STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Kona	78-6957 Kamehameha III Road Kailua Kona, HI 96740

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42160 Based on observations and interviews, the facility failed to ensure residents dignity for four residents (Resident (R)14, R156, R35, and R5) sampled. Residents were observed and/or reported having to wait 25 minutes or more for staff to address the resident's call lights and/or provide care as needed by the resident. As a result of this deficient practice, resident is at risk for more than minimal harm. Findings include: 1) On 09/22/24 at 10:58 AM, observed R14's call light on as this surveyor walked onto the unit. R14's room is the first resident room on the left after entering through the unit doors. No staff were visible in the hallway or at the nurse's station. At 11:15 AM, R14's call light was still on, and no staff were observed on the unit. This surveyor walked down the hallway and observed Licensed Practical Nurse (LPN)13 assisting another resident in the room. Then another staff entered the unit (through the unit doors), look up at R14's activated call light, then proceeded to go into the break room without checking in on R14. At 11:17 AM, LPN13 walked past R14's room, call light still activated, did not check on the resident or acknowledge the resident when walking past R14's room. At 11:19 AM, Certified Nurse Aide (CNA)6 entered the unit, walked past R14's room, did not look into the resident's room, and walked right past the door without acknowledging R14 or checking in to see if the resident was safe. At 11:21 AM, LPN13 entered R14's room and addressed R14. In a later interview with LPN13, it was confirmed there is not enough staff to provide care and/or address resident's call lights when staff are on their lunch break, especially on the weekends. (continued on next page)

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R14's most recent quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/20/24, Section C- Cognitive Patterns, Brief Interview for Mental Status (BIMS) score was 11, indicating R14 has moderate cognitive impairment. Section GG, Functional Abilities and Goals, documented R14 is dependent (helper does all of the effort) on staff for toileting hygiene, sitting to lying (ability to move from sitting on side of the bed to lying flat on the bed, and lying to sitting. R14 requires substantial/maximal assistance (helper does more than half of the effort) personal hygiene, rolling left and right, and upper and lower body dressing. 2) On 09/22/24 at 11:43 AM, conducted an interview with R156 in the resident's room. R156 was admitted to the facility on [DATE] for short-term rehabilitation and physical therapy after knee surgery. R156 was alert and oriented to person, place, time, and situation during the interview. R156 reported waiting 45 minutes to an hour for staff to answer the resident's call light. She stated that no one came in to check on what she needed and reported longer wait times on the weekend, especially on the evening and night shifts. R156 stated that she can tell when she must go to the toilet and requires staff's assistance to get to the bathroom but cannot hold herself for 45 minutes and ended up urinating in the bed. R156 said that she felt humiliated having to use the bathroom in her bed and she can't always get the help she needs when she needs it so she asked them for a bedpan so she wouldn't have to urinated on herself or in a diaper. R156 expressed worry that because there is not enough staff to help her up when she needs to go to the bathroom and less opportunities to get out of bed for short distances, it will lengthen her rehabilitation time. 3) On 09/23/24 at 09:35 AM, this surveyor was seated at the end of the hall, near R35's room and observed the resident's call light was activated as evidenced by the activated light about the room door. At 09:40 AM, observed Non-Certified Nurse Aide (NCNA)7 in another room changing the linen. From 09:35 AM to 10:01 AM, 13 staff, which included the Director of Nursing (DON) and the Administrator, passed by the resident's room with the activated call light and did not acknowledge R35 or check to ensure the resident was safe. At 10:01 AM, NCNA addressed R35's call light. During an interview with R35 on 09/23/24 at 10:36 AM, the resident confirmed he often waits 25 minutes or more for staff to answer his call light. R35 reported feeling frustrated because he can see staff walking past his room and hear him calling out, but staff keep walking by. R35 stated that on some occasions, he has had to wait for over an hour for staff to answer my call light, it makes me feel less than and like I don't matter. Review of R35's most recent quarterly MDS with an ARD of 09/19/24, Section C- Cognitive Patterns, BIMS score was 13, indicating the resident is cognition is intact. Section GG, Functional Abilities and Goals, documented R35 is dependent (helper does all the effort) on staff for toileting hygiene, shower/bath, transferring to any surface, and lower body dressing. R35 requires substantial/maximal assistance (helper does more than half of the effort) for personal hygiene, rolling left and right, and upper body dressing, 4) Review of R5's most recent quarterly MDS with an ARD of 07/18/24, Section C- Cognitive Patterns, BIMS score was 15, indicating the resident's cognition is intact. Section GG, Functional Abilities and Goals, documented. R5 requires substantial/maximal assistance (helper does more than half of the effort) for toilet transfer and transitioning from sitting to standing. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with R5 on 09/22/24 at 11:58 AM, R5 reported that she often must wait a long time for staff to answer her call light and if staff are busy, staff do not communicate with the resident to let her know they are busy and will be right with her or check to make sure she was safe. R5 stated, My call light could be on, and staff will walk right past my room, I can see them walking past the door and they don't even check to see that I'm safe. I could've fallen and been hurt, and staff wouldn't know. R5 reported on the weekends and nights it is not uncommon to have to wait 30 minutes or more for staff to answer your call light or address you. R5 informed this surveyor that she is aware the facility is short on the weekends, but staff should at minimum check to see the resident is okay and what they need, instead of having the resident wait with no idea if staff are aware that her call light is on and provide a timeframe for when the staff will be able to help the resident.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37954 Based on interviews and record review, the facility failed to ensure the resident's right to be free from abuse for two (Residents (R)8 and R5) sampled. R8 informed two different staff that R23 had run over her feet twice with his wheelchair, then cursed at R8 when she responded verbally to R23. On 07/16/24, an incident occurred where R5 informed staff that the Alleged Perpetrator (AP) caused her pain by handling the resident's gait belt roughly when transferring the resident to the toilet, AP yelled in R5's ear causing the resident numbness in her ear canal, and AP told R5 that the resident is fussy and that's why no one (staff) wants to work with her in response to the resident informing the staff of her preferences for transferring on and off the toilet. R5 reported because of R5 not doing what the staff wanted, AP deliberately called the resident fussy and told her no one wanted to help the resident, who is dependent on staff to transfer on and off the toilet. As a result of this deficient practice, residents are at risk for the potential of more than minimal harm. Findings include: Willful, as defined at 483.5 in the definition of abuse, and means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Guidance for 483.12(a)(1) documents, All staff are expected to be in control of their own behavior, are to behave professionally, and should appropriately understand how to work with the nursing home population. A facility cannot disown the acts of staff, since the facility relies on them to meet the Medicare and Medicaid requirements for participation by providing care in a safe environment .It is also not acceptable for an employee to claim his/her action was reflexive or a knee jerk reaction and was not intended to cause harm. Retaliation by staff is abuse, regardless of whether harm was intended . Cross Reference to F609 Reporting of Alleged Violation 1) On 09/22/24 at 01:05 PM an interview was conducted with R8. Inquired if any resident had ever hurt or abused her and R8 stated a resident comes over here sometimes and has run over my feet twice and he called me an F'n bitch. Inquired if she had reported this to any staff at the facility and she stated she reported it to two staff, the Activities Director and the Social Worker. Inquired when this occurred and R8 was unsure of the date. Inquired if the resident still lives in the facility and R8 was not sure. On 09/22/24 Record Review (RR) of R8's Electronic Health Record (EHR) revealed she is a [AGE] year-old admitted to the facility on [DATE] with a diagnosis that include, but are not limited to, acute respiratory failure with hypercapnia (higher than normal levels of carbon dioxide in the blood), Type 2 diabetes mellitus, chronic pain syndrome, muscle weakness and difficulty in walking, not elsewhere classified. R8's Minimum Data Set (MDS) completed on 08/27/24 identified her as having a Brief Interview for Mental Status (BIMS) score of 15 out of 15 identifying her as cognitively intact. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/24/24 at 08:45 AM requested facility investigation for reported resident to resident abuse (R23 towards R8) from Administrator. Administrator stated there was no investigation for this incident because it had been reported by staff as an accident. On 09/25/24 at 11:15 AM interview was conducted with the Administrator who stated yesterday (09/24/24) she reported the incident to the State Agency Office of Health Care Assurance (OHCA). Administrator stated she interviewed R8 and called the police to ask them to come and take resident's statement. Administrator stated she was not previously aware of the allegation(s) of abuse that occurred from R23 to R8, she had not been informed this incident was abuse, she was told it was an accident. On 09/25/24 at 09:53 AM interviewed Human Resource Director (HRD). Inquired of HRD when staff do abuse training and she stated upon hire and annually. Requested a copy of all staff's current abuse training dates. She stated she would provide the dates of staff's abuse training. On 09/27/24 at 01:39 PM Administrator provided a copy of staff's dates for abuse training by email. On 09/27/24 review of facility staff abuse-training data revealed a total of 76 staff listed, 25 staff were not current with this training making this 33% of staff outdated with their abuse training. Review of facility policy found the following Protection of Residents: Reducing the Threat of Abuse & Neglect . Position Statement & Guidelines . Residents must not be subjected to abuse by anyone. This includes but is not limited to: staff, other residents, consultants, volunteers, staff from other agencies serving our residents, family members, the resident representative, friends, or any other individuals. Policy . This facility has procedures in place to provide protection for the health, welfare, and rights of each resident residing in the facility. These procedures include, but are not limited to, the following seven components: 1. Screening 2. Training 3. Prevention 4. Identification 5, Investigation 6. Protection 7. Reporting and Response (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	. Reporting and Response . 2. All associates are mandated to immediately report suspected resident abuse and/or neglect to their immediate supervisor and/or facility representative. 3. All alleged or suspected violations involving mistreatment, abuse, neglect, injuries of unknown origin (e.g. bruising and skin tears) will be immediately reported to the administrator and/or director of nursing. 10. The administrator, director of nursing, or designated representative will complete an investigation of the incident including a written summary of the findings no later than five (5) working days after the reported occurrence. 42160 2) Cross Reference to F609 Reporting of Alleged Violation and F610- Investigate / Prevent / Correct Alleged Violation Review of R5's most recent annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/26/24 and most recent quarterly MDS with an ARD of 07/18/24 documented, Section C. Cognitive Patterns, scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition is intact. Section GG. Functional Abilities and Goals. GG.0170 Mobility, documented R5 requires substantial/maximal assistance- Helper does more than half the effort for sit to stand (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed), Chair/bed-to-chair transfer (ability to transfer to and from a bed to a chair/wheelchair), toilet transfer (the ability to get on and off a toilet or commode), and Tub/shower transfer (the ability to get in and out of a tub/shower. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Facility Reported Incident (FRI) #11120 (initial report date 08/06/24; completed report date 08/09/24), dated 08/06/24, for an allegation of staff to resident abuse which occurred on 07/16/24 at 02:00 PM. The report documented on 08/06/24, R5 reported to the Director of Nursing and the Executive Director that she felt as though she had been abused by AP. An abuse investigation was initiated, and AP has been suspended pending investigation. The completed report (08/09/24) documented, R5 reports that she felt as though the CNA(AP) abused her on 08/09/24 although the incident happened on 07/16/24. The facility documented that it wasn't until the 08/06/24 incident that they became aware of how R5 felt about the incident on 07/16/24. The report documented on 07/16/24, AP was assisting R5 to the bathroom and there was a discrepancy between how AP was completing the transfer and the resident's preference of only locking one side of the wheelchair to transfer in a manner which the resident felt comfortable and safe. As a result of the disagreement on mode of transferring the resident, AP claimed R5 was yelling at her, and AP made a comment about R5 being fussy and this is why staff do not want to work with her. R5 felt as if AP was shaking the resident while assisting her with maneuvering in the pivot disc which caused her pain. After the encounter R5 then asked to see the manager and AP assisted R5 to Registered Nurse (RN)32. RN32 reported the incident to the DON and the DON reviewed customer service with AP and reported she was better. The next few days R5 continued to improve and seemed to be back to her normal self. Social Service Director (SSD)1 spoke to R5 on 07/18/24, no concerns were brought to her attention. On 08/06/24, R5 overheard staff saying AP said R5 refused lunch, when in fact R5 had not refused lunch and was waiting for it to be delivered. R5 became upset about the situation and while the nurse attempted to deescalate the situation, R5 reported that she was upset because the incident that happened on 07/16/24, she then added in the pieces about being yelled at and shaken around making her feel abused. The nurse notified the DON, an abuse investigation was promptly started, AP was suspended pending investigation, police, and Adult Protective Service (APS) was notified. The facility continued the investigation by conducting interviews with the resident and staff. no concerns were related to AP, additional education was completed with AP regarding communication and care are without concerns. Informed AP she would not be assigned to R5 in the foreseeable future. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/22/24 at 12:08 PM, conducted an interview with R5 in the resident's room. The interview with R5 and the facility's completed report were different. R5 stated on 07/16/24 she was abused physically and verbally when AP assisted the resident to the toilet. R5 stated she had not been feeling good (in good health) that day and took a nap. At approximately, 02:00-02:30 PM, AP entered the room and assisted the resident to the bathroom to use the toilet. R5 stated that upon entering the room, AP appeared to be upset about something and was grumbling about something under her breath which R5 could not understand and was mumbling prior to helping R5 to the bathroom. During the transfer, R5 requested for AP to lock only one wheel of the wheelchair instead of two due to the set-up of the bathroom and the way the wheelchair needs to move in relation to the pivot disc. R5 reasoned that with both wheels locked it is a difficult position for R5 and she does not feel safe before she sat into the wheelchair. AP informed the resident that she had to lock both wheelchair wheels and R5 insisted on her preference to only lock one wheel. R5 reported AP became frustrated over R5's insistence of locking one wheel only and AP began to get louder out of frustration, to the point AP began to yell in R5's ear. R5 explained when AP picked her up using the gait belt, AP was rougher than normal and shaking the pivot disc bars in a manner which caused R5 to experience pain in her back. R5 reported she had not been handled in this manner by AP or other staff before when using the pivot disc and did not feel safe with AP. R5 recalled that AP is normally louder than other staff, but it wasn't that she was speaking loudly or AP's positioning to the resident, it was more than that, she was yelling in her ear, and she asked AP to stop yelling in her ear. AP then told R5,You know that meeting was all about you. You're so fussy, that's why no one wants to work with you. R5 recalled that all she wanted to do was to get safely into her wheelchair to get away from AP. R5 reported that as soon as she got into her wheelchair, she began wheeling herself out of the room and AP followed behind the resident, waving her hands in the air, mockingly yelling in the hallway, Yeah here she comes, coming to complaint about me, I didn't do anything. R5 reported the incident to Registered Nurse (RN)32 and RN32 took the time and care to calm R5 down. R5 reported AP was yelling in her ear as she wheeled herself out of the room. I was just telling AP of my preferences, what works for me, and how other staff transfer me. I felt like she was abusing me with her words, yelling into my ear, and her attitude towards me, and then shaking me with the gait belt which caused me pain. R5 stated that when she reported this incident on 07/16/24 to the nurse, the Director of Nursing (DON) or the Administrator did not come to talk to me to get my side of what happened or to see how I was feeling after the incident. It's like they did not believe me. R5 said that she told SSD1 about the incident and SSD1's response to her was that there were no marks or bruises to support the resident's claim that she was abused. Inquired if the DON or Administrator spoke with her (R5) after the incident on 07/16/24. R5 confirmed the DON did not speak to her to see what happened, she only spoke to AP. R5 stated she repeatedly inquired with the DON about the education and/or training AP received because of the 07/16/24 incident. R5 stated the DON informed her that AP received training but refused to provide the resident with the materials used in the training. R5 reported she felt unsupported, and the DON and Administrator did not believe or was interested her version of events on 07/16/24 and that the DON had already made up her mind that AP did not abuse her. R5 stated when AP told her Nobody wants to work with her it really affected her mood, R5 expressed she started to feel depressed and sad. R5 said, I depend on staff to go to the toilet, for my food, and care and to hear staff say that to you makes you feel less than and when the DON had already made up her mind and couldn't be bothered, how do I trust the DON to have my best interest in mind. I have nowhere else to go, this is my home, and it doesn't feel good to be treated this way and not liked by staff. During this interview, R5 was visibly affected by the 07/16/24 incident. R5's voice was shaky, cried, appeared to be in low spirit, and took breaks to compose herself. R5 stated, I know that I am particular about somethings, but those things don't change, and they are not unreasonable, for example, I only like to drink filter water, because of the quality of the unfiltered water, I don't feel like that is a new or unreasonable request. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/25/24 at 08:22 AM, conducted an interview with the DON and Administrator in the conference room regarding the incident on 07/16/204 with AP and R5. DON stated she was notified of the incident on 07/16/24 by RN32. DON confirmed she only spoke to AP about the incident and did not conduct an interview with R5 to get the resident's perspective. DON confirmed AP admitted that she told R5 that she was fussy, and no one wanted to work with her. Asked the DON if AP's statement to R5 could be identified as potential verbal abuse due to AP making a non-professional statement that any reasonable person would be offended by, there was conflict within the situation between R5 and AP, and the resident was dependent on staff to maneuver onto the toilet. DON stated she did not see it as verbal abuse because the resident is known to be picky about what she likes and how she wants things done, for example, she only likes filtered water and R5 gets upset when she's given another type of water. DON was firm that AP making that statement was not verbal abuse by AP and it was a customer service matter. Referred to the report which documented it took a few days for R5 to return to her baseline behavior. Inquired about the type of education and training AP received because of this incident. DON stated AP received education and training. Requested for the DON to provide a copy of the material used to educate and train AP. DON then stated, there was no formal education or training, when the DON spoke to AP about the incident, AP was informed to stay away from the resident and that was not an appropriate way to speak to a resident. On 09/25/24 at 08:56 AM, conducted an interview with SSD1 regarding the incident. SSD1 confirmed she spoke to R5 a couple of days after the incident. SSD1 stated that when there is an investigation, it was her role to speak to the residents. SSD1 reported AP was educated on customer service because of the incident but did not know what the education was comprised of. SSD1 confirmed R5 told SSD1 that AP abused her and confirmed that she did not see any marks on the resident and discounted the resident's allegation of abuse because the DON was handling the incident as a customer service issue. SSD1 confirmed R5 was upset about what AP said to her. On 09/25/24 at 09:31 AM, conducted an interview with RN32. RN32 recalled the incident and stated she saw R5 wheeling down the hallway and AP was following behind R5, saying that R5 is going to complain about her now. RN32 stated R5 was visibly upset and told AP to give the resident some space. RN32 confirmed R5 reported AP was yelling in her ear so loud the resident stated her ear canals were numb, AP told the resident she's so fussy and that's why no one wants to work with her, and that when AP was maneuvering the resident on the pivot disc, she was doing it in a manner that hurt the resident. RN32 stated, R5 was so upset over the incident that it took RN32 approximately 35 minutes to deescalate R5 after the incident.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37954 Based on interviews and record reviews the facility failed to report allegations of abuse of two residents (Residents (R)8 and R5) of 51 residents at the facility, to the facility administrator and/or state agency within two hours of being reported to staff by the resident. During the review of R8's allegation of abuse two facility staff were notified by R8, and the facility administrator was not notified abuse had occurred. Initial report of R8's allegation of abuse was submitted by the facility to the state agency on 09/24/24. The facility did not identify R5 allegations as having the potential for abuse and classified the incident as a customer service issue and did not report the incident within the two-hour timeframe. This deficient practice could affect all residents in the facility who have a reported or witnessed incident of abuse and the facility fails to notify the state agency within two hours. Findings include: 1) On 09/22/24 at 01:05 PM interviewed R8 and inquired if she has had any confrontations with other residents at the facility and she stated R23 comes over here sometimes and has run over my feet twice and called me an F'n bitch. Inquired what facility did about this and R8 stated they told me that they talked to him about it. Inquired who they were and R8 stated Social Worker and Activities Director. Inquired when this occurred and R8 was unable to recall the date this occurred and could not confirm if the resident still lived at the facility. On 09/22/24 Record Review (RR) of R8's Electronic Health Record (EHR) revealed she is a [AGE] year-old admitted to the facility on [DATE] with diagnoses that include, but are not limited to, acute respiratory failure with hypercapnia (higher than normal levels of carbon dioxide in the blood), type 2 diabetes mellitus, chronic pain syndrome, muscle weakness and difficulty in walking, not elsewhere classified. R8's Minimum Data Set (MDS) completed on 08/27/24 identified resident as having a Brief Interview for Mental Status (BIMS) of 15 identifying her as cognitively intact. On 09/24/24 at 11:15 AM requested from Administrator investigation that was conducted for R8's allegation of abuse from R23. Administrator stated she had not been told the incident was abuse, that it had been an accident. Surveyor explained R8 had reported R23 had run over her feet with his wheelchair two times and cursed at her when she said something to him. On 09/25/24 at 08:43 AM Administrator stated yesterday (09/24/24) she reported R8's allegation of abuse to State Agency Office of Health Care Assurance (OHCA). Administrator stated on 09/24/24 she interviewed R8 and called the police to take resident's statement. At this time inquired and Administrator confirmed she was not previously aware of the allegation of abuse from R23 to R8, she had not been informed this incident was abuse by staff and had been told it was an accident. 42160 Cross reference to F600, F610. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Kona	78-6957 Kamehameha III Road Kailua Kona, HI 96740

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/22/24 at 12:08 PM, conducted an interview with R5 in the resident's room. R5 informed this surveyor that on 07/16/24, R5 reported an incident to Registered Nurse (RN) 32 which included allegations of staff causing her intentional physical pain while using the pivot disc to transfer to and from the toilet. R5 confirmed she does not usually experience pain when using the pivot disc and reported the Alleged Perpertrator(AP) was willfully handling the resident roughly. R5 also reported that AP, who is normally speaks in a loud volume, was yelling in the resident's ear in a manner which caused her ear to feel numb and requested several times with AP for the staff to stop yelling in her ear. In addition to being handled in a rough manner and yelling in the resident's ear, R5 reported AP was upset and grumbling under her breath prior to assisting the resident and became increasingly more irritated with the resident and told the resident, You are so fussy, that's why no one wants to work with you. and informed the resident that there was a staff meeting about her. R5 also stated that she informed the Social Service Director (SSD) 1 that she felt like she was being abused by AP, two days after the incident occurred. R5 reported, she felt like SSD1 did not believe her and asked the resident if she had any bruises or marks, R5 replied she did not have physical evidence, but at the time AP did hurt her physically, was emotionally hurt by what the staff said to her, and felt like staff did not believe the resident or asked the resident about her account of the incident. R5 confirmed that facility did not interview her about the 07/16/24 incident with AP, it was only after she complained about the staff again on 08/06/24. During an interview with RN32 on 09/25/24 at 10:42 AM, staff stated the first time she became aware of the situation was on 07/16/24, when R5 rolled herself out of her assigned room quickly with AP following behind the resident's wheelchair, waving her hands, and loudly saying, I didn't do anything to her, she's (R5) going to complaint about me. RN32 also confirmed AP did not wheel R5 out of her assigned room and the resident was telling the staff to get away from her. RN32 stated it took approximately 30 minutes or more to verbally deescalate R5 because the resident was extremely upset about the incident between R5 and AP. After conducting an interview with RN32, both R5 and RN32's account of the incident was aligned and similar. RN32 stated that her first action was to separate R5 and AP, so AP was reassigned to another section of residents. Then, RN32 called the Director of Nursing (DON) and informed her of the incident. Then RN32 attended to R5 and calmed the resident down. RN32 reported that R5 was extremely upset and affected by the incident with AP and required a lot of time and attention to calm down R5. Also, it took R5 a couple of days to get back to her normal self and R5 regularly ruminated on the incident. During an interview with the Administrator and DON on 09/25/24 at 08:22 AM. During the interview, the DON confirmed she did not identiy the incident with R5 and AP on 07/16/24 as a potential abuse but viewed the situation as a customer service issue. DON reported R5 did not have any identifiable marks and did not tell staff she was abused. Inquired if DON was aware that AP called R5 fussy and told resident that was why no one wanted to work with her. DON confirmed AP admitted to saying this to R5 on 07/16/24 when she interviewed AP over the phone. DON stated she informed AP that it was not okay to speak to the residents in this manner and still did not identify it as potential abuse. Inquired if DON was aware that RN32 spent more than 30 minutes directly after incident to calm and deescalate R5. DON confirmed she was aware the RN32 spent time calming the resident down, and confirmed she did not identify that R5 could have potentially experienced psychosocial harm and stuck to her decision to treat the incident on 07/16/24 as a customer service issue. DON confirmed the incident on 07/16/24 was not reported because it was not identified as having a potential for abuse. Review of the Facility Reported Incident (FRI) #11120 (initial report date 08/06/24; completed report date 08/06/24) included the incident from 07/16/24.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 42160 Based on interviews and record review, the facility failed to ensure all alleged violations are thoroughly investigated, in response to an allegation of abuse for one (Resident (R)5) sampled. On 07/16/24, R5 reported an incident that the Alleged Perpetrator (AP) was rough with the resident's gait belt when assisting the resident during a transfer, yelling in the resident's ear, and told the resident she was fussy and that's why no one wanted to work with her. RN23 reported spent approximately 30 minutes deescalating R5 after she reported the incident to the Director of Nursing (DON). The DON conducted an interview only with AP, did not interview the resident, did not conduct a thorough investigation, did not identify the incident as having a potential for abuse (physical, verbal, and psychosocial harm), and classified the incident as a customer service issue. Two days after the incident, R5 informed the Social Service Director (SSD)1 that she felt like AP abused her on 07/16/24 and the facility did not initiate an investigation. As a result of this deficient practice, residents are at risk for more than minimal harm related to the facility not identifying the potential for abuse and conducting an immediate thorough investigation. Findings include: Cross Reference to F600- Free from Abuse, Neglect, and Misappropriation and F609- Reporting of Alleged Violation On 09/22/24 at 12:08 PM, conducted an interview with R5 in the resident's room. R5 informed this surveyor that on 07/16/24, R5 reported an incident to Registered Nurse (RN)32 which included allegations of staff causing her intentional physical pain while using the pivot disc to transfer to and from the toilet. R5 confirmed she does not usually experience pain when using the pivot disc and reported the Alleged Perpetrator (AP) was willfully handling the resident roughly. R5 also reported that AP, who is normally speaks in a loud volume, was yelling in the resident's ear in a manner which caused her ear to feel numb and requested several times with AP for the staff to stop yelling in her ear. In addition to being handled in a rough manner and yelling in the resident's ear, R5 reported AP was upset and grumbling under her breath prior to assisting the resident and became increasingly more irritated with the resident and told the resident, You are so fussy, that's why no one wants to work with you. and informed the resident that there was a staff meeting about her. R5 also stated that she informed the Social Service Director (SSD)1 that she felt she had been abused by AP, two days after the incident occurred. R5 reported, she felt like SSD1 did not believe her and asked the resident if she had any bruises or marks, R5 replied she did not have physical evidence, but at the time AP did hurt her physically, was emotionally hurt by what the staff said to her, and felt like staff did not believe the resident or asked the resident about her account of the incident. R5 confirmed that facility did not interview her about the 07/16/24 incident with AP, it was only after she complained about the staff again on 08/06/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with RN32 on 09/25/24 at 10:42 AM, staff stated the first time she became aware of the situation was on 07/16/24, when R5 rolled herself out of her assigned room quickly with AP following behind the resident's wheelchair, waving her hands, and loudly saying, I didn't do anything to her, she's (R5) going to complaint about me. RN32 also confirmed AP did not wheel R5 out of her assigned room and the resident was telling the staff to get away from her. RN32 stated it took approximately 30 minutes or more to verbally deescalate R5 because the resident was extremely upset about the incident between R5 and AP. After conducting an interview with RN32, both R5 and RN32's account of the incident was aligned and similar. RN32 stated that her first action was to separate R5 and AP, so AP was reassigned to another section of residents. Then, RN32 called the Director of Nursing (DON) and informed her of the incident. Then RN32 attended to R5 and calmed the resident down. RN32 reported that R5 was extremely upset and affected by the incident with AP and required a lot of time and attention to calm down R5. Also, it took R5 a couple of days to get back to her normal self and R5 regularly ruminated on the incident. During an interview with the Administrator and DON on 09/25/24 at 08:22 AM. During the interview, the DON confirmed she did not identify the incident with R5 and AP on 07/16/24 as a potential abuse but viewed the situation as a customer service issue. DON reported R5 did not have any identifiable marks and did not tell staff she was abused. Inquired if DON was aware that AP called R5 fussy and told the resident that was why no one wanted to work with her. DON confirmed AP admitted to saying this to R5 on 07/16/24 when she interviewed AP over the phone. DON stated she informed AP that it was not okay to speak to the residents in this manner and still did not identify it as potential abuse. Inquired if DON was aware that RN32 spent more than 30 minutes directly after the incident to calm and deescalate R5. DON confirmed she was aware that RN32 spent time calming the resident down, and confirmed she did not identify that R5 could have potentially experienced psychosocial harm and stuck to her decision to treat the incident on 07/16/24 as a customer service issue. DON confirmed the incident on 07/16/24 was not investigated thoroughly because it was not identified as having a potential for abuse. Review of the Facility Reported Incident (FRI) #11120 (initial report date 08/06/24; completed report date 08/06/24) included the incident from 07/16/24.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47783 Based on interview and record review, the facility failed to provide proper notification of transfer/discharge for two of four residents sampled for hospitalization (Residents (R)1 and R8). Specifically, the facility failed to provide written notification of transfer/discharge to the residents or their representatives. This deficient practice has the potential to affect all residents at the facility who are discharged or transferred. Findings include: 1) R1 was admitted to the facility on [DATE]. On 07/16/24, R1 was transferred to an acute care hospital for gastrointestinal bleeding. Review of the Electronic Health Record (EHR) was conducted, and no documentation was found of the facility providing a written notification of transfer to R1 or his representative. Asked Administrator if a written notification was sent to R1's representative. Administrator said she will check the paper files. On 09/25/24 at 10:27 AM, Administrator was interviewed in the conference room. Administrator said she was not able to locate document to show written notification of R1's discharge was provided to R1's representative. 37954 2) On 09/22/24 at 01:27 PM interviewed R8. Inquired if resident had been hospitalized while she lived at the facility and she stated, a couple of times. Asked R8 why she went to the hospital, and she stated one time when she was found unresponsive and in the in ICU for a couple of days and can't remember why for the other time she went to the ER and was admitted to the hospital. On 09/22/24 record review of R8's EHR found she is a [AGE] year-old admitted to the facility on [DATE]. Review of R8's Minimum Data Set (MDS) revealed she was admitted on [DATE], discharged on [DATE] and returned to the facility on [DATE] and discharged on [DATE] and admitted back to the facility on [DATE]. Review of R8's progress notes revealed she was discharged from the facility on 08/09/24 and sent to the emergency room for SOB (shortness of breath) and further evaluation. R8 returned to the facility on [DATE] and had been hospitalized for COPD (Chronic obstructive pulmonary disease). R8 was discharged on [DATE] when she was found unresponsive but breathing by facility staff. R8 was transferred to the emergency room and admitted to the hospital ICU (intensive care unit). R8 returned to the facility on [DATE] and had been hospitalized for acute-on-chronic hypoxemic and hypercapnic respiratory failure (occurs when there is not enough oxygen and too much carbon dioxide in the body leading to breathing to stop). On 09/25/24 at 08:45 AM requested from the Administrator copies of R8's discharge/transfer notification that was provided to R8 or her representative for her discharges on 08/09/24 and 08/17/24. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 at 01:02 PM in an email reply by the Administrator she was able to provide a copy of the discharge/transfer notice that was given to R8's representative for the 08/17/24 transfer. Administrator, stated in her email response, that she was not able to find the transfer notification form for 08/09/24.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47783 Based on interview and record review, the facility failed to ensure written notification of the facility's bed hold policy was provided to three of four residents sampled for hospitalization (Residents (R)1, R30 and R8). This deficient practice has the potential to affect all residents at the facility who are discharged to an acute care hospital. Findings include: 1) R1 was admitted to the facility on [DATE]. On 07/16/24, R1 was transferred to an acute care hospital for gastrointestinal bleeding. A review of the Electronic Health Record (EHR) was conducted, and no documentation was found of the facility providing a written notification of the bed hold policy to R1 or his representative. 2) R30 was admitted to the facility on [DATE]. On 07/01/24, R30 was transferred to an acute care hospital for an abscess to his AV (arteriovenous) fistula (surgical connection made between an artery and a vein used to access the blood for dialysis). A review of the EHR was conducted and no documentation was found of the facility providing a written notification of the bed hold policy to R30 or his representative. On 09/24/24 at 10:03 AM, requested from Administrator a copy of written notifications given to both R1 and R30 regarding the facility's bed hold policy when they were transferred to an acute care hospital. Administrator said she will check the paper charts. On 09/25/24 at 10:27 AM, Administrator said she was not able to locate the written notifications of the bed hold policy give to R1 and R30 in the paper charts. Review of the facility policy titled Bed-Hold Policy stated, . The Bed-hold policy should be given upon admission, upon transfer of a resident to the hospital . to ensure that the residents are made aware of the facility' bed-hold and reserve bed payment policy before and upon transfer to the hospital . notice must be provided to the resident, and if applicable the resident's representative, at the time of transfer, or in cases of emergency transfer, within 24 hours. 37954 3) On 09/22/24 record review of R8's EHR found she is a [AGE] year-old admitted to the facility on [DATE]. Review of R8's progress notes revealed she was transferred to an acute care hospital two times in August 2024, once on 08/09/24 for SOB (shortness of breath) and further evaluation and on 08/17/24 when R8 was found unresponsive but breathing by facility staff. During this record review no documentation was found of the facility providing written notification of the bed hold polity to R8 or her representative. On 09/25/24 at 08:45 AM requested from Administrator copies of R8's written notifications of the bed hold policy for the transfers/discharges that occurred on 08/09/24 and 08/17/24. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/27/24 at 01:39 PM Administrator sent an email to surveyor stating she was unable to locate the bed hold policy forms for R8's transfers/discharges that occurred on 08/09/24 and 08/17/24.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37954 Based on observation, record review (RR), and interview the facility failed to develop and implement a comprehensive care plan for two residents (Resident (R)8 and R32) sampled. R8 has a physician's order for 2 (two) liters/(per) minute of continuous oxygen via nasal cannula and a care plan was not developed for this medical intervention. R32 has a physician's order for an opioid pain medication and R32's care plan did not include non-pharmacological pain-relieving interventions. The deficient practice could affect all residents at the facility if the facility fails to develop and implement a comprehensive person-centered care plan for each resident to attain or maintain the resident's highest practicable physical well-being. Findings include: 1) On 09/22/24 at 01:05 PM, observed and interviewed R8 in her room with O2 (oxygen) tubing connected to an O2 concentrator and oxygen administered via nasal cannula at 2L/minute. Resident did not appear to be in distress. Tubing was noted to be long enough to go into the bathroom with her. On 09/25/24 at 08:10 AM during RR of R8's Electronic Health Record (EHR) found resident was admitted to the facility on [DATE] with the diagnosis of acute respiratory failure with hypercapnia. R8's Brief Interview for Mental Status (BIMS) score is 15 which identifies her as being cognitively intact. During this RR found R8 does not have a CP for her continuous O2 use. Review of R8's physician's orders found she has the following order: Oxygen at 2 liters/minute continuously per nasal cannula. Document every shift for sleep apnea, obesity hypoventilation syndrome which was written on 09/23/24. On 09/25/24 at 09:03 AM, reviewed with Administrator who confirmed R8 does not have a CP in place for her O2 use. 42160 2) Review of R32's EHR documented, the resident has an order for, Norco Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 4 hours as needed for pain, which is an opioid analgesic pain medication which acts on the central nervous system to relieve pain. Review of R32's care plan documented interventions did not include non-pharmacological interventions. On 08/25/24 at 08:22 AM, during an interview with the Administrator and the Director of Nursing, it was confirmed the CP did not include non-pharmacological interventions as an option for treatment of the resident's pain and it should have been included.

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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** 37954 Based on observation and interview the facility failed to provide adequate supervision for one Resident (R)52 who was found outside of the facility sitting in her wheelchair, by herself, at a table with her back facing the facility door. The deficient practice puts residents at risk for accidents if they are not provided proper and adequate supervision. Findings Include: On 09/23/24 at 04:30 Surveyors were leaving the facility and noticed a female resident was sitting outside of the facility in her wheelchair with her back facing the facility door. R52 called out I need help! Can you help me? Surveyor inquired what she needed and R52 stated she wanted to go back inside. Surveyor buzzed the front door and asked for staff to come and assist R52 back into the building. Facility staff came out to help R52 back into the unit. On 09/24/24 record review of R52's Electronic Health Record (EHR) found she was admitted to the facility on [DATE] and her diagnoses include, but are not limited to, history of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (stroke with weakness on the right side), difficulty in walking and legal blindness, as defined in USA. R52's Minimum Data Set (MDS) completed on 09/03/24 has her Brief Interview for Mental Status (BIMS) score at 13 out of 15 identifying her as Intact/borderline cognition. On 09/24/24 at 11:19 AM an interview was conducted with the Administrator. Inquired what had occurred with R52 the previous day (09/23/24) when she was left by herself outside the front of the facility. Administrator reported hospitality aide and the resident had an understanding when the resident was to return to the unit. Administrator reported the resident wanted to be in for dinner which is at about 5 PM. The resident meant go in at 4:00 PM for dinner. Inquired of Administrator how do residents notify staff inside if they need assistance when the resident is left outside the facility by themselves. Administrator confirmed the resident would not be able to notify staff because she is not able to move herself in her wheelchair and the facility does not have any signaling device outside the facility that communicates with staff inside the building. On 09/24/24 at 11:55 AM interviewed Hospitality Aide (HA). HA stated yesterday she took R52 outside after lunch to sit in front of the facility. Inquired what time this was and HS was not sure exactly when she took R52 outside and stated resident wanted to come back inside the facility at 4 PM. HA stated she finishes at 3 PM and she told the nurse before she left for the day. HA stated she checked on resident one last time at 2:57 PM and came back to the unit and told the nurse R52 wants to come in at 4 o'clock for dinner and HA said nurse stated ok staff would bring her in. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/24/24 at 12:27 PM, interviewed R52 who thanked surveyor for helping her. HA told them to bring me inside at 4 PM but they forgot. They always forget me. Inquired if this has happened before and R52 confirmed it has and stated When someone passes me outside, I ask them for help. It has happened before, but I cannot remember how many times. Inquired if she can notify staff that she wants to go inside if she is outside sitting at the table by herself and R52 stated I have no way of telling them. Only when someone passes by I ask them for help. R52 stated It is wonderful here but there are not enough people . to coordinate to bring me in on time. Sometimes we have three nurses and then none.

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	125052	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Kona	78-6957 Kamehameha III Road Kailua Kona, HI 96740

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 37954 Based on interview and record review the facility failed to perform annual performance reviews with their Certified Nurse Aides (CNAs) in identifying any weaknesses they may have and address them with in-service education. This deficient practice puts all the residents in the facility at risk for not receiving quality care from CNAs who have had their weaknesses identified and education provided that enhances the resident's life. Findings Include: On 09/25/24 at 11:04 AM an interview was conducted with the Director of Nursing (DON) and Administrator. Inquired if DON does annual performance reviews with CNAs and she stated, they are currently sitting on my desk. Inquired again, yes or no, if this was done and DON stated no. Requested from the Administrator a list of facility CNA names, date last performance review was done and next performance review is due. On 09/27/2024 at 01:39 PM an email was sent by the Administrator who provided a copy of the facility CNA names, date last performance review was done and when the next performance review is due. Review of the information provided revealed the following: Facility has 24 CNAs. 8 of the 24 CNAs are new hires and their annual performance review is due in 2025. 13 of the 24 CNAs are outdated with their annual performance review from the last time they had an annual performance review done, most as far back as 05/21. 16 of the 24 CNAs are outdated with their next review which was due either 05/24 or 06/24.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 42160 Based on interview and record review, the facility failed to ensure an account of all controlled drugs is maintained. Reconciliation of the controlled medication reconciliation sheet and the medication documented a discrepancy between the count of the medication and the number of actual pills. As a result of this deficient practice, there is the potential for more than minimal harm. Findings include: On 09/24/24 at 09:57 AM, conducted an inspection of a medication cart with Licensed Practical Nurse (LPN)13. Review of R41's-controlled medication reconciliation sheet for Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) documented 38 tablets. Counted the actual pills stored in the locked compartment with LPN13 which documented only 37 pills. Reviewed R41's Medication Administration Record (MAR) with LPN13. R41's MAR did not contain documentation the medication was administered to the resident. LPN13 reported R41 was administered Oxycodone HCl 5 mg at 07:30 AM for the resident's complaint of a pain level, 5 out of 10. LPN13 confirmed she should have updated the Controlled Medication Reconciliation sheet when the medication was initially removed from the locked container and the administration should have been documented in the MAR but was not. Review of the facility's policy and procedure, Administration of Medications (Reviewed 09/16/2024) documented, .f. Right Documentation .Controlled substances should be signed out from the descending count sheet and documented on the MAR for each routine and PRN (as needed) dose of medication administered.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47783 Based on observation, record review and interview, the facility failed to monitor the temperature for the refrigerator and freezer to ensure the foods are stored in accordance with professional standards. The facility also failed monitor the disinfectant level for the dishwasher to ensure the dishes used to serve food were appropriately sanitized. This deficient practice placed all the residents in the facility at risk for possible foodborne illnesses. Findings include: On 09/22/24 at 10:01 AM, initial brief tour of the kitchen was conducted. Observed a document in a clear plastic sleeve on the wall between the walk-in refrigerator and freezer titled Refrigerator/Freezer Temperature Log. Month and year section of the log was blank but when asked [NAME] (C)6 if the log was for the current month, she said, Yes, it's for September. When asked how often they document the temperatures, C6 said, Twice a day. Observed missing entries for the morning checks on the following dates: 09/19/24, 09/20/24, and 09/21/24. Missing entries were also noted for the afternoon checks on the following dates: 09/11/24, 09/12/24, 09/18/24, and 09/19/24. Asked C6 what the importance is for checking the temperature, C6 said, To make sure the temperature is okay. On 09/22/24 at 10:13 AM, observed Dietary Aide (DA)7 loading the dishwasher. Observed a paper log a on the wall titled Low Temperature Dish Machine Log. Asked DA7 how often are they supposed to check and log the temperature and disinfectant level for the dishwasher. DA7 said three times a day when they use the machine. Asked DA7 if the dishwasher was used on the dates with missing entries on the log. DA7 said they use the dishwasher three times a day and the staff forgot to complete the log on those days. The log had missing entries for the following dates: 09/01/24, 09/02/24, 09/08/24, 09/09/24,.09/10/24, 09/15/24,.09/16/24, 09/17/24, 09/18/24, 09/19/24, 09/20/24 and 09/21/24. On 09/25/24 at 08:49 AM, an interview was conducted with the Nutrition Coordinator (NC) in the kitchen. NC confirmed that the staff are supposed to complete the refrigerator and freezer log twice a day, and the dishwasher log three times a day to ensure the temperatures and disinfectant levels are in range. Review of the facility policy titled Food Safety stated, . Temperatures are recorded at least twice daily on the Refrigerator/Freezer Temperature Log using an inside thermometer . any problems will be reported immediately . Review of the facility policy titled Sanitation and Maintenance stated, . The temperature and parts per million (PPM) of the sanitizer (50-100 ppm for chlorine) will be recorded on the Low Temperature Dish Machine Log a minimum of three times per day.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37954 Based on record review and interview the facility failed to assure two residents reviewed, of the 18 sampled, had accurate information placed in their Electronic Health Record (EHR). Review of R20's Advanced Health Care Directive (AHCD) found it was signed by the agent the resident had selected to be his decision maker and not by the resident. R2's physician documented resident as [AGE] years old over a three-year span, identified the resident as full code when he is a Do Not Resuscitate (DNR) and documented resident did not have any allergies when he is allergic to Clindamycin. The deficient practice puts all residents at risk if the resident's AHCD is not filled out correctly prior to it being utilized by the facility and resident's health status is not accurately documented by the physician. Findings Include: 1) On 09/23/24 during record review of R20's EHR found there is a copy of his AHCD which shows his agent, the person named as the one making healthcare decisions for R20 signed the form where R20 should have signed. On 09/24/24 at 12:05 PM, interviewed Administrator. Shared R20's AHCD was not signed by him instead was signed by his agent. Administrator reviewed AHCD for 20 and confirmed he should have signed the AHCD and not his agent. 2) On 09/24/24 during record review of R2's Electronic Health Record (EHR) found Practitioner Notes written by R2's physician stating resident as a [AGE] year-old male for all the provider notes he completed from 03/12/21 - 09/11/24. Physician also has documented in Practitioner Notes R2's Allergy List: No known medication allergies. No known allergies. but EHR lists Clindamycin as an allergy. R2's EHR also shows he is a DNR (Do Not Resuscitate) with Comfort Measures with a Physician Orders for Life Substantiating Treatment (POLST) filled out and signed by his guardian and physician on 02/17/21. R2's physician's last Practitioner Note dated 09/13/2024 lists resident's Code Status: Full Code. On 09/26/24 at 03:35 PM an interview was conducted with R2's physician who confirmed he had not updated R2's age as he got older, physician confirmed the software used to write the Practitioner Notes does not interface with Point Click Care (PCC) and the updates are not done automatically such as a resident's age or changes that are made in PCC such as the resident's allergies and code status. Physician stated these were errors he made.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47783 Based on observations, interviews, and record reviews, the facility failed to implement infection prevention and control measures when providing care for residents on isolation. The facility did not ensure that staff were wearing applicable personal protective equipment (PPE) when providing care to Resident (R)1, who was on Enhanced Barrier Precautions (EBP), and performing hand hygiene between glove changes. This deficient practice placed the residents at risk for the potential spread of infections and communicable diseases. Findings include: On 09/22/24 at 10:43 AM, observed a sign by the entrance of R1's room that stated, Enhanced Barrier Precautions . Everyone Must: . Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing . Transferring . Wound Care: any skin opening requiring a dressing . On 09/23/24 at 11:00 AM, observed RN (registered nurse) Care Manger (CM) and Certified Nursing Assistant (CNA)23 change the dressing to R1's open wounds to his back and buttocks. CM and CNA23 entered R1's room without wearing a gown. CM placed the supplies on the bedside table, performed hand hygiene and donned a clean pair of gloves. CM then removed the old dressing, assess the wound, removed her gloves and donned new gloves without performing hand hygiene. CM then cleaned the wound, applied a cream, measured the wound and changed gloves again without performing hand hygiene. After applying a new dressing to the wound, CM changed gloves again without performing hand hygiene and helped CNA23 change R1's clothes and transfer him from the bed to his wheelchair using the mechanical lift. Both CM and CNA23 were not wearing a gown. On 09/24/24 at 02:41 PM, an interview was conducted with the Infection Preventionist (IP) in her office. IP confirmed that both the CM and CNA23 should have been wearing a gown while changing the dressing, changing R1's clothes and transferring him to his wheelchair. IP added that staff were trained to perform hand hygiene with either the alcohol-based hand rub or soap and water after removing their gloves. Review of facility policy titled, Enhanced Barrier Precautions stated, . indicated for residents with the following: . Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized . Review of facility policy titled hand Hygiene stated, . perform hand hygiene (even if gloves are used) in the following situations: . After removing personal protective equipment (e.g., gloves, gown, eye protection, face mask) .

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 47783 Based on record review and staff interviews, the facility failed to ensure pneumococcal vaccine was offered to one of the five residents (Resident (R)1) in the sample. This deficient practice placed the resident at risk for acquiring, transmitting, and developing possible complications from pneumococcal disease. Findings include: Review of the Electronic Health Record (EHR) of R1 was conducted. Vaccination tab of the EHR had the records of all vaccines administered to the R1 including vaccines not given at the facility. Review of the vaccination records revealed that R1 has not received the pneumococcal vaccine. On 09/24/24 at 02:09 PM, a concurrent interview and record review was conducted with the Infection Preventionist (IP) in her office. Asked IP if there were any records or scanned documents in the EHR to show if R1 was given the pneumonia vaccine or if he declined the vaccine. IP was not able to find a consent or declination in the EHR and said will ask Administrator if there was one paper in the paper chart. On 09/24/24 at 03:29 PM, Administrator confirmed that R1 was not offered the pneumonia vaccine yet and will contact family representative to get consent. Review of the facility policy titled, Influenza Vaccine & Pneumococcal Vaccine Policy for Residents stated, . Each resident should be offered pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized .