STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125046	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pu'Uwai 'o Makaha	84-390 Jade Street Waianae, HI 96792

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853 Based on observation, interview, and document review, the facility failed to provide a comfortable temperature of hot water to residents that received showers in two shower rooms in Unit Two. In addition, there was no hot water available in the bathroom sink between room [ROOM NUMBER] and 29. Findings include: On 07/22/24, at approximately 08:30 AM, during the initial tour of Unit Two, identified the hot water in the bathroom sink between Room (Rm) 27 and 29 did not get warm. On 07/25/24 at approximatley 01:30 PM, during an interview with the Maintenance Director, he said the facility had been having problems with the hot water on Unit Two, and had recent work completed to provide warm/hot water, but the issue continued. At that time, accompanied the Maintenance Director to the Unit Two. He ran the water in the sink of Rm 27/29 and confirmed there was no hot water. The two shower rooms were then checked by the Director, which were also confirmed not to have warm water of a comfortable temperature for showers. Reviewed the invoices dated 02/14/2024, 02/29/2024, 03/21/2024, 03/27/2024 and 06/12/2024, 06/12/2024, provided by the Maintenance Director, which confirmed previous issues with the hot water on this unit.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 38870 Based on record review (RR) and interview, the facility failed to: 1. Include an accurate assessment of resident's psychological state in the quarterly Minimum Data Set (MDS) for one Resident (R32) and; 2. Failed to identify that a bed alarm was in place. The deficient practice failed to accurately assess the resident's psychosocial wellbeing. The residents in the facility with psychological needs are affected. Findings include: Cross reference to F741 Behavioral health services. Electronic Medical Record (EMR) reviewed 06/17/24. Mood and behavior were not coded on the Annual Minimum Data Set (MDS) with Assessment Reference Date (ARD) 06/17/24 with any indicators of psychosis and the bed alarm was not coded as being used. The bed alarm is documented throughout the nursing notes as being in place for R32. Interview on 07/25/24 at 2:51 PM with the Director of Nursing (DON) and Social Services Director (SSD). The surveyor asked why the mood and behavior assessments didn't include an accurate description of the resident's documented behaviors. The SSD replied that the behaviors may not have been present at the time of the assessment. The surveyor discussed that R32's agitated behaviors are documented in the record prior to the annual review date, per the nursing care plan 12/14/23.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853 Based on observation, interview, and record review (RR) the facility failed to revise one Resident's (R35) care plan (CP) timely to reflect the status/treatment of her fractured leg after a fall. As a result of this deficiency, staff may not have been aware of the treatment plan required monitoring and interventions needed. This deficient practice could affect any resident. Findings include: R35 is a [AGE] year-old who had lived at the facility since 03/02/21. She had cognitive communication deficit, major depressive disorder, severe psychotic symptoms, and dementia with behavioral disturbance. R35 has muscle weakness, difficulty walking and uses a wheelchair for mobility. She is moderately impaired with a Brief interview for Mental Status (BIMS) score of 8. On 05/24/24 R34 fell and injured her left lower leg. She was transferred to the emergency room for care, where she was diagnosed with fracture of the tibia/fibula. She returned to the facility on [DATE] with an orthopedic boot splint on her leg. On 07/24/24, at approximately 02:00 PM, observed R35 in the dining room in a wheelchair with her left leg elevated. She had a pink cast on her left lower leg (LLE). RR revealed on 06/17/24, the nursing progress note documented .Res (R35) left for appt. (ortho (Orthopedic)) this morning res turned [sic] at around 1303 (1:05 PM). Res with noted cast to LLE. On referral form: keep cast dry, non-weight bearing to Legy [sic] f/u (follow up) in 4 weeks for cast removal (July 15, 2024) at 10 am. Reviewed R35's active CP, which included: Problem: Resident has a left ankle fracture and has a splint cast applied. Resident is non-compliant and keeps on removing the splint. Start date 5/31/24. Goal: Resident will maintain and keep the splint on until further instruction and treatment. Approach: Notify ortho and PCP (primary care physician) of resident's refusal to keep splint in place-ortho moved up appointment with note to keep splint on. Encourage resident to keep splint on. Provide distractions. Educate on reason for splint. Start date 06/08/24. Approach: Emphasize the importance of keeping the splint on at all times. Offer pain medications as needed. Check for circulation, motion, sensation (CMS) every (Q) shift. RR of nursing progress note revealed on 05/25/24, when R35 returned from the Emergency Department after the fall, she had a newly diagnosed fracture with a splint/wrap for treatment. The CP was not revised timely to reflect this change and the interventions needed until 05/31/24. On 06/17/24, the splint was replaced with a cast at the orthopedics office. The CP was not revised at the time of survey to reflect that change. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/25/24 at 2:45 PM, during an interview and concurrent RR with the Resident Care Manager (RCM)1, The RCM1 confirmed the CP had not been revised to reflect the current status of her fracture.

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853 Based on observation, interviews, and record review (RR), the facility failed to make arrangements for one Resident (R35) to be transported to an appointment with a consultant. As a result of this deficiency, there was a delay taking her cast off. This deficient practice could affect any resident with outside appointments and may prevent them from meeting their highest potential of psychosocial and medical well-being. Findings included: R35 is a [AGE] year-old who had lived at the facility since 03/02/21. Diagnoses included cognitive communication deficit, major depressive disorder, severe psychotic symptoms, and dementia with behavioral disturbance. R35 has muscle weakness, difficulty walking and uses a wheelchair for mobility. She is moderately impaired with a Brief interview for Mental Status (BIMS) score of 8. On 05/24/24 R34 fell and injured her left lower leg (LLE). She was transferred to the emergency room for care, where she was diagnosed with fracture of the tibia/fibula. She returned to the facility on [DATE] with an orthopedic boot splint on her leg, with directions to follow up with the orthopedic (ortho). RR revealed the following progress note dated 06/17/24 entered at 5:07 PM: .Res (R35) left for appt. ortho this morning .Res with noted cast to LLE. On referral form: keep cast dry, non-weight bearing to Legy [sic] f/u (follow up) in 4 weeks for cast removal (July 15, 2024) at 10 am. On 07/24/24, at approximately 2:00 PM, observed R35 in the dining room in a wheelchair with her left leg elevated. She had a pink cast on her left lower leg (LLE). On 07/25/24 at 2:45 PM had an interview with the Resident Care Manager (RCM)1, in the nurse's station of Unit two. At that time reviewed the progress note that documented R35 was to have her cast removed on July 15, 2024. The RCM said the process to make appointments/arrangements for transport to outside appointments is when a resident returns from a visit, the RN reviews the consult notes and if there is another appointment made by the office, they notify the Unit Coordinator (UC) by phone, and she makes the arrangement. The RCM called the UC and asked about R35's appointment to remove the cast. After he got off the phone, he said another appointment had been made, but could not explain why R35 did not go on July 15th. On 07/25/24 at 3:00 PM interviewed the UC in her office. She said she arranges for transportation of Residents for upcoming apts. She went on to say the nursing staff will either give her the apt card that is returned with the Resident with a new apt detail on it, or they will call and notify her of the new apt date and time documented in the consult note. When inquired about R35's apt for the cast removal, she said it is arranged for August 5th, at 09:45 AM. The UC said she was not informed of the original appointment for July 15th. This caused a missed appointment and delay in removal of R35's cast.

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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** 39853 Based on observation, interviews, and record review RR), the facility failed to provide supervision of one Resident (R) 3 to ensure the safety of female residents. Specifically, the facility investigated an allegation that R3 inappropriately touched a female resident (R6). As a result of that investigation R3 was to be supervised when in the presence of vulnerable females to ensure their safety. R3 was observed to be alone in the dining area with a female resident (R39) on 07/24/24, which put her safety at risk. If R3 is not supervised, it puts all female residents at risk of a similar occurrence, which could result in psychological or physical harm. Findings include: The Office of Healthcare Assurance (OHCA) received a facility incident report, (FRI) intake 11041 regarding an alleged resident to resident abuse. The report documented on 06/29/24 a Certified Nurse Assistant (CNA) observed R3 seeming to touch resident's (R6) private area over her clothing. Nursing attempted to find out more about the situation from R6, but R6 has very limited short-term memory and was not able to provide further details . Final report included: Based on interview with certified nursing assistant (CNA), she was entering the Station 2 dining area, . when she saw R3 touching/grabbing the private area of R6 over her clothing. No other residents or staff were present in the dining area. CNA asked R3 what he was doing and told him to stop, and he laughed and backed his wheelchair away saying he was doing nothing.R6 said R3 had grabbed her boobs and his touching had not been consensual. Based on interview with CN (Charge Nurse), .CN stated CNA had told her she had seen R3 touching Resident 6 in the lower private area. Based on interview with Social Services Director (SSD) . SSD spoke with resident 6, who stated that resident 3 had touched her and she did not like it. Per SSD, resident 6 stated resident 3 had touched her pubic area under her brief when asked. Resident 6 denied being afraid of resident 3. Resident 6 wanted police involved . Based on interview with SSD, she also spoke with resident 3 and asked him to explain what had occurred with resident 3 the day prior. Resident 3 said he had his hand on resident 6's thigh but denied touching her up there . Facility documented interventions implemented included Close monitoring of alleged perpetrator (P3) whereabouts when not in his room. Reviewed the facility Incident investigation and summary signed by the Administrator on 07/11/24. The additional information read Resident (R6) seen being touched inappropriately on private area over clothes by another resident (R3) in dining area. Resident had not called for help, .when asked if it was consensual stated she did not want to be touched. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	P3 is a [AGE] year-old male who had lived at the facility since 2017. His diagnoses included Type 2 Diabetes with left below the knee amputation. He has a history of impulsivity and provoking other residents. P3 uses a wheelchair (w/c) for mobility and is able to move himself around easily. He is cognitively intact with a Brief Interview for Mental Status (BIMS) of 15. Review of R3's care plan (CP) included: Problem start date 06/30/24, Category: Behavioral symptoms. R3 had physical behavior, alleged sexual, toward another female resident (R6). Short Term Goal: R3 will not touch or intimidate another resident. He will not be in the same area as the alleged victim or any vulnerable females unless he is supervised. Approach: Explain the details of this care plan to R3 who agreed and stated he understood. Approach: Keep R3 separated from other vulnerable females when out in the common area unless supervision is available. If vulnerable females come out into the common area, ask R3 to go to another area or his room .unless he is supervised. Problem start date 10/31/23, Category: Behavioral symptoms. R3 may use inappropriate language and expletives during dressing changes and medication passes. He also may make rude gestures and can be difficult to redirect. Approach start date 06/29/24: Monitor resident's whereabouts when not in his room. Provide supervision in the dining area when resident is present with other residents. Enforce rules about inappropriate/unacceptable behavior. Problem start date 10/30/24. Category: Behavioral symptoms. R3 has history of (hx)aggressive behavior: 10/30/23: Slapping staff hard and spewing profanities. 10/31/23. Pushing a nurse and swearing while she was giving wound care.11/05/23: Threatened to punch a CNA .01/29/24: Grabbed another residents hand to stop him from turning the dining room lights on and off. Long Term Goal: R3 will not harm staff or others. Reviewed R3's Psychiatry consult dated 07/05/24. The consult noted included: Chief Complaint/Reason for visit: Intrusive, argumentative in depression/cognitive decline. Orientation: aox3 . Psychiatric Diagnosis evaluated: Cognitive decline (likely MCI [mild cognitive impairment] at least) with impulsivity/verbally or physically intrusive, hx of situation-related depression but declined treatment. Plan/Recommendations: - Continue supervision in common area to deter pt from another inappropriate physical touch, he seems to have sufficient insight regarding appropriateness/legal implications and had complied thus far with expected boundary setting. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/22/24 at approximately 11:00 AM, observed R3 in dining area with several other residents. Staff was present playing cards. On 07/23/24 at 1:20 PM, observed R3's room door open with the curtains pulled all the way around the bed with no viability of the bed or R3. Surveyor knocked on the door and called his name, but no response. It was assumed at that time R3 was asleep in the room. A few minutes later observed R3 in his w/c, outside in the lanai area alone. Asked how long he had been outside, and he said awhile. Observed a door at the end of the building and asked R3 to confirm his room was at the end of the hall, close to that door, and he confirmed it was. R3 said he uses that door to go to the lanai. This area has very limited visibility from staff, unless walking outside from building to building. On 07/24/24 at approximately 3:50 PM, the surveyor walked into the dining room and observed R3 unsupervised sitting in his w/c at in front of the television, watching Family Feud. Noted one other Resident (R)39 in back of dining area sitting at a table. Surveyor sat at the back of the room for approximately 10 minutes and confirmed no staff came to monitor R3. Surveyor proceeded to Unit 2 Nursing Station to inform staff the whereabouts of R3 and that he was unsupervised. Notified the Administrator, who was on the unit. On 07/24/24 at approximately 4:05 PM, interviewed the Charge Nurse (RN6) in the nurse's station. Asked how they assign someone to supervise R3. She said they take turns, and sometimes the dietary and activity staff also assist with monitoring. RN6 said she was unaware that R3 was in the dining area unsupervised and said, I don't know how that happened. At that time, together reviewed R3's CP, and she confirmed R3 was to be supervised when in the dining area. Asked RN6 if she would consider R39 to be vulnerable. She hesitated and said. She would yell if someone approached her, and she didn't want them to. On 07/24/24 at approximately 4:30 PM, interviewed the Administrator in her office. Asked her if she could explain what had happened, and what surveyor had observed, and the Administrator. replied He's (R3) supposed to be supervised and he was not.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38870 Based on observation, interview, and record review (RR) the facility failed to: 1. Ensure it provided an environment to promote the mental and psychosocial wellbeing for one resident in the sample Resident (R) 32 was agitated and distressed evidenced by loud yelling and acting out while isolated in his room. 2. The nursing staff did not monitor R32's behaviors or; 3. Report changes to the physician for four days and; 4. Implement non-pharmacological interventions in his plan of care. The deficient practice resulted in the resident having poor psychological and emotional health and self-inflicted injuries that occurred as a result of his behavioral outbursts. Residents in the facility with psychological and emotional health needs are at risk. Findings include: R32 is a [AGE] year-old male resident admitted to the facility on [DATE]. His Diagnoses included cerebral infarction (stroke) with left sided weakness; vascular dementia with behavioral disturbances; aphasia (unable to speak) and severe anxiety. His cognitive status is severely impaired (per RR of his Annual Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 06/17/24. Per his RR, R32 was diagnosed with COVID-19 and placed in isolation on droplet precautions on 07/17/2024. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/23/24 at 1:15 PM during an observation and interview on the unit, loud yelling and banging was heard outside R32's room. A large red sign on the door stated, red room, indicating the resident is on droplet precautions for positive COVID 19. The yelling inside the room continued for 30 minutes between 1:15 PM to 1:45 PM. At 1:45 PM the surveyor went into the room with Registered Nurse (RN)12. R32's bed was placed in the middle of the room away from the walls. The bed was in lowest position from the floor with two fall mats on the right side of the bed and one fall mat on the left side of his bed. He had a fall alarm clipped to his gown and faced to the left with one hand holding onto the left candy cane side rail. The other hand was holding onto the headboard and shaking it back and forth. He appeared in distress; his hair was messy, and the sheets and blanket tangled around him. His gown was wet. R32 was nonverbal, and his upper body was very stiff. RN12 spoke to him and firmly pulled his hands from the left bed rail and headboard to reposition him. Surveyor observed DVDs and a television in his room, although the television was not turned on. Two call lights were hanging on the wall and out of R32's reach. RN12 stated that R32 is very agitated today and explained that the Trazodone (medication used to treat depression) was put on hold about five days ago which has caused R32 to become more agitated. RN12 stated that since he started working at the facility six weeks ago, R32 has always been nonverbal and occasionally agitated. The surveyor asked why his bed was in the middle of the room. R12 said he used to be next to the window, but it was moved because the team felt that he might kick the window out. The surveyor asked if R32 is a danger to his self and how can he call for help. RN12 stated that R32 can't use the call light, so we check on him frequently and he has a fall alarm in place. On 07/23/24 at 1:55 PM in the unit one nurse's station, the surveyor asked the Director of Nursing (DON) why R32 was so agitated. The DON said the trazodone was stopped due to an interaction with the Covid medicine (Paxlovid). The surveyor asked if R32 was given an alternative medication to help with the agitation. The DON stated that she just got off of the phone with the doctor and received an order to give half of the regular dose of his trazodone and the complete dose tomorrow. EMR review dated 07/19/24 revealed that R32's Trazodone and the Belsomra, (medication to treat a sleep disorder) were placed on hold from 07/19/24 to 07/23/24. Review of the Care Plan (CP) was developed for Falls 06/26/20. Resident at risk for falling related to . restlessness & trying to get out of bed .09/07/23 found on floor mat by bed. 06/18/24 unwitnessed fall at bedside, bump to left side of head .Resident has right eye bruise 01/10/24; Resident has right calf bruise 01/18/24; Resident has self-inflicted laceration to forehead 05/22/24. Review of the resident's incident reports verified the injuries. 06/18/2024 unwitnessed fall at bedside with bump to left side of head. Nursing approaches include the purposeful rounding .Keep call light in reach . Occupy resident with meaningful distractions: music, movies, open window to look outside. CP for behaviors 12/14/23, banging and pulling headboard, throwing linens, pillows on floor .Seen by psychiatrist, as needed medication added .01/04/24. Medication changes . Medication changes made by psychiatrist on 06/26/24. Nursing approaches include the following: Contacted psychiatrist on 06/27/24 . Administer PRN medication .Behavior Monitoring N/A - Not applicable. Non-Pharmacological interventions to address yelling, banging headboard and self-injurious behavior not documented. Orders reviewed. Medication: Abilify (anti-psychotic for agitation. [NAME] frequency how often behavior occurred & intensity how resident responded to redirection, every shift. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Behavior flowsheet reviewed 01/01/24 to 07/25/24, no documentation of behavioral observations by the staff was found. Progress notes reviewed 06/27/24 Social Services .bed placement is being reconfigured 06/26/24, kicking at the windowpane and previously pulling at the window blind cords. He is also becoming more restless and helicoptering in his bed . 06/29/24. Resident can be heard shaking bed rails throughout the night. Difficult to redirect. Bed locked in lowest position, clip alarm on. 7/17/24. 16:08 alert to self. very restless, yelling, swearing, trying to damage mattress, ripping at it and bed, grabbing, and shaking parts violently, unable to redirect resident all shift .remains on isolation for Covid+ . 07/20/24. 14:52 alert to self. remains restless, yelling and shaking his bed violently on and off this shift. unable to redirect. remains on isolation for Covid+ . 22:36 .At times, patient observed yelling loudly and shaking bed. Receiving . 07/21/24. 7:20 AM, heard resident making loud/yelling noises throughout the entire night and shaking bed rails . Difficult to redirect. 07/23/24. 14:06 Spoke with psychiatrist regarding residents increased agitation today .Provider ordered for today Trazodone 12.5mg, to be given this evening . Resident to resume regular Trazodone orders. Activity Director (AD) interviewed on 07/25/24 at 1:54 PM. The surveyor asked how the activity staff are providing the activities to R32. The AD replied, no one is seeing him while he is in isolation although the nursing staff should turn the TV on for him when they go into his room. Interview and concurrent record review with the Director of Nursing (DON) and Social Services Director (SSD) on 07/25/24 at 2:51 PM. The surveyor asked how the nursing staff is monitoring his behavior? The DON said the behavior is being documented in the progress notes. His agitation comes and goes. The surveyor asked if the nursing staff contacted the physician to report R32's agitated behaviors of yelling and shaking the bed? The DON said she thought the physician was aware. Upon review of the record the DON was unable to find documentation to verify the physician was called. The surveyor asked what type of non-pharm interventions are being done for R32? The DON stated they place him out of bed on the floor mat. R32 likes it on the floor.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pu'Uwai 'o Makaha	84-390 Jade Street Waianae, HI 96792

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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. 37954 Based on record review and interview the facility failed to assist Resident (R) 13 in scheduling a dental appointment that he missed on 11/28/23 (per Dental clinic) and 12/05/23 (per resident's Care Plan) for a cleaning. The deficient practice could affect all residents in the facility who require assistance in scheduling dental appointments. Findings Include: On 07/23/24 at 10:48 AM during Record Review (RR) of R13's Electronic Health Record (EHR) found resident has a Care Plan (CP) in place for at risk for mouth or facial pain related to decaying (cavity) and/ or broken natural teeth 10/19/23 oral thrush. Dental appointment made for 12/05/23 for cleaning. During this record review of R13's progress notes found a nurse had documented on 12/5/23 R13 left the facility to go to an appointment but the facility nurse did not state what the appointment was for. Another progress note dated later in the day on 12/5/23 was written by another facility nurse who documented R13 returned to the facility at 4 PM but did not state where he returned from. On 07/25/24 at 12:20 PM interview and concurrent RR with Resident Care Manager (RCM) 1. At this time reviewed progress notes dated 12/05/23 with RCM1. Inquired of RCM1 if he could tell me if R13 went to the dentist on 12/05/23. RCM1 was unable to determine if the appointment resident returned on 12/05/23 was from the dentist. RCM1 also reviewed consult forms for 12/5/23 for R13 and did not find any dental consult for that day in R13's record. On 07/25/24 at 12:27 PM requested documentation from the Administrator regarding dental appointment for R13 that was scheduled for 12/05/23. Administrator interviewed on 07/25/24 at 02:08 PM regarding R13's dental consultation form, she stated she was not able to get any documentation from the dentist office because it was closed. Administrator stated she would call the dentist office the next day (07/26/24) and request the latest consultation form for R13 and provide surveyor with a copy. On 07/26/24 at 11:56 AM Administrator emailed surveyor a copy of R13's last dental consult report dated for 08/15/23. Administrator emailed last dental appointment for R13 was in August 2023. Administrator explained in her email that when she spoke with the dentist office, she was told R13 was not seen in November 2023 or December 2023. Through email inquired of the Administrator and Director of Nursing (DON) what appointment R13 attended on 12/5/23 and DON shared R13 went to see his vascular surgeon. On 07/29/24 at 10:38 AM surveyor called and spoke to dental clinic staff, where R13 went for his 08/15/23 dental appointment. Dental clinic staff explained R13 had missed his scheduled 11/28/23 appointment and facility staff had called the office to let them know R13 was not feeling well. Inquired if facility staff had rescheduled R13's dental appointment at that time and dental clinic staff stated the dentist appointment had been rescheduled today (07/29/24) and R13 would be seen on 07/31/24.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37954 Based on observations, temperature log review and interview, the facility failed to: 1. Store clean dishes, pots, and pans on a rack free of rust colored debris: 2. Failed to document temperatures of all refrigerators and freezer on their logs for one day (07/14/24) and: 3. Failed to take off and dispose of dirty gloves before going from one kitchen to another. The deficient practice could affect all residents and visitors who eat meals provided by the kitchen. Findings Include: On 07/22/24 at 8:30 AM during initial tour observed clean dishes and clean pots and pans stored on a dirty rack which had rust colored debris. Inquired with Kitchen Manager who acknowledged rust colored debris on the rack. During this initial tour of the kitchen requested to review the temperature logs for the refrigerators and freezers and Kitchen Manager brought out five paper sheets of logs. Inquired which log belonged to each refrigerator or freezer and Kitchen Manager was unable to say. [NAME] was able to state which log belonged to each refrigerator and freezer, but surveyor noted two logs have the same heading which do not differentiate them from one another. Kitchen Manager stated the cook comes in the morning about 30 minutes before everyone else and at that time logs the temperatures which are kept in a binder. During revisit to the kitchen on 07/22/24 at 12:00 PM observed Kitchen Manager wash her hands, put on clean gloves, walk outside of the main kitchen building to go to the second kitchen area, open the outside door while wearing the gloves and proceed to take off saran wrap from cold beverage cups and take the temperatures. Kitchen Manager passed a lunch tray to Resident (R) 3 which included juice that she put on his tray. Kitchen Manager than got a paper plate, opened the refrigerator, took out two half papayas to put on the paper plate to give to the resident. Afterwards Kitchen Manager left the kitchen area, walked outside, and took off her gloves. At this time surveyor discussed observations with Kitchen Manager, pointing out she had worn dirty gloves into the second kitchen area, did not dispose of the dirty gloves, did not perform hand hygiene, and did not put on new clean gloves before she assisted R3 with his lunch tray and she stated, I'm sorry and acknowledged deficient practice. Observation in the kitchen on 07/24/24 at 1:30 PM the surveyor pointed out the dirty rack, where clean dishes, pots and pans are stored to Dietician 1, who stated they are in the process of replacing the rack. Interviewed the Kitchen Manager on 07/25/24 at 9:47 AM and inquired about the refrigerator and freezer logs that had a blank row for 07/24/24. Kitchen Manager stated, that's my mess. Inquired if a cook was working that day and she stated the cook was off and she was covering. Kitchen Manager acknowledged she had forgotten to log the temperatures on the log that day.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37954 Based on Record Review (RR) and interview the facility failed to completely and accurately document on four residents reviewed out of the 16 sampled residents, Resident (R) 13, R32, R53 and R60. The deficient practice could affect all residents if their medical record is not complete and accurate. Findings Include: 1) On [DATE] during RR found R13 has a Care Plan (CP) in place for at risk for mouth or facial pain related to decaying (cavity) and/ or broken natural teeth [DATE] oral thrush. Dental appointment made for [DATE] for cleaning. Reviewed progress notes to see if R13 went to his dental appointment on [DATE]. Review of the progress notes written by facility nurses did not include where R13 went when he left the faciity on [DATE] and did not include where he returned from on [DATE] when facility nurses documented in R13's record progress note that R13 returned to the facility at 4 PM. On [DATE] at 12:20 PM interview and concurrent RR with Resident Care Manager (RCM) 1. At this time reviewed progress notes that were written by facility nurses on [DATE]. RCM1 was unable to determine what appointment R13 returned from on [DATE]. Inquired if R13 returned from the dentist that day and RCM1 was unable to verify this as there was no dental consult from [DATE] in R13's record. RCM1 confirmed he was not able to state what appointment R13 had gone to on [DATE] and where he returned from on [DATE] based on progress notes written by facility nurses and consultations in R13's record. 2) On [DATE] during RR of R53's record found resident's hospice certification expired on [DATE]. During this RR did not find an updated hospice certification form, no Hospice Care Plan, and no progress notes in R53's record were found. On [DATE] at 10:49 AM inquired of Director of Nursing (DON) where the progress notes from the hospice nurses would be kept for R53. DON stated she will look and find out and let me know. Also inquired where the hospice re-certification for R53's is kept and DON stated she would look for that too and provide a current copy. On [DATE] at 02:47 PM DON provided a copy of Hospice Progress Notes written on one piece of paper. Reviewed Progress Notes from Hospice which included the first admission note dated [DATE]. Next note was dated ,d+[DATE] (no year included with date), [DATE] [sic], [DATE] [sic], and ,d+[DATE] (no year included with date). There were no February notes written after the hospice admission note on [DATE] and no Hospice progress notes from March, April, May, and [DATE]. On [DATE] at 04:11 PM reviewed R53's Hospice binder and did not find any other progress notes from Hospice. At this time interviewed Resident Care Manager (RCM) 1 who confirmed the Hospice progress notes would be kept in this binder for R53. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 04:30 PM DON was able to provide copies of Hospice re-certification, progress notes and care plan for R53 which was provided to the DON from the hospice company that day ([DATE]). Review of the documents found R53's Hospice was renewed from [DATE] -[DATE] and 12 Hospice progress notes and Hospice care plan were sent to the facility which had not been previously in R53's Hospice binder or Electronic Health Record (EHR) prior to this survey and surveyor's request. On [DATE] at 09:55 AM interviewed DON regarding documents supplied from Hospice on [DATE]. Don confirmed this is the first time the facility received the progress notes and re-certification for R53 besides the one page of progress notes that was in R53's Hospice binder. DON stated she spoke with the nurse manager at the Hospice facility regarding documentation from the Hospice nurses and DON stated the Hospice nurse manager stated she will be talking to her nurses, and they will either give a copy right then and there after the visit (with R53) or email or fax the note to the facility. 39853 4) R60 was a [AGE] year old female with a medical history that included acute respiratory failure due to acute on chronic heart failure. RR revealed the following: Physician written order start date [DATE]: Code Status: Do Not Attempt Resuscitation/No artificial nutrition by tube. Provider Orders for Life-Sustaining Treatment (POLST) Document dated [DATE]: Do Not Attempt Resuscitation/DNAR (allow natural death) signed by R60. Social Service (SS) Progress note dated [DATE] at 10:44 AM.She does not wish to fill out an advance directive nor did she want educational pamphlet explaining it. Full code status . The SS progress note was inaccurate. 38870 3) R32 is a [AGE] year-old male resident with a diagnosis that included Dementia with other behavioral disturbances. R32's cognitive status is severely impaired (per RR of his Annual Minimum Data Set (MDS) with Assessment Reference Date (ARD) of [DATE]. During an observation on the unit on [DATE] at 1:15 PM observed R32 had a fall alarm clipped to his gown. RR of CP for Falls [DATE]. Resident at risk for falling related to .restlessness & trying to get out of bed XXX[DATE] found on floor mat by bed. [DATE] unwitnessed fall at bedside, bump to left side of head . Resident has right eye bruise [DATE]; Resident has right calf bruise [DATE]; Resident has self-inflicted laceration to forehead [DATE]. RR of the care conference summary [DATE], protective devices assessed. Restraints: Alarm due to behavior of sliding off mattress to alert staff he is moving . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician order report reviewed: No orders found for a bed alarm. Interview and concurrent RR with the DON and Social Services Director (SSD) on [DATE] at 2:51 PM. The surveyor asked if there is a Physician order for the bed alarm. The DON looked in the record and did not find an order for a bed alarm.