STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125041	A. Building B. Wing	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liliha Healthcare Center	1814 Liliha 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 39754 Based on resident interviews and policy review, the facility failed to treat two Residents (R) 9 and R139, 68 of eight residents sampled, with respect and dignity. Findings include: Resident interview on 01/23/24 at 01:30 PM, R68 said that Staff would respond to the call bell and say they would be back but not return until several hours later. R68 said that this made him/her feel ignored. Resident interview on 01/24/24 at 08:45 AM, R9 revealed the following: Staff would respond to the call bell and say they would be back but it would take several hours for them to return, Staff would ignore and not pass on a request to speak to the doctor or other person, Staff would speak to each other in a language other than English and it felt as if they were talking about him/her. Review of policy on Resident Rights read Policy; The facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility . Resident rights; The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility . 36930 R139 stated during an interview on 01/23/2024 that often he would press call bell, staff would acknowledge the call bell and state to R139 they would be back soon. R139 went onto to say staff would return after a long time, one time 40 minutes. Minimum Data Set (MDS) for R139 displayed under Section GG, that R139 required substantial assistance for movement. R139 due to extensive edema of both lower and upper extremities was unable to move by themselves without staff assistance. R139 stated during interview on 01/29/2023, that they would call for assistance to move when in pain, and waiting lengthy time periods increased the pain. R139 was tearful during the interview while relying this information. R139's reliance on staff assistance, and their lack of timely assistance did not provide care for these residents in a dignified manner.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 43245 Based on record review and interview, the facility failed to ensure 2 of 6 residents sampled (Residents 33 and 55) were informed of their right to develop an advance health care directive, aided in doing so, and/or was periodically reassessed in his/her decision-making capacity to do such. As a result of this deficient practice, the residents were placed at risk of not having their wishes honored for future health care decisions, should they become incapacitated. This deficient practice has the potential to affect all the residents at the facility. Findings include: 1) On 01/24/24 at 11:23 AM, during a review of Resident (R)33's electronic health record (EHR), an advance health care directive (AHCD) was not found. A review of the social services progress notes revealed no mention of an AHCD. The documentation was requested from the facility. On 01/25/24 at 02:22 PM, an interview with the Social Services Director (SSD) was done in his office. The SSD confirmed that R33 was admitted to the facility in August of 2023, and that there was no documentation available indicating that R33 had an AHCD, or was offered assistance in creating one. 36930 2) An AHCD was not found during a review of R55's EHR on 01/24/2024. A request to the SSD was made on 01/24/2024 for the AHCD for a list of residents including R55. No AHCD was found by the SSD for R55. A request to the SSD was made on the afternoon of 01/25/2024 for any documentation to show that R55 had been offered information on the option of formulating an AHCD on admission and was further offered on other occasions during the resident's admission. No documentation was provided. The same request was made to the administrator on the morning of 01/26/2024. No documentation was received.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43245 Based on observations, record review, and interview with staff members, the facility did not ensure that the development and implementation of comprehensive person-centered care plans were done for 3 of 25 residents (Residents 33, 60 and 139) in the sample. As a result of this deficient practice, 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. This deficient practice has the potential to affect all the residents at the facility. Findings include: 1) Cross-reference to F688 Increase/Prevent Decrease in ROM/Mobility. Despite identifying positioning/mobility needs for Resident (R)33, the facility failed to develop a care plan to effectively address those needs. 36930 2) During interview with R60 on 01/23/2024, R60 expressed a desire to mobilize more with the Hemi-Walker available to R60. R60 feels confident this could be achieved if staff walked him daily. R60 had a care plan in place for altered ADL function, with an approach/intervention stating uses Hemi-walker and Wheelchair for mobility stating CNAs and nursing are the responisble disciplines to carry out this approach/intervention. Record review conducted on 01/24/2024, showed that R60 particpated in a restorative nursing program, which provided R60 assistance and guidance in using the Hemi-Walker. The care plan was missing the frequency of occurance for this intervention for R60. Interview with MDS staff, confirmed there was no frequency included in the care plan, as the care plans are generalized and not indivalized. 3) Minimum Data Set (MDS) for R139, displayed under Section GG, that R139 required substantial assistance for movement, including moving from lying to sitting, sitting to lying and moving from left to right sides and vice versa. Progress notes have documented on several occasions that R139 requires 3-4 person assist. Due to extensive edema to both lower and upper extremities, R139 is dependent on staff for all movement. Care plans are in place for R139 for altered self care and decrease in Activities of Daily Living (ADL) performance. These careplans have interventions in place to encourage resident to use enablers and to be independent. There are no interventions that state the required amount of assistance that R139 requires to move in bed, sit from lying and lie down from sitting. Interview with MDS staff member verified there are no specific interventions on the amount of assistance that is required by R139, stating their careplans are generalized an individualized.

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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** 43245 Based on observation, record review, and interview, the facility failed to ensure Resident (R)33 received the appropriate treatment, equipment, and/or services to increase or prevent further decrease in range of motion (ROM) of her neck/head. As a result of this deficient practice, R33 was hindered from reaching her highest practicable well-being. This deficient practice has the potential to affect all the residents at the facility with ROM deficits. Findings include: Resident (R)33 is a [AGE] year-old female admitted to the facility on [DATE] for long-term care. R33's diagnoses include but are not limited to left-sided hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness) following a stroke, anarthria (complete loss of speech), and gastrostomy status (a surgical opening into the stomach made for a feeding tube). A review of R33's most recent Occupational Therapy (OT) Discharge Summary on 04/19/23 notes a discharge impairment of 100% . This score indicates that she [R33] requires 27 hours of 1:1 (one to one) care to complete her basic ADLs [activities of daily living] per week. In addition, R33's Functional Skills Assessment indicated she was completely Dependent (100% assist, or 2 or more helpers) . in all categories [eating, hygiene, transfers, bathing, and dressing] with a Self Care Function Score (score 0-12; 12 being the highest function) = 0. The discharge summary also included documentation of caregiver training of . Positioning maneuvers, Proper body mechanics . PROM [passive range of motion] . with 100% return demonstration provided during session. A review of R33's Comprehensive Care Plan noted the following intervention under the Category: Med [medication] Management . Maintain body in functional alignment when at rest. Despite being completely dependent on staff for positioning, there were neither interventions addressing positioning/proper body mechanics under the category of ADLs Functional Status, nor was there a separate category/care plan addressing positioning. Multiple observations were made of R33 in bed on 01/23/24 at 09:21 AM, 09:30 AM, 11:11 AM, and 02:24 PM, on 01/24/24 at 11:14 AM, 11:59 AM, and 02:14 PM, and on 01/25/24 at 08:45 AM, with her head bent heavily and uncomfortably to the right, with her right ear less than two inches from her right shoulder. No pillows, neck rolls, or braces were observed to assist in positioning her head in functional alignment with her shoulders or body. On 01/25/24 at 08:45 AM in particular, R33 was observed with a wedge pillow under her right shoulder, propping her right shoulder up, causing her head to be positioned back and heavily bent to the right. R33 was noted to be moaning in her sleep, which was not observed on previous days. On 01/25/24 at 11:36 AM, an interview was done with Unit Manager (UM)3 at R33's bedside. UM3 agreed that R33 appeared uncomfortable with her head in misalignment with her shoulders and body, bent heavily towards her right shoulder. When asked if R33 was able to straighten her neck anymore, as all observations up until then had her with her head in the same position, UM3 stated she did not know. UM3 also reported that she was unaware of any neck braces, or orthotic devices ordered to assist in positioning R33's head.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on observation, interview, and record review, the facility failed to ensure 1 of 4 residents in the sample (Resident 52) was free from accidents hazards. Resident (R)52 was observed ambulating with slippers oversized for her feet, placing her at increased risk for an avoidable fall. Despite previously being identified as a high risk for falls, the facility failed to recognize R52's oversized footwear as a potential hazard until pointed out by the State Agency (SA). This deficient practice has the potential to affect all ambulating residents at the facility. Findings include: Resident (R)52 is a [AGE] year-old female admitted to the facility on [DATE] for long-term care. Her current diagnoses include but are not limited to dementia, difficulty in walking, history of syncope (fainting) and collapse, and restlessness and agitation. On 01/23/24 at 10:53 AM, observed R52 sitting in the second-floor dining room at activities. Noted a bright yellow Falls Risk identification bracelet around her right ankle, an oversized pair of slippers on her feet, no socks, and a front-wheeled walker next to her. A review of R52's electronic health record (EHR) noted no documentation that a risks versus benefits discussion had taken place regarding R52's use of oversized slippers for ambulation. On 01/23/24 at 01:51 PM, an interview was done with Unit Manager (UM)3 in the second-floor dining room. During a concurrent observation of R52 ambulating back to her room with stand-by assistance, UM3 confirmed that the slippers were too large for her feet, and combined with her high falls risk status, were safety hazards. UM3 reported that the oversized slippers were provided by R52's family and were the only footwear R52 had. UM3 noted that R52 loved her slippers, refused to wear non-slip socks, and always put her slippers on when she wanted to walk anywhere. On 01/24/24 at 08:35 AM, an interview was done with UM3 in her office. UM3 confirmed that the oversized slippers were not previously identified as a safety hazard contributing to an increased risk of falls, and so had not been care planned for. Concurrent review of R52's Comprehensive Care Plan (CP) noted an intervention for proper well-maintained footwear under the category of Falls, but it did not define what proper footwear would be. UM3 agreed that proper footwear is too vague, and that for R52, proper footwear should include proper fit, which no one had assessed before.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on observation, interview, and record review (RR), the facility failed to ensure nurse competency in pain assessment for 1 of 1 resident (Resident 64) sampled for pain management. As a result of this deficient practice, Resident (R)64 remained on a narcotic with a high risk of addiction and dependence for pain that could potentially have been managed with non-narcotic medication. This deficient practice placed R64 at risk for avoidable addiction and dependence in addition to other adverse effects of taking Fentanyl, and has the potential to affect all the residents at the facility receiving narcotic pain medication. Findings include: Resident (R)64 is a [AGE] year-old female admitted to the facility on [DATE]. Her current diagnoses include but are not limited to Alzheimer's disease, muscle weakness, an almost healed sacral pressure ulcer (pressure sore on the lower back), and severe protein-calorie malnutrition. A review of her electronic health record (EHR) noted that R64's primary language is Cantonese, and that she was discharged off of Hospice care in November 2023. On 01/24/24 at 08:20 AM while doing morning rounds, asked R64 how she was doing. R64 did not respond. Asked R64 are you OK? R64 answered no. Due to the language barrier, asked R64 how come no? To which it sounded as if R64 responded, sore feet. Repeated sore feet back to her, and R64 answered yes, and pointed towards her right foot. Asked to see her feet, to which she nodded yes, but while trying to unwrap her feet which were tightly tucked into her blanket, R64 repeated sore, sore. Refrained from attempting to unwrap feet any further so as not to cause additional pain. Grabbed the Cantonese picture cards at the bedside and pointed to the pictures/writing for pain and medicine. R64 nodded yes. Informed Registered Nurse (RN)9 that R64 was complaining of pain. RN9 responded quickly, stating she would give R64 some acetaminophen. At 11:50 AM, checked back with R64, who reported that her pain was a little bit better. A review of R64's medication administration record (MAR) noted that RN9 had given R64 her routine acetaminophen 650 milligrams (mg), due at 09:00 AM, earlier that morning when she had complained of pain, and had not given any as needed analgesics. Further review of R64's MAR revealed routine orders for acetaminophen 650mg three times a day for pain, and fentanyl patch 25 micrograms (mcg)/hour, one patch applied every three days for pain management, with the last patch documented as applied on 01/21/24 at 08:00 PM. Also noted were the following as needed orders for pain: acetaminophen 650mg every four hours, and tramadol 50mg three times a day for severe pain if routine . [acetaminophen] is ineffective. Neither as needed medication had been documented as given at any time during the month of January. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/24/24 at 12:00 PM, an interview was done with RN9 in the hallway outside of R64's room. When asked where R64 usually had pain, RN9 reported that she was uncertain, stating that it could be R64's feet or that there might be contractures (a tightening of muscle, tendons, ligaments, or skin which prevents normal movement of the associated body part) in her lower legs that were causing pain. RN9 did a concurrent review of R64's EHR to confirm where her pain usually was. After a brief review, RN9 reported that she was unsure what was the location, source, or character of R64's pain. When asked if she had assessed R64's feet or legs earlier that morning when she had complained of pain, RN9 stated that she did not assess the source of pain this morning, but stated that she had before. After further review of R64's EHR, RN9 could find no documentation in the progress notes, physician orders, or MAR to indicate the location or characteristics of R64's pain, or why she continued to have a routine fentanyl order, a medication known to be a powerful narcotic. At 12:08 PM, as Unit Manager (UM)3 walked by, RN9 stopped her to ask if she knew why R64 had the routine fentanyl order. UM3 stated her belief that it was a carryover order from when R64 was on Hospice for pain associated with her pressure ulcer, however RN9 reported that the pressure ulcer was almost healed with no openings remaining to the surface of the skin. On 01/25/24 at 11:15 AM, an interview was done with UM3 in her office. UM3 reported that following her own review of R64's EHR, she could find no clear documentation of the location and character of R64's pain. UM3 agreed that a more thorough pain assessment should be done to identify where R64 was feeling pain, what her level of pain was, and if the routine pain medications could be reduced. On 01/26/24 at 09:56 AM, an interview was done with the Director of Nursing (DON) in the conference room. The DON confirmed that his expectation is for nurses to conduct a thorough pain assessment when administering any pain medication, whether routine or as needed.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on interview and record review, the facility failed to provide or obtain from their dental consultant, routine dental services to meet the resident's needs. This deficient practice has the potential to affect all residents currently residing in the facility. Findings include: Resident (R)27 is an [AGE] year-old female admitted to the facility on [DATE]. During an interview with her family representative (FR)5 on 01/23/24 at 01:34 PM at her bedside, FR5 reported that R27 had not received any routine dental visits since her admission. On 01/25/24 at 10:20 AM, a review of R27's electronic health record (EHR) found no documentation of any dental visits or exams since admission. On 01/25/24 at 11:15 AM, an interview was done with Unit Manager (UM)3 in her office. When asked, UM3 reported that the facility dentist had not been in for routine or emergency dental services since COVID began in 2020. UM3 confirmed that for dental emergencies, residents were sent out to his office, but that routine dental services had not been done since he (the facility dentist) stopped coming in. A review of the facility's Dental Services policy, last revised 06/2023 revealed the following: It is the policy of this facility to assist residents in obtaining routine . and emergency dental care . and; Routine dental services means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor partial or full denture adjustments, smoothing of broken teeth, and limited prosthodontic procedures .

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36930 Based on observations the facility failed to provide a comfortable environment for residents, staff and the public by not maintaining the environment in good repair. Findings include: Observations on 01/23/2024 - 01/26/2024, showed wallpaper on upper half of walls in the hallway of 1st floor, is lifting off in several areas and curling over. Outside of room [ROOM NUMBER] there is patch of wallpaper missing, approximately 12 x 18. It appears this patch has been torn off. On the opposite wall a picture has been removed with the area underneath significantly lighter in color than the rest of the wallpaper, providing an appearance of unkept cleaning of walls. The disrepair of the state of the wallpaper, is unkept and not conducive to a homelike environment. Watermarks are apparent on several areas of the wallpapered area of the hallway on the 1st floor unit.