| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 125038 | A. Building<br>B. Wing | 08/09/2024 |

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| Aloha Nursing & Rehab Centre | 45-545 Kamehameha Highway<br>Kaneohe, HI 96744 |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38870<br><br>Based on interviews and record review, the facility failed to ensure the resident's right to formulate an Advanced Health Care Directive (AHCD) for three of six Residents [(R)151, R87, and R97] sampled.<br><br>Findings include:<br><br>R151 is an [AGE] year-old male, admitted to the facility on [DATE], after a hospitalization for metabolic encephalopathy (brain dysfunction caused by an underlying illness), and has full code status per his medical record face sheet.<br><br>R151's Electronic Health Record (EHR) reviewed. No AHCD found. No supporting documentation about formulating or obtaining an AHCD was found in the progress notes or Care Plan (CP) dated 07/24/24.<br><br>Copy of the AHCD and/or supporting documentation for R151 requested from the Administrator on 08/07/24 at 11:40 AM.<br><br>Social services progress note dated 08/07/24 at 12:35 PM reviewed that documented the following: Previously inquired about AHCD? POLST and spouse said that they have a will which she believes includes that, requested she bring in a copy. Reminded spouse today if she was able to find the will. She hasn't had the time to look for it.<br><br>Social Services Manager (SSM)8 interviewed on 08/09/24 at 09:34 AM. SSM8 stated that when R151 was admitted to the facility on [DATE], the spouse was asked at the time of admission for a copy of the AHCD, but there was no follow up in obtaining a copy of R151's AHCD.<br><br>42160<br><br>Cross reference to F657: Timing/Revision of Care Plan<br><br>2) A review of R87's EHR on 08/07/24 at 10:08 AM did not contain documentation of the resident's AHCD on file. Review of R87's Admission Agreement documented R87 did not have an AHCD formulated and R87 returned from the hospital on 07/17/24.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 08/07/24 at 11:40 AM, requested a copy of R87's AHCD with the Administrator. At approximately 02:00 PM, the Administrator provided a progress note written by Social Services Manager (SSM)8 on 08/07/24 at 01:11 AM (after surveyor requested a copy of R87's AHCD with the Administrator) which documented, TCT (telephone call to) Res' (resident's) dtr (daughter) and inquired about the AHCD. She (daughter) stated that someone is helping her mom w/ it (with it) but they haven't completed it yet.<br><br>On 08/07/24 at 02:38 PM, conducted a concurrent interview and review of R87's EHR with SSM8 regarding R87's AHCD after returning from the hospital on the facility's processes for formulating and/or reviewing AHCD with the resident and/or the Resident's Representative (RR) after returning from the hospital. SSM8 reported in the admission packet the family is asked if they have an existing AHCD, then it is discussed at the initial care plan meetings if they would like to formulate one and if they do have an AHCD, if there are still okay with the interventions previously selected by the resident. Inquired if there is any documentation of an AHCD directive for R87 and if the resident did not have an AHCD, if the resident would like to formula one. SSM8 confirmed R87 did not have an AHCD and has not had a care plan meeting since returning from the hospital on 07/17/24 and was not on the calendar to have a care plan meeting since returning to the facility.<br><br>On 08/07/24 at 03:25 PM, conducted a concurrent interview and record review with the DON and Administrator regarding R87's AHCD. DON navigated R87's EHR and confirmed R87 did not have an AHCD on file and there is no documentation (prior to this surveyor request) that the facility discussed R87's right to formulate an AHCD.<br><br>48351<br><br>3) R97 is an [AGE] year-old male, who was admitted to the facility on [DATE]. A review of R97's EHR noted that a Brief Interview for Mental Status (BIMS) assessment was conducted by SSM8 on 07/31/24. SSM8 documented R97's score a 15, indicating the resident's cognition is intact.<br><br>Reviewed R97's EHR on 08/07/24 at 08:39 AM. At the time of the review there were no documentation that R79 had an AHCD or if facility staff had provided information on creating one.<br><br>On 08/07/24 at 11:40 AM, a list containing residents whose AHCD were not found in the EHR was given to the Administrator. R97's name was on that list.<br><br>On 08/07/24 at 02:00 PM, the Administrator provided a copy of an EHR documentation created by SSM8 and a review of it was conducted. The progress note was created on 08/07/24 at 01:34 PM by SSM8. SSM8 noted, TCT [telephone call to], [NAME], to inquire if Res [resident] has an AHCD or POLST [Physician Orders for Life Sustaining Treatment]-left msg [message]. Res doesn't think he has anything like that.<br><br>Interview with SSM8 was conducted on 08/09/24 at 10:02 AM. SSM8 confirmed that the phone call to R97's Public Guardian (PG) was made after the Administrator was given the list. SSM8 stated that she assumed R97's PG handled everything, so she had not discussed AHCD with R97 or R97's PG. |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.<br><br>42160<br><br>Based on interviews and record review, the facility failed to electronically transmit and complete the Minimum Data Set (MDS) data to the Centers for Medicare & Medicaid Services (CMS) system within 14 days for one Resident [(R)87] sampled.<br><br>Findings include:<br><br>On 08/07/24 at 02:49 PM, conducted an interview and concurrent record review of R87's Electronic Health Record with the Minimum Data Set Coordinator (MDSC)1. Reviewing R87's Minimum Data Set (MDS) documented there was a late warning for the submission of the admissions MDS, R87 returned from the hospital on 07/17/24. The MDS had not yet been submitted. MDSC1 confirmed R87's MDS was late and should have been submitted to the CMS system but was not.<br><br>During an interview with the Director of Nursing (DON) and the Administrator on 08/07/24 at 03:25 PM, requested the MDS 3.0 Final Validation Report. DON provided the MDS 3.0 Final Validation Report on 08/09/24 at 09:58 AM which documented R87's target date was 07/23/24 Assessment Completed Late: Z0500B (assessment completion date) is more than 14 days after A2300 (Assessment Reference Date). The DON confirmed the resident should have had an admissions MDS completed and transmitted by 08/06/24 but it was not completed. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47783<br><br>Based on observations, staff interviews, and record review, the facility failed to ensure a comprehensive person-centered care plan was developed and/or implemented for three residents (Resident (R)300, R250 and R52) in the sample. Specifically, a care plan was not developed to monitor for adverse effects of taking a blood thinner for R300. No care plan was developed for the care of R250's Peripherally Inserted Central Catheter (PICC) line (tube inserted into a vein in the upper arm and threaded into a large vein above the heart to provide intravenous treatments), The facility did not develop a care plan to address R52's skin condition. As a result of these deficient practices, these residents were placed at risk for a decline in their quality of life, and were prevented from attaining their highest practicable physical, mental, and psychosocial well-being. These deficient practices have the potential to affect all the residents at the facility.<br><br>Findings include:<br><br>1) R250 is a [AGE] year-old resident, admitted to the facility on [DATE] for short-term rehabilitation and long-term intravenous (IV) antibiotics administration with diagnoses included but not limited to infection and inflammatory reaction due to cardiac valve prosthesis, bacteremia (bacteria in the blood) and endocarditis (inflammation of the inner lining of the heart).<br><br>On 08/06/24 at 09:21 AM, observed R250 sitting upright in a wheelchair in his room. On the side of his bed was an IV pole with an IV pump (device used to administer IV medications). R250 observed to have a PICC line on his right upper arm.<br><br>Review of R250's Electronic Health Record (EHR) conducted on 08/08/24. There was no mention of R250 having a PICC line for the administration of IV antibiotics in the resident's current care plan.<br><br>During an interview with the Director of Nursing (DON) on 08/09/24 at 10:00 PM in the conference room, DON confirmed that there was no care plan developed for the care of R250's PICC line. DON also said that R250 was admitted to the facility with the PICC line, and the interdisciplinary team should have developed a care plan for it.<br><br>Review of the facility policy Baseline Care plans stated, . Interventions shall be initiated that address the resident's current needs . Any special needs such as for IV therapy . goals and interventions shall be documented in the designated format.<br><br>2) R52 is a [AGE] year-old resident admitted to the facility on [DATE] for long-term care. During an interview with him on 08/07/24 at 09:29 AM in the dining area, R52 said there was something on his left arm and he needs to see a doctor about it. R52 was wearing a long sleeve shirt and did not want this surveyor to roll up his sleeve because he said, It hurts when it is touched.<br><br>On 08/07/24 at 01:05 PM, an interview was conducted with Registered Nurse (RN) 14 outside R52's room. RN14 said that here was a raised growth on his left forearm but the skin is intact. RN14 said it was found a couple of weeks ago when he bumped his arm on the wall and complained of pain to the area. RN14 added she took a picture of it and uploaded it into the EHR.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of R52's EHR conducted, unable to find a picture of the left arm that RN14 took. Documentation found in the progress note dated 07/21/24 at 12:30 AM stated, Resident with raised growth to left forearm. Photo taken and uploaded into PCC (Point Click Care - EHR the facility uses). Has h/o (history of) squamous cell carcinoma (skin cancer) and has had [NAME] procedure (surgery for treating skin cancer lesions) in the past . There was no mention of the left forearm skin condition in the current care plan.<br><br>During an interview with the DON on 08/09/24 at 10:00 AM in the conference room, DON confirmed that there should have been a specific care plan developed by the interdisciplinary team to address the left forearm skin condition of R52.<br><br>48351<br><br>3) R300 is a [AGE] year-old male, admitted to the facility on [DATE]. R300 has a medical history which includes, but not limited to, congestive heart failure, left lower extremity thrombosis (blood clot) and embolism (blockage of blood flow), and long-term use of anticoagulants (blood thinner).<br><br>A review of R300's current care plan was conducted in the EHR. R300's care plan did not contain a care plan for the use of a blood thinner.<br><br>Concurrent interview and record review were conducted with the DON on 08/08/24 at 10:26 AM. DON confirmed that R300 was on a blood thinner. DON stated that R300 should have a care plan in place for monitoring side effects of the blood thinner. DON reviewed R300's EHR and confirmed that he did not have a care plan in place for the use of blood thinner. DON added, side effects monitoring and a care plan should have been in place for the length of time R300 has been residing in the facility.<br><br>The facility policy titled, Anticoagulants, dated 04/10/24, was conducted. The facility policy documented, The resident's plan of care shall alert staff to monitor for adverse consequences. Risks associated with anticoagulants include: Bleeding and hemorrhage (bleeding gums, nose bleed, unusual bruising, blood in urine, or stool), fall in hematocrit or blood pressure, thromboembolism. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42160<br><br>Based on interviews and record review, the facility failed to ensure the resident's comprehensive person-centered care plan was revised for one Resident (R)87 of 22 residents in the sample.<br><br>Findings include:<br><br>Review of R87's Electronic Health Record (EHR) documented R87 was discharged to a hospital on 06/28/24 and returned to the facility on [DATE].<br><br>On 08/07/24 at 02:38 PM, inquired with Social Services Manager (SSM)8 if R87 had a care plan meeting since the resident returned from the hospital. SSM8 confirmed R87 has not had a care plan meeting since the resident returned from the hospital (07/17/24) and was not currently on the facility's calendar to have a care plan meeting. SSM8 reported when the Minimum Data Set (MDS) is submitted, it triggers facility to schedule a care plan meeting on their calendar.<br><br>(Cross reference with F640: Encoding/transmitting/Resident Assessment) During a concurrent record review and interview with MSDC1, it was confirmed the facility had not yet submitted R87's MDS to the Centers for Medicare & Medicaid Services system since R87 returned from the hospital. MDSC1 also confirmed R87 was not scheduled for a care plan meeting on the facility's calendar.<br><br>During a concurrent interview and record review with the Director of Nursing and Administrator on 08/07/24 at 03:25 PM, confirmed R87 had not had a care plan meeting since returning from the hospital on 07/17/24. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38870<br><br>Based on record review and interview, the facility failed to ensure one resident (R)150 of 22 in the sample, was free of accidents during her stay in the facility and failed to develop a discharge plan that would ensure the resident was safely discharged . R150 had multiple falls during her stay in the facility. The deficient practice increased the resident's risk for injury and has the potential to affect residents who are discharged home.<br><br>Findings include:<br><br>Aspen Complaint Tracking System (ACTS) intake #10993 dated 05/30/24 documented, R150 had several falls while in the facility and was discharged home from the facility on 05/25/24, without home supervision, and without family support due to an unsafe environment.<br><br>Telephone call to R150's Family Member (FM) and Power of Attorney on 08/08/24 at 5:06 PM. FM stated the day before she was going to be discharged , R150 had a fall, and that she had at least four while in the facility. I worked with the Social Services Assistant (SSA)2 and told her that R150 isn't safe by herself, because me and my husband are at work during the day and my kids go to school, there is no one to supervise my mom during the day. The SSA2 told me my mom needed to go home and wouldn't be able to stay at the facility and it was our problem to find help for her. Then she gave me some papers to fill out to see if she could qualify for Medicaid, and some numbers to call for help, but she didn't help me or tell me how to fill out the paperwork. The original date they were going to release her was on May 11, 2024. An hour and a half before the discharge, my mom fell and hit her head and was taken to the hospital. After she went back to the facility the SSA2 told me I needed to take my mom to the primary care provider (PCP) before her next discharge. She told me my mom only needed supervision with her mobility, but when I took her to the appointment on May 17, I realized that she needed a lot more help than just supervision. It was very difficult to get in and out of the car, she shuffled her feet when she walks, she was very unsteady. The PCP voiced his concern to my mom and to me that she can't go home and be alone, it was too unsafe. I told the social worker this and they said there was nothing they could do. We had a conference on the 05/23/24 with the SSA2, the PT, OT, and Dietary. There was no one from nursing at the conference. We discussed her discharge. I didn't get a written notice when her services ended, or that I could appeal the discharge, I learned this from the long-term care ombudsman who told me I could file an appeal. They withheld information from us about the appeal process. I went to the administrator and told her about the appeal and that I wouldn't take my mom home because she was not safe and would be alone. The Administrator threatened to call the adult protective services because I wouldn't take her home. My mom did not receive services in the home after her discharge.<br><br>Electronic Medical Record (EMR) was reviewed and documented, R150 is a [AGE] year-old female, admitted to the facility on [DATE] for surgical aftercare following surgery for a malignant neoplasm of the brain.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R150's admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) 04/09/2024 documented, Section C. Cognitive Function, the resident scored an 11 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition is moderately impaired. Section GG- Functional Abilities and Goals documented the resident has impairment of one of the upper extremities, used a wheelchair for mobility, requires partial/moderate assistance for sitting to lying (ability to move from sitting on the side of the bed to lying flat on the bed), Lying to sitting on the side of the bed, sit to standing (ability to safely come to a standing position form sitting in a chair or on the side of the bed); Chair/bed-to-chair (ability to safely come to a standing position from sitting in a chair or on the side of the bed; Toilet transfer (ability to safely get on and off a toilet or commode).<br><br>Review of R150's Morse Fall Scale (a method of assessing a patient's likelihood of falling) conducted on 04/24/21 documented a score of 80, indicating the resident is a High Risk for Falling.<br><br>Progress notes reviewed from 04/11/24 to 05/25/24 documented several falls while R150 resided in the facility. The resident's last fall occurred on 05/24/24, the day before the facility discharged the resident.<br><br>- 04/23/24. R150 is moderate to maximum assist with ADL's and transfers.<br><br>- 04/24/24. Resident found sitting on floor in room . resident unable to remember to use call light for assistance. Continues with poor safety awareness.<br><br>- 04/28/24. Resident went to bathroom without calling for assistance and states she fell against the wall by the toilet and scraped her back. Fall was unwitnessed. 1 inch scrape noted to left scapula, no other injuries .<br><br>- 05/01/24. Resident attempted to get up and ambulate without assistance several times on this shift, res seen walking in the hallway without her mobility device, resident also wanted to take the stairs to the first floor, needs redirection and needs reminder to call before getting up for safety, residents' gait can be unsteady.<br><br>- 05/07/24. Resident wanders during the night. With episode of confusion noted .<br><br>- 05/24/24 .resident's left elbow was bleeding . resident told them that she went to the bathroom and lost her balance on the way back to her bed.<br><br>Review of R150's Care Plan (CP) documented, a falls care plan was initiated on admission and despite having multiple falls, only one revision was made (05/25/2024) for staff to assist the resident with routine toileting, despite the resident having multiple falls. Also, no discharge plan was initiated for R150 in the care plan. A care plan conference summary on 04/08/2024 documented Discharge plan to home. Steps, needs DME, (PT)/(OT). Goal is independent as possible. However, the facility did not take into consideration the steps the resident needs to be able to walk-up and down when assessing R150's readiness and safety upon being discharged .<br><br>PT Discharge Summary reviewed 05/27/24. Discharge Recommendations: Assistance with ADLs, Assistive device for safe functional mobility, home exercise program, home health services and 24 hour care. Patient has been educated on use of FWW and recommendation of having supervision for safety. Pt. verbalized understanding, however, displays questionable carryover.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Conducted a concurrent interview and record review with Physical Therapist (PT)15 on 08/09/24 at 10:35 AM, in the rehab services office on the second floor. Inquired with PT15 what was R150's level of function at the time of discharge. PT15 stated that she was a standby assist level with poor safety awareness and balance deficits. We informed the family that R150 would need supervision 24/7 upon discharge to home. The family said that no one would be home because of work and school, and they were concerned about her falling at home.<br><br>On 08/09/24 at 11:02 AM, conducted a concurrent interview and record review with Director of Nursing (DON). Inquired as to how many falls R150 had during her stay in the facility? After reviewing the HER and the care plan, DON stated, I only see one. Inquired about R150's risk factors for having falls. DON replied, the resident was alert but forgetful. DON confirmed R150's care plan was not timely updated after each fall.<br><br>Social Services Manager (SSM)8 interview on 08/09/24 at 09:34 AM in the first-floor training room. The surveyor asked her what the discharge process was for R150 and when did it begin for the resident. The SSM said, we discuss the discharge plan at the CP meeting. The SSA2 who worked with R150 is no longer here. R150 had several falls, and she went to the hospital on 05/11/24 which was the day after her last covered day. R150 returned to facility and her last covered date was 5/25/24. A meeting was held on 5/23/24 and the recommendations from the primary care provider were discussed. The recommendation was for a private duty hire and adult day care program. R150 needed more assistance with ambulating and toileting and would need supervision at home. The surveyor asked the SSM is it was safe to discharge R150 home since she had so many falls and she was moderately cognitively impaired. She responded that it was the residents wishes to go home.<br><br>Reviewed the progress note from SSA2 dated 05/28/24 with the SSM8 on 08/09/24 at 10:09 AM that stated Resident has Medicare but was here under an employer plan. The surveyor asked the SSM8 for clarification on whether or not the resident had Medicare, if so would R150 have been eligible to receive services under Medicare after the employer provider benefit ended? The SSM8 said she would check and get back to the surveyor. The SSM8 returned and stated that the resident was covered under an employer health plan and didn't have Medicare. She was working under an employer plan and that's why she didn't receive the Notice of Medicare Non-Coverage (NOMNC) or information about the appeal process. Asked the SSM8 again, if the resident didn't have Medicare, wouldn't the facility help sign the resident up for Medicare so she may qualify for additional services under Medicare? |

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| Aloha Nursing & Rehab Centre | 45-545 Kamehameha Highway<br>Kaneohe, HI 96744 |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>47783<br><br>Based on observation, interview and record review, the facility failed to provide appropriate services to prevent urinary tract infections for one resident (Resident (R) 52) sampled. The deficient practice exposed the resident to contaminants that may cause preventable urinary tract infections. This has the potential to affect all residents with a urinary catheter.<br><br>Findings include:<br><br>On 08/06/24 at 11:58 AM, observed R52 in a wheelchair being assisted out of the elevator on the second floor. R52 had a urinary catheter tubing connected to a collection bag placed in a privacy cover hung under the wheelchair seat. While R52 was being pushed from the elevator to the dining area table, the catheter tubing was dragging on the floor.<br><br>Review of the Electronic Health Record (EHR) for R52 revealed that he has a suprapubic catheter (tube inserted into the bladder through a cut in the abdomen to drain urine) and went out on 08/06/24 to see his doctor to have it changed.<br><br>On 08/08/24 at 01:33 PM, an interview with the Infection Preventionist (IP) was conducted, IP confirmed that the urinary catheter tubing and collection bag are not supposed to be coming in contact with the floor to prevent possible exposure to contaminants that could cause infections.<br><br>Review of facility policy Urinary Catheter stated, . 13. Make sure the catheter tubing and drainage bag are kept off the floor. |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>42160<br><br>Based on observation, interviews, and record review, the facility failed to ensure that staff implemented specific competencies necessary for resident safety. This deficient practice has the potential for harm.<br><br>Findings include:<br><br>1) Review of Resident (R)34's Electronic Health Record (EHR) documented on the most recent quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/23/24, Section C. Cognitive Patterns, R34 scored a seven (7) on the Brief Interview for Mental Status (BIMS), indicating R34's cognition is severely impaired.<br><br>On 08/06/24 at 10:29 AM, conducted an observation of R34 is the resident's room, seated in a wheelchair, with a bedside table in front of the wheelchair, with ten (10) medications tablets on the table, and no staff present in the room or in the line of sight of the resident. Inquired with R34 about the pills on the bedside table and if he took any, he reported those were his medications and could not remember if he took any of the medications.<br><br>On 08/06/24 at 11:05 AM, conducted a concurrent interview and record review with Registered Nurse (RN)39 regarding observation of R34, unattended with medication on the bedside table. RN39 pulled out a cup of medications and confirmed this was the medications on R34's bedside table. RN39 confirmed the resident was left unattended and should not have been. Inquired with RN39 if R34 took any medication(s). RN39 was unsure and proceeded to reconcile the medication in the cup with the 08:00 AM scheduled medications. When reviewing the Medication Administration Record (MAR), RN39 confirmed marking the medication as administered, prior to actually administering the medication to R34 and confirmed she should have marked the medication as given after observing R34 take the medication but did not.<br><br>Review of R34's EHR, documented the resident scheduled 08:00 AM medications included:<br><br>- Sennosides Oral Tablet 8.6 MG (Sennosides); Give 1 tablet by mouth two times a day for Constipation *Hold for loose stools<br><br>- Hydralazine HCl Oral Tablet 25 MG (Hydralazine HCl); Give 25 mg by mouth three times a day for HTN (hypertension) Hold for SBP (Systolic Blood Pressure) <110<br><br>- Lexapro Oral Tablet 5 MG (Escitalopram Oxalate) (2 tabs); Give 10 mg (milligrams) by mouth one time a day for Depression<br><br>- Prazosin HCl Oral Capsule 2 mg (Prazosin HCl); Give 1 capsule by mouth two times a day for HTN *Hold for SBP <110. Hold for sedation<br><br>- Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 100 MG (Metoprolol Succinate); Give 1 tablet by mouth in the morning for HTN *Hold for SBP <110, HR <55<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - Apixaban Oral Tablet 2.5 mg (Apixaban); Give 1 tablet by mouth two times a day for Atrial Fibrillation<br><br>- Vitamin B12 Oral Tablet 500 Mcg (microgram) (Cyanocobalamin); Give 1 tablet by mouth one time a day for Supplement<br><br>- Magnesium Oxide 400 Oral Tablet; Give 1 tablet by mouth in the morning for Supplement<br><br>- Levetiracetam Oral Tablet 500 mg (Levetiracetam); Give 2 tablet by mouth two times a day for Seizure<br><br>- Felodipine ER Oral Tablet Extended Release 24 Hour 10 mg (Felodipine); Give 10 mg by mouth one time a day for HTN hold SBP less than 120<br><br>After reconciling the medication left in the cup with the scheduled medications, R34 took:<br><br>- Levetiracetam Oral Tablet 500 mg (Levetiracetam); Give 2 tablet by mouth two times a day for Seizure<br><br>- Felodipine ER Oral Tablet Extended Release 24 Hour 10 mg (Felodipine); Give 10 mg by mouth one time a day for HTN hold SBP less than 120<br><br>On 08/09/24 at 11:35 PM, during an interview with the Director of Nursing, it was confirmed RN39 should not have marked the MAR prior to administering the medications to R34 and should have not left the resident unattended with the medications. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>48351<br><br>Based on observations, interviews, and records review, the facility failed to determine that drug records are in order and that an account of all controlled drugs is maintained and reconciled. This deficient practice increases the risk for diversion of residents' medications.<br><br>Findings include:<br><br>Concurrent observation, record review, and interview was conducted during a medication cart check on 08/08/24 at 08:20 AM. The facility document titled, Verification of Controlled Substance Count, dated August 2024, contained a blank spot for the oncoming day shift nurse signature for 08/08/24. Registered Nurse (RN)7 was informed of the missing signature. RN7 was observed placing his signature in the blank space. RN7 stated that he had forgotten to sign his name after he counted the medications with the outgoing night shift nurse. RN7 confirmed that signing the form together with the outgoing shift is the correct process.<br><br>Interview was conducted with the Director of Nursing (DON) on 08/08/24 at 10:22 AM. DON stated that outgoing and incoming nurses will both go to the medication cart and go through the count, verifying each controlled medication with one another. After completing the count and verifying that it is correct, both nurses sign off on the cart and handoff is complete. DON confirmed that RN should have signed off the same time the outgoing nurse had signed off.<br><br>Facility policy titled, Medications: Narcotic Record, with a revision date of 01/23/24 was conducted. The facility policy documented, Narcotics are verified at the beginning and end of shift with licensed staff signature indicated on the Verification of Controlled Substance Count Record. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>48351<br><br>Based on interview and record review, the facility failed to review and act upon a pharmacist's recommendation on a monthly Medication Regimen Review (MRR) for one of five sampled residents (Resident (R) 79). This deficient practice has the potential to negatively affect R79's overall health and well-being.<br><br>Findings Include:<br><br>A review of R79's Electronic Health Record (EHR) was conducted. R79's EHR documented a MRR dated 05/31/24. The MRR noted a recommendation by the pharmacist, This resident continues to receive an atypical antipsychotic. Please consider, lipid panel [measurement of cholesterol and triglyceride in the blood], LFT [Liver Function Test], A1C [measurement of the average amount of sugar in the blood in the past few months].<br><br>Further review of R79's EHR, did not contain lab results for lipid panel, LFTs, and A1c.<br><br>An interview with the Director of Nursing (DON) was conducted on 08/08/24 at 01:55 PM, near the conference room. DON confirmed that R79's MRR, dated 05/31/24, was not reviewed by the physician. Therefore, the recommendations for the lab work were not completed. DON added that it should have been reviewed by the physician.<br><br>A review of the facility policy titled, Medication Regimen Review, with a revision date 04/01/24, was conducted. The facility policy documented, Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities. |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48351<br><br>Based on interviews and record review, the facility failed to accommodate a diet preference for one of 25 sampled residents (Resident (R)300). This deficient practice has the potential to affect R300's overall well-being.<br><br>Findings include:<br><br>R300 is a [AGE] year-old male admitted to the facility on [DATE].<br><br>Interview was conducted with R300 on 08/06/24 at 09:25 AM in R300's room. R300 stated that a dietician and cook had taken notes on his diet/food preference, and he often does not receive what he had requested. When asked what was listed on his preference, R300 stated he was a vegetarian. R300 continued to add that on multiple occasions he was served food that contained meat. R300 stated that he was served spaghetti with meat sauce at one point. He also mentioned two occasions when the kitchen had served him potato chips, when he specifically asked for fries.<br><br>Interview was conducted with R300 on 08/07/24 at 12:35 PM. R300 was observed eating spaghetti with tomato sauce. R300 stated that the kitchen had originally given him beef stew for lunch. R300 added, beef stew is not very vegetarian.<br><br>An interview was conducted with Physical Therapist (PT)5 on 08/07/24 at 12:57 PM. PT5 confirmed that he saw beef stew served on R300's lunch tray.<br><br>Interview was conducted with the Executive Director (ED) for the kitchen on 08/07/24 at 01:38 PM. ED stated that he is aware of R300's vegetarian food preference, but one of the kitchen staff had mistakenly placed beef stew on R300's lunch tray, instead of spaghetti with tomato sauce.<br><br>A review of R300's Electronic Health Record (EHR) was conducted. R300's current care plan, noted, Nutrition: (R300) is at risk for fluid and nutritional imbalance/deficit r/t: inadequate intake, increased needs for healing, vegetarian/limited preferences, and CHF.<br><br>A review of the facility policy titled, Resident Rights, with a revision date of 03/04/24, was conducted. The policy noted, The facility will treat each resident with respect and dignity and will evaluate and make reasonable accommodations for the individual needs and preferences of a resident. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38870<br><br>Based on observation, interview and review of the policy, the facility failed to store food in a safe manner and maintain a sanitary cooking area. Two nourishment refrigerators on the first and second floors internal temperatures were not kept at or below 41 degrees. Perishable foods in the refrigerators were found to be at temperatures that were at 49.5 and 51 degrees. One pantry refrigerator in the main kitchen was found with an internal temperature at 43 degrees. Opened foods were not labeled with an indication of when staff should dispose of the food in the pantry, dry storage, and cooking areas. The deficient practice places residents in the facility at risk for foodborne illness.<br><br>Findings include:<br><br>Observation in the Kitchen on 08/06/24 at 08:40 AM in the pantry refrigerator, observed an open package of shredded [NAME] mozzarella cheese with no label or date. There was no internal thermometer found inside the unit. The external digital temperature reading was 48 degrees. The surveyor asked the kitchen manager to check the internal temperature of the unit. The thermometer read 43, and stated the temp is running a little on the warm side. In the dry storage room, observed an open box of biscuit mix with an unsealed plastic bag. In the kitchen near the cook station on the left side, a container of cattleman's barbecue sauce was 25 percent (%) full and sitting on the shelf with other dry spices. When asked by this surveyor, the Kitchen Supervisor said, it really shouldn't be up here and removed it. He asked the cook who was preparing food in the area if he opened this today, the cook shook his head and said no. In the same cooking area near the shelf was a fan with heavy dust on the back screen. The fan was facing toward the cook station and stove where the food is being prepared.<br><br>Observation of the nourishment refrigerator on the second floor on 08/08/24 at 12:30 pm, observed the thermometer inside the refrigerator read 58 degrees. The temperature log found on the shelf had temperatures documented from 11/2024 and 12/2024. The surveyor checked the internal temperature for a turkey sandwich inside the refrigerator that read 50 degrees. Notified Registered Nurse (RN) 12 of the unsafe temperatures and advised they remove all the perishable food items from the refrigerator.<br><br>Observation of the nourishment refrigerator on the first floor on 08/08/24 at 12:45 PM. The thermometer inside the refrigerator read 51 degrees. The surveyor checked the internal temperature for a tuna sandwich inside the refrigerator that read 49.5 degrees. Notified RN7 of the unsafe temperatures and advised all the perishable food items from the refrigerator be removed.<br><br>Interview with the Maintenance (M)5 at 12:55 PM on the second floor in the dining area, stated that they just filled it this morning, and they open it a lot, that's why it's warm. When asked where the temperature logs are kept since there wasn't a log found with the current date. M5 stated that the temperature is logged in the computer where we can check it. M5 pointed to a metal box located on top of the refrigerator with a metal cord coming out of the box. He added that these ice boxes are new, they are only a year old. Noted thick frost in the back of the refrigerator. The electronic temperature logs by the maintenance department weren't available for review.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Sodexo. Sanitation & Infection Control food safety policy #11.12 Date revised: 05/2023 reviewed. 7. Refrigerators must maintain Temperature Controlled for Safety (TCS) foods at 41degrees F or below . 9. All foods prepared in operation must be covered and labeled as to the contents and date of preparation prior to storage in refrigerators and freezers. |

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| F 0838<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.<br><br>47783<br><br>Based on record review and interview, the facility failed to include in the facility assessment the staffing resources required to meet the needs of their resident population. This deficient practice has the potential to affect all the facility's resident's ability to maintain or attain their highest practicable physical, functional mental and psychosocial well-being.<br><br>Findings include:<br><br>The facility assessment stated the facility is licensed for 141 beds with an average daily census of 95 residents based on the resident population profile from 06/05/23 to 06/04/24.<br><br>Review of the facility assessment found documentation that describes the facility's resident population and acuity levels, however, there was no documentation of the staffing levels required to meet the residents' needs.<br><br>On 08/09/24 at 10:04 AM, a concurrent interview and record review was conducted with the Administrator and the Director of Nursing (DON) in the education room. Asked Administrator and DON how staffing levels are determined. DON said it is based on the census and acuity. Asked if the required staffing levels were documented in the facility assessment. After reviewing the facility assessment, the Administrator and DON confirmed that staffing levels were not documented in the facility assessment. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47783<br><br>Based on observations, interviews, and record reviews, the facility failed to implement the facility's infection prevention and control measures. While providing care for Resident (R)250, the facility staff was not wearing applicable Personal Protective Equipment (PPE), did not perform hand hygiene between glove change, and did not follow guidelines to prevent possible cross-contamination of clean supplies. These deficient practices placed the resident at risk for developing preventable infections and other adverse health complications.<br><br>Findings include:<br><br>Review of R250's Electronic Health Record (EHR) revealed he was admitted to the facility on [DATE] for short-term rehabilitation and long-term intravenous (IV) antibiotics administration. R250 has a Peripherally Inserted Central Catheter (PICC) line (tube inserted into a vein in the upper arm and threaded into a large vein above the heart to provide intravenous treatments) for the administration of prescribed IV antibiotics.<br><br>On 08/08/24 at 08:11 AM, observed Registered Nurse (RN)17 administer prescribed IV antibiotic. Sign outside R250's room stated that he was on Enhanced Barrier Precaution (EBP) and the use of a gown, gloves and mask are required when providing high contact care. RN17 entered room without donning a gown and place the IV antibiotic bag, prefilled normal saline syringes (used to flush the PICC line after use), PICC line caps, and alcohol wipes on the resident's bedside table right next to his urinal. RN17 did not use a barrier to place the clean supplies on. RN17 performed hand hygiene, donned a pair of gloves, and proceeded to flush and change the cap of the PICC line arterial port. RN17 then prepared the IV antibiotic bag, connected the lines, and set up the IV pump. After removing the air from the lines, RN17 changed her gloves without performing hand hygiene, cleaned and flushed the venous port, connected the IV line, and started the IV infusion.<br><br>On 08/08/24 at 01:34 PM, an interview was conducted with the Infection Preventionist (IP) by the first-floor conference room. Asked IP if administering an IV medication to a resident with a PICC line considered high contact care. IP said it is and staff should be using a gown when performing this task. Asked IP if it was acceptable to place clean supplies used when administering IV medications next to a urinal that the resident uses. IP said the expectation is for the staff to use a barrier on a clean surface prior to setting the supplies down. When asked if staff are supposed to perform hand hygiene between glove changes, IP said, Yes.<br><br>Review of facility policy Infection Control - Enhanced Barrier Precaution stated, . gowns and gloves available immediately near or outside of the resident's room. High-contact resident care activities include: . Device care or use: central lines . |