying and pasting of assessments or portions of assessments should not happen. UM8 stated that she was surprised and disappointed to see incorrect documentation happening even once, but repeatedly over the course of two days was unacceptable. UM8 agreed that accurate assessments were important for appropriateness and quality of care. 48351 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Concurrent observation and interview were conducted on 08/14/24 at 01:20 PM near the 1st floor nurse's station. A medication cart was parked in front of the nurse's station with the computer screen facing the hallway and the tv/dining room. The screen displayed one of the resident's EHR. The tv/dining room had five residents sitting at the tables. The hallway had a newly admitted resident in a wheelchair that was being pushed by a visitor. The visitor paused in front of the medication cart waiting for staff to acknowledge him and the new resident. As they both waited, the visitor was observed looking at the computer screen with a resident's EHR displayed. Registered Nurse (RN) 24 was nearby and the State Agency (SA) informed RN24 of the opened computer screen. RN24 stated the computer did not belong to her and that it belonged to RN10. RN24 quickly closed the resident's EHR and confirmed that it should not have been left open. RN10 was informed of the opened EHR; she agreed that she should have logged off prior to leaving the computer unattended. A review of the facility policy titled, Computer Terminals/Workstations, with a revised date of 04/2014, was conducted. The policy documented, A user may not leave his/her workstation or terminal unattended unless the terminal screen is cleared, and the user is logged off. Each user must log off at the end of his/her work shift.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on interview and record review, the facility failed to ensure the Binding Arbitration Agreements ([NAME]) they asked the residents (or their representatives) to enter into, were explained in a form and manner that they could understand. This is evidenced by 1 of 3 residents or resident representatives (of Resident 63) sampled stating she did not have the BAA explained to her in a way that she understood what it meant. Findings include: On 08/13/24 at 12:00 PM, an interview was done with the resident representative/family member (FM3) for Resident (R)63 at his bedside. During a concurrent review of a copy of the signed BAA and being asked if she recognized it, FM3 reported that she believed it was a form in a bunch of forms that had been sent to her to sign once when R63 was being readmitted from the acute care hospital. FM3 also reported that she could not recall the form being explained to her and stated that she wasn't sure what it was for. After the state agency (SA) explained the BAA form to her, FM3 stated that she was sure the form had not been explained to her before, because if it had, she would not have signed it. When shown the Voluntary Arbitration Program Information Sheet and asked if it had been read to her by a facility representative, FM3 responded that she did not recall seeing the Information Sheet before, nor did she remember it being read to her. FM3 stated that she did receive a phone call about the Admission Packet forms but was only asked if there were any changes. When she responded that there were no changes, FM3 stated that she was asked to review and sign the forms. On 08/14/24 at 02:19 PM, an interview was done with the Director of Medical Records (DMR) outside of the Administrator's Office. The DMR confirmed that the BAA would have been sent to FM3 for e-signatures with about 27 [other] forms in the Admission Packet [all requiring signatures]. The DMR also confirmed that the social services representative that had signed off as reviewing the BAA information with FM3 no longer worked for the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43414 Based on observation and interview, the facility failed to provide a safe, sanitary, and comfortable environment to prevent the development and transmission of communicable diseases and infections for two of six residents sampled for infection control (Resident (R) 126 and R85). R85's humidifier bottle was not properly secured to the oxygen concentrator. During R126 sacral wound dressing change, the nurse didn't sanitize hands after removing dirty gloves and before putting on clean gloves. This failure could place the resident at risk for infection. Findings include: 1) On 08/12/24 at 08:38 AM, during an observation of R85's room, observed R85 on oxygen, oxygen contractor running, and the humidifier bottle had broken off tape around it and was taped on the bottom sticking to the ground. The rubber band that secured the humidifier bottle to the concentrator was broken and there was tape around the concentrator. R85 reported the humidifier bottle was taped to the concentrator this morning but it fell off and he had issues with his oxygen tube soon after, .there was a kink in the machine and the tubing was changed right after. R85 reported the rubber band holding the humidifier bottle had been broken for a while but could not provide how long or the date when he first noticed it broken. On 08/15/24 at 10:39 AM, an interview with Infection Preventionist (IP) was done. Inquired if an oxygen humidifier bottle on the floor would be acceptable. IP stated no because the floor is not sanitary with possible germs, bile, and infectious diseases on the floor. IP admitted this could put the resident at risk of infection. 38870 2) R126 is a [AGE] year-old male admitted to the facility on [DATE] with primary diagnoses that includes heart failure; septicemia; wound infection and an unhealed stage four pressure ulcer of the sacral region, per Record Review (RR) of the face sheet. Wound care team observed on 08/14/24 at 08:45 AM. Licensed Practice Nurse (LPN) 3 and Registered Nurse (RN) 22 started the dressing change on R126's stage four sacral wound. During the dressing change, observed LPN3 clean the wound and remove her dirty gloves then put clean gloves on without sanitizing her hands. The surveyor asked LPN3 if she should sanitize her hands after removing the dirty gloves and before putting on the clean gloves. LPN3 said yes and proceeded to remove the gloves, apply the hand sanitizer, and replaced with the clean gloves. Wound Care policy and procedure, 2001 MED-PASS, Inc. (Revised October 2010) reviewed. 7. Cleanse wound with ordered wound cleanser . 8. Pull glove over and discard into appropriate receptacle. Wash and dry your hands thoroughly or may use alcohol-based sanitizer as an alternative . 9. DON new gloves.