STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125026	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kuakini Geriatric Care, Inc	347 North Kuakini Street Honolulu, HI 96817

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 37954 Based on interview and record review the facility failed to consult with the physician for three residents reviewed when Resident (R) 12 and R26 reported allegations of abuse by staff and R33 was witnessed by a staff being abused by another staff. This deficient practice could affect all residents at the facility and impede care the physician would order. Findings Include: Cross reference F600 - Free From Abuse and Neglect 1) On 07/17/24 at 11:54 AM interviewed ADON who confirmed he was present at R12's bedside with DON when they interviewed her. ADON reported resident stated CNA was rough handling her during her shower. ADON was not sure if it occurred more than once, not sure of the details. ADON reported R12 was afraid but not physically hurt, looked a little upset and concerned. ADON stated R12 was worried that CNA in question would retaliate against her. ADON stated the CNA no longer works at facility, stated she was a contract worker and they canceled the remaining contract. On 07/17/24 during RR of R12's EHR did not find a progress note from the licensed staff stating R12's physician was notified of R12's family's reported allegation of abuse by staff. On 07/19/24 at 12:25 PM interviewed R12's physician. Inquired if physician was notified of R12's family reported allegation of staff abuse and she stated she was on leave and would have to review her call log and would let the DON know. On 08/07/24 the DON sent surveyor an email stating R12's physician had emailed her the following response: No, I was not informed of this issue/ family concern. 2) On 07/17/24 at 11:54 AM interviewed ADON for R26's incident that was reported on 03/20/24 and reported that it was her night shift nurse aide that was in question. ADON stated according to the charge nurse, the incident likely happened between 03:00 AM to 04:30 AM. ADON confirmed he was present at R26's bedside with DON for the interview. R26 had reported night shift CNA had started to provide care for her (changing her brief) but had not told her what she was doing. On 07/17/24 during RR of R26's EHR did not find a progress note from the licensed staff stating R26's physician was notified of R26's reported allegation of abuse by staff. (continued on next page)

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/19/24 at 11:10 AM interviewed R26's physician and inquired if he was notified of R26's allegation of abuse by staff. Physician stated he was not notified. Inquired what he would have done if he had been notified and he stated he would have asked the DON to investigate this incident and to check for physical or psychological harm. 3) On 07/18/24 at 02:55 PM interviewed nursing supervisor (NS)1. NS1 confirmed she was the nursing supervisor working on 07/05/24 at 07:30 PM when the incident occurred with R33. Inquired how she was informed and NS1 stated I just got a phone call on the supervisor's phone by the off going charge nurse (RN2) as she was leaving. I went upstairs from 3rd floor to 6th floor to talk to CNA3 to ask what happened, she told me that she was coming in to start her shift around 7-7:30 PM, she came to the nurses station, saw CNA4 with R33 who was offering him pudding, she (CNA3) went to the bathroom, came out of the bathroom and she (CNA3) saw CNA4 stomp on resident's foot and CNA3 stated she told CNA4 don't do that. Inquired what NS1 did and she stated she spoke with CNA4 who stated the resident was trying to use his walker to hit CNA4's feet and she stepped on his foot to stop him from doing this. Inquired if R33's doctor was notified of this incident and NS1 stated she did not know if the resident's doctor was notified. On 07/18/24 during RR of R33's EHR did not find a progress note from the licensed staff stating R33's physician was notified of staff (CNA3) reported witnessed abuse by staff (CNA4). Review of completed report of Event Report submitted to Office of Health Care Assurance on 07/12/24 states R33's physician was not notified of this incident. On 07/19/24 at 01:47 PM Interviewed R33's physician who confirmed she had not been notified of R33's witnessed staff abuse. Inquired what she would had done if she had been notified and she stated she would have asked staff to notify the DON, do an incident report and then she (physician) would have seen R33 the next day. On 07/19/24 review of facility policy titled Dependent Adult Abuse/Neglect with an Effective Date 11/2019. found under Procedure page 6 and 7 of 10, I. Reporting/ Response C. Patient Care Coordinator/ Shift Coordinator (SC) responsibilities: . 2. In collaboration with the Charge Nurse, immediately initiate the action necessary to protect the client until the investigation is completed, including removing the suspected individual from direct contact with the affected client and from all direct care with clients. 4. Notify the client's physician and family respectively.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 37954 Based on interviews and record review, the facility failed to protect the resident's right to be free from physical abuse by staff. Three residents reviewed, Resident (R) 12 and R26 reported allegations of abuse by staff and R33 was witnessed by a staff being abused by another staff. This deficient practice could affect all residents in the facility, placing the residents at risk of harm, if the facility fails to protect resident's right to be free from abuse by staff. Findings Include: Cross Reference F580 - Notify of Changes (injury/decline/room, Etc.) 1) On 07/17/24 at 10:47 AM interviewed Registered Nurse (RN) 1. Inquired if she was working with R12 on 03/20/24 and she said yes, stated on March 20th it was resident's Care Plan day meeting and during the meeting they discuss with the family any concerns and they (the family member) mentioned R12 had told them that a staff had pushed her head down while she was showering her, that the staff had pushed her head against the wall. Family member was not sure what day this occurred. R12 told the family member that she did not like the agency staff who was black. RN1 spoke with R12 right after the phone call with R12's family member. The resident stated during her shower, not sure what day it was, the staff pushed her head down while she was showering her. RN1 asked staff working on 03/20/24 during day shift (7 AM - 3 PM) if they received any report from R12 regarding complaint of a staff member being rough with her in the shower. Staff stated no and RN1 reported it to Assistant Director of Nursing (ADON) and Director of Nursing (DON). On 07/17/24 at 11:54 AM interviewed Assistant Director of Nursing (ADON) confirmed he was present at R12's bedside with DON when they interviewed her. Resident stated CNA was rough handling her during her shower. Not sure if it occurred more than once. Not sure of the details. Resident was afraid but not physically hurt, looked a little upset and concerned. ADON stated R12 was worried that CNA in question would retaliate against her. ADON stated the CNA no longer works at facility, stated she was a contract worker and they canceled the remaining contract. 2) On 07/17/24 at 10:47 AM interviewed RN1. Inquired if she was working with R26 on 03/20/24 and she stated she was. RN 1 stated Certified Nurse Assistant (CNA) 1 reported that R26 had told her (CNA1) she has a concern about her care. CNA1 reported she asked resident what her concern was, R26 told CNA1 that she was sleeping and woke up and was like naked, the diaper was open and her gown was open. CNA1 told RN1 that R26 asked her why did the girl not tell me before doing it? RN1 reported to ADON (is the nursing supervisor during day shift if there is no supervisor) and DON. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/17/24 at 11:14 AM interviewed CNA1. CNA1 stated R26 was not assigned to her but remembers that morning, On 03/20/24 between 6:30-7:30 AM she heard resident crying out to her from her room. R26 stated she needed help. R26 had told her she did not want the black woman and resident told CNA1 what happened to her. CNA1 stated R26 stated she was rudely awaked by staff (night shift CNA) undressing her when the blanket was off and the brief was open, uncovered. R26 stated night shift CNA told resident she was wet. CNA1 contacted the charge nurse for the day, RN1. Resident repeated the same story of what occurred during night shift to CNA1 and RN1. RN1 reported the incident and ADON and DON came to the floor to investigate. On 07/17/24 at 11:54 AM interviewed ADON for R26's incident that was reported on 03/20/24. ADON stated the resident (R26) did not specify a time the incident occurred and reported that it was her night shift nurse aide that was in question. Inquired when night shift is and ADON stated our night shift is from 11:30 PM to 08:00 AM. ADON stated according to the charge nurse, the incident likely happened between 03:00 AM to 04:30 AM. ADON confirmed he was present at R26's bedside with DON for the interview. R26 had reported night shift CNA had started to provide care for her (changing her brief) but had not told her what she was doing. 3) On 07/17/24 at 11:54 AM interviewed ADON. ADON confirmed he was working this day (07/05/24) but had gone home by the time this incident occurred at 07:30 PM. There was a nursing supervisor working who received the phone call that a CNA had stomped on resident's foot. Supervisor reported this to the DON who then relayed this to the ADON. Inquired about R33 and ADON stated R33 is confused, has a diagnosis of Alzheimer's and is forgetful and was not interviewed after the incident. ADON explained R33 has a history of being agitated. R33 was reported as being restless and wandering to the other side of the floor. R33 was on a 1:1 (close monitoring by one staff with one resident) at the time the incident occurred with CNA4. Inquired about the interview with CNA4 and ADON explained CNA4 admitted to stepping on his (R33's) foot, that she explained it as a kiss a light touch. ADON stated we think it was intentional because she stated he (R33) was trying to hit her feet with his Front Wheel [NAME] (FWW). ADON stated the DON told him and the nursing supervisor that CNA4 could not work with R33. Inquired how the facility handles allegations of abuse by staff and he stated usually the staff would be reassigned to different resident or different location. After this incident CNA4 was not allowed to work on the 6th floor. On 07/18/24 at 09:30 AM interviewed CNA3. Inquired of CNA3 what occurred on 07/05/24 at 07:30 PM. CNA3 stated she came in early to work, went to use the bathroom that is located behind the nurse's station on the 6th floor. CNA3 stated once she came out of the bathroom she looked up and saw CNA4 step on R33's foot. Inquired if she thought it was a mistake or by accident and she said no. CNA3 stated R33 was sitting down, appeared very restless. CNA3 stated I saw with my two eyes that CNA4 stomped his foot. CNA3 stood up and stomped her foot on the ground to demonstrate what CNA4 had done. CNA3 stated I went to her and told her don't do that, that's not nice. CNA3 explained CNA4 was wearing crocs and R33 was wearing only socks when this occurred. CNA3 went to the charge nurse and told her to talk with CNA4 to tell her not to do that. CNA3 stated she spoke with CNA4 and CNA4 tried to lie saying that she only tapped the resident's foot softly but CNA3 stated she did it harder than that. CNA3 stated the supervisor had asked staff to write up what happened on a yellow sheet. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/18/24 at 11:07 AM interviewed RN2. RN2 stated she was working day shift (from 07:00 AM till 3:30 PM) when the incident occurred with R33 on 07/05/24 at 07:30 PM. RN2 stated she was working till 7 PM that day so that she could compete her admission. RN2 stated she was in the office when this occurred and did not witness the incident. RN2 stated she was told as I was leaving, I had clocked out. RN2 confirmed one of the CNAs (CNA3) who witnessed this incident told me about the incident, I think it was CNA3 who had come to work early. CNA3 told me that she actually saw CNA4 step on the resident's foot. I was clocked out and heading out and told the other nurses there to notify the supervisor and make sure there is an investigation. I also called the nursing supervisor to make sure too. Inquired who the nursing supervisor was and RN2 provided the name. On 07/18/24 at 02:55 PM interviewed nursing supervisor (NS)1. NS1 confirmed she was the nursing supervisor working on 07/05/24 at 07:30 PM when the incident occurred with R33. Inquired how she was informed and NS1 stated I just got a phone call on the supervisor's phone by the off going charge nurse (RN2) and she was leaving, cannot remember the exact time, almost 8 PM and she (RN2) said something happened and that you have to check regarding a staff and a patient, no details but to check with CNA3. I went up stairs from 3rd floor to 6th floor to talk to CNA3 to ask what happened, she told me that she was coming to start her shift early around 7-7:30 PM, she came to the nurses station, saw CNA4 with R33 who she was offering him pudding, she (CNA3) went to the bathroom, came out of the bathroom, and stated she (CNA3) saw CNA4 stomp on resident's foot, and CNA3 stated she told CNA4 don't do that. Inquired what NS1 did and she stated she spoke with CNA4 who stated the resident was trying to use his walker to hit CNA4's feet and she stepped on his foot to stop him from doing this. On 07/19/24 review of facility policy titled Dependent Adult Abuse/Neglect with an Effective Date 11/2019 under Procedure page 6 of 10, I. Reporting/ Response C. Patient Care Coordinator/ Shift Coordinator (SC) responsibilities: . 2. In collaboration with the Charge Nurse, immediately initiate the action necessary to protect the client until the investigation is completed, including removing the suspected individual from direct contact with the affected client and from all direct care with clients.

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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. 37954 Based on interviews and record reviews the facility failed to report allegations of abuse to the state agency within two hours of being reported to the Charge Nurse (CN), Nursing Supervisor (NS), or Assistant Director of Nursing (ADON) and Director of Nursing (DON). During the review of two Residents (R) 26 and 33 allegations of abuse were reported to a NS, or ADON and DON. Initial reports submitted by the facility were sent to the state agency two days after the incidents were reported to the CN, NS, or ADON and DON. This deficient practice could affect all residents in the facility who have a reported or witnessed incident of abuse and the facility fails to notify the state agency within two hours. Findings Include: Cross Reference F600 Free From Abuse and Neglect 1) On 07/17/24 at 11:54 AM interviewed ADON for R26's incident that was reported on 03/20/24. ADON stated the resident (R26) did not specify a time the incident occurred and reported that it was her night shift nurse aide that was in question. Inquired when night shift is and ADON stated our night shift is from 11:30 PM to 08:00 AM. ADON stated according to the charge nurse, the incident likely happened between 03:00 AM to 04:30 AM. ADON confirmed he was present at R26's bedside with DON for the interview. R26 had reported night shift CNA had started to provide care for her (changing her brief) but had not told her what she was doing. On 07/17/24 review of the Facility Reported Incident (FRI) for R26 found it was sent via email to the Office of Healthcare Assurance (OHCA) on 03/22/24 at 05:00 PM with the following boxes checked off staff to resident and mistreatment. On 03/20/24 at 11:15 AM R26 reported the allegation of abuse to the CNA who reported it to charge nurse and two days later the incident was initially reported to the state agency. 2) On 07/17/24 at 11:54 AM interviewed ADON. ADON confirmed he was working this day (07/05/24) but had gone home by the time this incident, witnessed staff abuse of R33, which occurred at 07:30 PM. There was a nursing supervisor working who received the phone call that a CNA had stomped on resident's foot. Supervisor reported this to the DON who then relayed this to the ADON. Inquired about R33 and ADON stated R33 is confused, has a diagnosis of Alzheimer's and is forgetful and was not interviewed after the incident. ADON explained R33 has a history of being agitated. R33 was reported as being restless and wandering to the other side of the floor. R33 was on a 1:1 (close monitoring by one staff with one resident) at the time the incident occurred with CNA4. Inquired about the interview with CNA4 and ADON explained CNA4 admitted to stepping on his (R33's) foot, that she explained it as a kiss a light touch. ADON stated we think it was intentional because she stated he (R33) was trying to hit her feet with his Front Wheel [NAME] (FWW). On 07/18/24 review of the FRI for R33 was sent via email to the state agency on on 07/08/24 at 3:30 PM with the following boxes checked off staff to resident and mistreatment. Staff to resident abuse occurred on 07/05/24 at 07:30 PM. Almost three days later the facility initially reported the incident to the state agency. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/19/24 at 01:30 PM interviewed DON who confirmed she interviewed residents who had reported allegations of abuse by staff. Inquired about reporting FRI's to the state agency and she stated she had been told the reports were submitted, she had not been informed they were submitted days later. On 07/19/24 review of facility policy titled Dependent Adult Abuse/Neglect with an Effective Date 11/2019 under Procedure I. Reporting/ Response on page 6 and 7 of 10, E. Director of Nursing or designee (Patient Care Coordinator/ Shift Coordinator) responsibilities: 2. Notify State Officials in accordance with State law. a. Notify Department of Health, Office of Healthcare Assurance and Department of Human Services, Adult Protective Services and Honolulu Police Department per regulatory guidelines. b. Complete question #1 of the Notification of Event Memorandum,. and fax it to the Department of Health, Office of Healthcare Assurance (DOH, OHCA), (See Attachment G) within 24 hours or by the shorter time-frames noted in the KGC Reporting a Suspected Crime under the Federal Elder Justice Act Policy number 02-0401C5 if a KGC-ICF or SNF resident is the alleged victim.

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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. 37954 Based on interview and record review the facility failed to provide sufficient nursing staff on 02/07/24 and 07/05/24 during their second shift (03:00 PM - 11:30 PM) on the skilled nursing unit. The deficient practice puts the residents at risk for harm such as abuse by staff and staff working outside of their scope of practice. Findings Include: Cross Reference F600 - Free From Abuse and Neglect and F726 Competent Nursing Staff On 07/17/24 at 11:54 AM interviewed Associate Director of Nursing (ADON) who was able to provide copies of staffing on 02/07/24. Inquired if ADON was working on 02/07/24 and he confirmed he was. Inquired if he was informed of an RN delegating medication administration to a CNA to pass medication to Resident (R)40 and he stated the Director of Nursing (DON) notified him. Inquired if the facility teaches the nurses to delegate medication pass to the CNA's and he denied this. ADON confirmed he and DON met with the staff (RN3 and CNA5) to discuss their scope of practice and what was allowed and not allowed at the facility. Continuation of interview with ADON confirmed he was working on 07/05/24 but had gone home by the time this incident (staff to resident abuse) occurred at 07:30 PM. ADON explained there was a nursing supervisor working who received the phone call that a CNA had stomped on resident's foot. Supervisor reported this to the DON who then relayed this to the ADON. Inquired about R33 and ADON stated R33 is confused, has a diagnosis of Alzheimer's and is forgetful and was not interviewed after the incident. ADON explained R33 has a history of being agitated. R33 was reported as being restless and wandering to the other side of the floor. R33 was on a 1:1 (close monitoring by one staff with one resident) at the time the incident occurred with CNA4. Inquired about the interview with CNA4 and ADON explained CNA4 admitted to stepping on his (R33's) foot, that she explained it as a kiss a light touch. ADON stated we think it was intentional because she stated he (R33) was trying to hit her feet with his Front Wheel [NAME] (FWW). On 07/19/24 review of the facility's staffing matrix (per facility is Intended as a guideline for staffing levels. Specific resident care needs will always dictate actual staffing requirements.) and facility Census/Staffing forms found on 02/07/24 during the evening shift (03:00 PM - 11:30 PM), the Skilled Nursing Facility (SNF) floor had 37 residents and per the staffing matrix should have had 2 Registered Nurses (RNs), 2 Licensed Practical Nurses (LPNs) and 4 or 5 Certified Nurse Aides (CNAs). On 02/07/24 there were 2.5 RNS, no LPNs and 3.5 CNAs which means the floor was short 1.5 LPNs and short 0.5 - 1 CNAs for this shift. On 07/05/24 the SNF floor had 31 residents and per the staffing matrix for the evening shift (03:00 PM - 11:30 PM) should have had 1 RN, 2 LPNs and 4 or 5 CNAs. Review of the facility Census/Staffing form dated 07/05/24 found the facility had 2.5 RNs, no LPNs and 4 CNAs. The unit was short 0.5 LPN and up to 1 CNA.

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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. 37954 Based on interviews and record review the facility failed to assure a Registered Nurse (RN) and a Certified Nurse Aide (CNA) practiced within their professional scope of practice. This deficient practice could affect all residents and put them at risk for harm if licensed staff delegate tasks to unlicensed staff such as medication administration, which is outside their scope of practice. Findings Include: On 07/17/24 at 11:54 AM interviewed Associate Director of Nursing (ADON) who was able to provide copies of staffing on 02/07/24. Inquired if ADON was working on 02/07/24 and he confirmed he was. Inquired if he was informed of an RN delegating medication administration to a CNA to pass medication to Resident (R)40 and he stated the Director of Nursing (DON) notified him. Inquired if the facility teaches the nurses to delegate medication pass to the CNA's and he denied this. ADON confirmed he and DON met with the staff (RN3 and CNA5) to discuss their scope of practice and what was allowed and not allowed at the facility. On 07/18/24 at 2:25 PM interviewed Certified Nurse Aide (CNA)5 who confirmed she worked on 02/07/24. Inquired if she was asked by Registered Nurse (RN)3 to give R40 her bedtime medication. CNA5 stated she was directly involved, she took care of the resident and stated she did her best to provide care and that R40 was very irritated. CNA5 stated R40 was demanding her bedtime medication and CNA5 stated she told R40 that RN3 was helping another resident and that she would tell RN3 that she is requesting her medication. CNA5 told RN3 that R40 wanted her medication and RN3 handed CNA5 the medication cup with the pills inside and told her to give R40 the medication. CNA5 stated she took the medication into R40 and R40 asked CNA5 why is she giving her the medication and not the nurse. R40 refused to take the medication. Inquired if CNA5 knew she was not supposed to do this because she is not a nurse and CNA5 confirmed she knew this. On 07/18/24 at 03:50 PM interviewed RN3 and inquired if she had asked CNA5 to give R40 her medication and RN3 confirmed this. RN3 confirmed she is not supposed to do this, that it is outside her scope of practice. RN3 stated there was an incident the day before, on 02/06/24, with R40 and per RN3 R40 yelled at her. RN3 stated she did not feel comfortable going into R40's room. Inquired if RN3 asked the other nurse who was working with her to pass the bedtime medication to R40 and RN3 stated The other nurse was busy. Inquired if she asked the Nursing Supervisor (Shift Coordinator) for help and RN3 denied this, stated she was busy on the other floor testing residents. RN3 stated she gave CNA5 the medication cup and she (RN3) stayed at the resident's door as CNA5 offered the medication to R40. Inquired if R40 took the medication and RN3 stated she did not take her medication that night, she refused it. On 07/19/24 review of facility policy titled Administering Medications states Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretations and Implementation 1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so.

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	125026	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kuakini Geriatric Care, Inc	347 North Kuakini Street Honolulu, HI 96817

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 37954 Based on interview and record review the facility failed to assure staff accurately documented medication offered to and refused by resident (R)40. This deficient practice could affect all residents who receive medication in the facility if their medication administration is not documented accurately. Findings Include: On 07/18/24 at 03:50 PM interviewed RN3 and inquired if she had asked CNA5 to give R40 her medication and RN3 confirmed this. RN3 stated there was an incident the day before, on 02/06/24, with R40 and per RN3 R40 yelled at her. RN3 stated she did not feel comfortable going into R40's room. Inquired if RN3 asked the other nurse who was working with her to pass the bedtime medication to R40 and RN3 stated The other nurse was busy. Inquired if she asked the Shift Coordinator for help and RN3 denied this. RN3 stated she gave CNA5 the medication cup and she (RN3) stayed at the resident's door as CNA5 offered the medication to R40. Inquired if R40 took the medication the CNA offered and RN3 stated R40 refused the medication. Record review on 07/19/24 of R40's Medication Administration Record (MAR) found RN3 had documented at 2113 R40 had taken her Tylenol 625 mg by mouth and Melatonin 3 mg by mouth.