STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125061	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kauai Care Center	9611 Waena Road Waimea, HI 96796

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 39754 Based on record review (RR), staff interview, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to ensure that information populated in the Minimum Data Set (MDS) was accurate for one of two residents sampled (Resident (R)51). R51's electronic health record (EHR) documented the resident was discharged home. Review of R51's discharge MDS documented the resident was discharged to an acute hospital. Failure to complete the MDS assessment accurately could potentially lead to missed opportunities for generating appropriate care plans and possibly not providing needed services, which could result in harm to the resident. Findings include: During record review of R51's discharge MDS, Assessment Reference Date 02/05/24, Section A Identification Information, A2105. Discharge Status, documented 04. Short-Term General Hospital (acute hospitals, IPPS) indicating R51 was discharged from the facility to acute hospital. Review of R51's progress notes documented R51 was discharged to home on 02/05/24. During staff interview on 04/04/24 at 12:30 PM, Executive Director confirmed R51 was discharged home and the resident's RAI, discharge MDS inaccurately documented the resident was discharged to an acute hospital. Executive Director stated that they would do the necessary correction. Review of the Long-Term Care Facility RAI 3.0 User's Manual read the following: The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20(b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status . In addition, an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations . As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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, interviews, and RR, the facility failed to revise the care plan for one of 14 residents sampled (R12). R12's care plan (CP) was not revised to include an updated oxygen administration order. R12's care plan did not include a new order to maintain R12's oxygen saturation be maintained between 88%-92%. Failure to revise care plans to reflect new orders could potentially lead to resident's not receiving appropriate nursing and medical care which has the potential to harm resident(s). Findings include: Cross Reference F-684: Quality of Care R12 is a [AGE] year-old female with diagnosis that include but not limited to severe persistent asthma, muscle weakness, acute and chronic respiratory failure, hypertension, pulmonary hypertension (increased blood pressure in the arteries of lungs, which causes shortness of breath, and swelling of legs), anxiety disorder, seizure disorder and gastrointestinal hemorrhage. On 04/01/2024 at 10:20 AM, observed R12 resting with her eyes closed, in the resident's assigned room. The resident's bed was against the wall. R12 was in a seated-position, perpendicular to the bed, with her back against the wall and feet hanging off the side of the bed and had several pillows behind her back which propped the resident up. Observed the resident receiving 3 liters of oxygen by nasal cannula via concentrator located at her bedside. On 04/04/2024 at 11:00 AM, observed R12 in the activity/dining area in a wheelchair at a table. The resident was receiving 3 liters of oxygen from a concentrator located next to her. While conducting an interview with R12 on 04/04/2024 at 11:15 AM, the resident stated she always uses the oxygen and cannot go without it. She was able to speak full sentences with mild shortness of breath. Reviewed R12's CP, which identified on 09/02/2023 she had Alteration in respiratory status r/t (related to) Asthma. Interventions included The resident has O2 via nasal prongs/mask @ 2-4L (liters per minute) continuously with humidifier, dated 09/02/2023. Reviewed R12's EHR. On 03/12/24, the Director of Nursing (DON) revised R12's oxygen administration order. The order summary documented, Oxygen: 2-3 liters per minute Delivery: cannula to keep sats between 88-92%, every shift for COPD (chronic obstructive pulmonary disease). Review of R12's CP documented it was not revised to reflect this order.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853 Based on observations, interviews, and RR, the facility failed to provide the needed care within the professional standards of practice that met the needs for three of 14 residents sampled (R8, R12, and R17). As a result of this deficient practice, all residents at the facility are at risk of the potential for harm due to not achieving their highest practicable physical, mental, and psychosocial well-being. Findings include: 1) R17 is a [AGE] year-old female transferred to the facility on [DATE]. Her diagnosis included, but not limited to Type 2 diabetes mellitus with diabetic chronic kidney disease, major depressive disorder, spinal stenosis, and morbid obesity. She is bedbound and uses a Hoyer lift with two staff assistance for transfers and positioning in bed. R17 is alert and oriented. Her active medications for diabetes management include Levemir Flex Pen subcutaneous 100 unit/ml (milliliters), 3 units in the evening, Novolog Flex Pen subcutaneous 100 unit/ml, 2 units before meals, Jardiance 10 mg (oral) every morning and Glimepiride (oral). On 04/01/2024 at approximately 11:30 AM, observed R17 lying comfortably in bed when the Charge Nurse (CN)11 came in to check her blood sugar (BS). Her BS sugar was 215. CN11 proceeded to give R12 her scheduled injection for diabetes. At that time, interviewed CN11, who said R17's BS was very unpredictable and often fluctuated over 200. Reviewed R17's Blood Sugar Summary for the month of March 2024. The results revealed R12's lowest BS was 145 on 03/03/2034, and the highest BS was 389, on 3/24/2024. It was not unusual for R17's BS to run over 200. Review of R17's lab results revealed her last hemoglobin A1C (tells average BS sugar over the past 2-3 months) was on 01/13/2023, which was resulted at 7.1%. RR of R17's Provider (P)1 notes dated 03/04/2024 revealed the plan for R17's diabetes included -Monitor A1C q (every) 6 (six) months if at goal /q 3 months if not at goal. Goal is less than or equal to 7.5% in the healthy elderly, and less than or equal to 8% in the [sic] those with multiple comorbidities, and less than or equal to 8.5% in the very complex/ill with limited life expectancy. On 04/04/2024 at 11:10 AM, during an interview and concurrent RR of R71's EHR with the DON in the nursing station, reviewed R17's provider note dated 03/04/2024. She reviewed R17's lab orders and results to confirm there had not been an A1C drawn since the note was written and the last time R17 had one done was 01/13/2023. The DON notified surveyor later she had contacted the provider to clarify the order, and confirmed the providers intent was to have an A1C drawn at the time she wrote the progress note, and then ongoing monitoring of A1C based on those results. The DON went on to say the provider stated she had given a verbal order to the nursing staff the day she wrote the progress note, but the staff failed to follow through with the order. The staff was no longer at the facility for interview. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) R12 is a [AGE] year-old female admitted to the facility on [DATE] for rehabilitation after hospital admission. She has been re-hospitalized twice since her admission. The last hospitalization was on 02/28/2024 for aspiration pneumonia. She returned to the facility on [DATE] to continue rehabilitation. R12 has extremity weakness and right shoulder pain. She does not ambulate independently due to unsteady gate and uses a wheelchair. R12 requires one person assist for dressing, toileting, bathing, and transfers. Her diagnosis includes, but not limited to severe persistent asthma, muscle weakness, acute and chronic respiratory failure, hypertension, pulmonary hypertension (increased blood pressure in the arteries of lungs, which causes shortness of breath, and swelling of legs), anxiety disorder, seizure disorder and gastrointestinal hemorrhage. R12 has chronic shortness of breath and uses oxygen (O2) continuously via nasal cannula. On 04/01/2024 at 10:20 AM, observed R12 sleeping in her room. The side of her bed was against the wall, and she was propped up with her back against the wall with several pillows and her legs were off the side of the bed. R12 was sleeping and was on 3 liters (L) of oxygen by nasal cannula via concentrator located at her bedside. Reviewed R12's O2 saturation (amount of oxygen in blood) level summary for March 2023, which revealed her oxygen saturation (sat) level was never documented to be below 95%. Reviewed R12's active orders, which revealed her oxygen administration order was revised on 03/12/2024. The new order read: Oxygen: 2-3 liters per minute Delivery: cannula to keep sats between 88-92% every shift for COPD (Chronic Obstructive Pulmonary Disease (O2 should be controlled due to risk of too much carbon dioxide in blood resulting in respiratory failure)) Cross Reference F-657: Care Plan Revision. R12's active CP included the intervention initiated on 09/02/2023 The resident has O2 via nasal prongs/mask @ 2-4L (liters per minute) continuously with humidifier. The CP was not updated to reflect the revised order of O2 at 2-3L to maintain O2 sat range of 88-92%. On 04/03/2024 at 10:30 AM, during an interview with the Resident Care Manager (RCM)1, outside R12's room, she said she frequently cared for R12. She said R12 had continuous oxygen and has not been tried to wean due to her chronic condition. She went on to say R12 becomes very anxious without her oxygen. RCM1 was asked to review R12's current oxygen order, and when confirmed the O2 sat range was to be maintained at 88-92%, she commented, But she's always over 96%. RCM1 also confirmed R12 did not have a diagnosis of COPD. She acknowledged she had not been aware of the specifics of that order and would contact the provider for clarification. On 04/04/2024 at 11:00 AM, during an interview with the DON, reviewed R12's oxygen order revised on 03/12/2024. The DON stated she was the one who reviewed the orders from the hospital when R12 was readmitted to the facility and entered them in the medical record. She said the process is to discuss the orders with the facility provider, confirm the orders and enter them as verbal orders. The provider would then sign off on the orders. The DON said she made an error and entered them incorrectly as prescriber written, which resulted in the order not being authenticated and signed by the facility provider. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RR revealed a new oxygen administration order for R12 was entered on 04/03/2024 at 07:00 PM by P1. The order read Oxygen 2-3 liters per minute: Delivery: cannula to keep sats above 90%. Directions every shift for Severe Asthma, SOB, or difficulty breathing. On 04/04/2024 at 11:00 AM interviewed R12 in the activities room/dining area. She was in her wheelchair (w/c) pulled up to a small dining table with the oxygen concentrator set at 3L, next to her. R12 said she uses the O2 all the time and does not take off. She was able to speak in full sentences. The revised oxygen administration order with restricted O2 sat range had been in place since 03/12/2024. The nursing staff failed to identify the order was not the standard of care because R12 did not have a diagnosis of COPD and should have notified the provider for clarification. 42160 3) During an interview with R8 on 04/02/24 at 09:30 AM, the resident informed this surveyor that she was feeling dizzy and activated the call light. Certified Nursing Aide (CNA)99 responded to the call light. The resident informed CNA99 that she was feeling dizzy. CNA99 replied, I will let the nurse know. On 04/02/24 at 02:43 PM, conducted a review of R8's EHR which documented, R8 was admitted to the facility on [DATE]. R8 has diagnosis which include, but are not limited to hypertension, hemiplegia and hemiparesis following a cerebrovascular disease affecting the left non-dominant side, Type 2 Diabetes Mellitus, and chronic migraines. Review of R8's most recent quarterly MDS with an ARD of 02/09/24, Section C. Cognitive Patterns, R8 has a Brief Interview for Mental Status (BIMS) scored of 13, indicating the resident's cognition is intact. Review of R8's physician orders documented an order to monitor the resident's blood glucose, document the results, hypo/hyperglycemia protocol, and an order for a sliding scale dose of insulin Aspart Flex Pen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart), to be administered subcutaneously before meals and at bedtime related to type 2 diabetes mellitus without complications and an order to monitor blood glucose. Review of R8's blood glucose levels documented prior to the resident reporting feeling dizzy, the most recent blood glucose level was taken on 04/01/24 at 05:52 AM, 92.0 mg/dL (milligram per deciliter). Following R8 reports of feeling dizzy at 09:30 AM, the resident's next blood glucose was completed at 12:41 PM (141.0 mg/dL). Review of the times nursing staff completed blood glucose checks indicated staff regularly did the checks four times a day. Review of R8's April 2024 medication administration record (MAR) documented CN11 did not document a blood glucose value or number of units administered to R8 on 04/02/24 at 06:45 AM. Review of R8's March 2024 MAR also documented on 03/19/24, staff did not document a blood glucose value or the number of units, if any, were administered to the resident for the 06:45 AM administration time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/24 at 11:52 AM, conducted a concurrent review of R8's EHR and interview with the DON. Informed the DON of the observation of R8 reporting to CNA99 of feeling dizzy and the missing blood glucose testing. DON reviewed R8's EHR and confirmed the resident's blood glucose level was not documented for the 06:45 AM administration time and there is no other place staff would document these values. DON reviewed R8's MARs (April and March), then confirmed on 03/19/24 and 04/02/24 at 06:45 AM, day-shift staff is responsible for this administration time, and staff did not carry out R8's physician's orders as prescribed by the physician. DON also confirmed the blood glucose value taken at 05:52 AM was not valid to be used for the 06:45 AM administration time due to the length of time between 05:52 AM and 06:45 AM, it would not be safe or a standard of practice to administer insulin an hour after the blood glucose level after it was taken. DON stated the expectation of staff is to take the blood glucose level immediately prior to administering insulin, then administer the insulin as prescribed by the physician. DON also confirmed staff should have taken a blood glucose reading to ensure the resident was not experiencing a hypo/hyperglycemic episode but did not. On 04/04/24 at 09:05 AM, conducted a follow-up interview with R8 in the resident's assigned room. R8 confirmed CN11 did not take the resident's blood glucose level on 04/02/24 at 06:45 AM as scheduled and did not take a blood glucose reading after she complained of feeling dizzy to CNA99.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 39853 Based on interviews, observation, and document review, the facility failed to meet regulatory requirement for having a designated Full-time (working 40 or more hours a week) director of nursing. The individual identified by the facility as the DON was also designated as the infection preventionist, and responsible for the Infection Prevention and Control Program (IPCP). As a result of the designated DON not being able to allocate 40 hours or more a week to oversee the nursing department, there is the potential the quality of care provided, and resident outcomes may be impacted and could affect all residents living at the facility. Findings include: The facility is licensed for 52 beds, Review of the facility assessment included: B.2. Acuity - Care Requirements (page (pg.)15): Staff/Personnel required: . DON . Infection Preventionist, . C.1. Cognitive - Care Requirements (pg. 18): Staff/Personnel required: .DON, . D.4. Cultural - Care Requirements (pg. 22) : Staff/Personnel required: .DON.Infection Preventionist. Reviewed the survey binder provided on entrance. The binder included documents related to infection prevention and control. The facility identified the DON as the Facility's Infection Preventionist. It also listed a facility Regional IP Consultant, (IPC)1. The binder included infection prevention training documents for the DON, IPC1 and five other individuals. These individuals later were identified by the DON and Administrator as corporate resources available to the corporate facilities. Reviewed a policy titled Infection Preventionist, revised date 10/2027. The Procedure included: 1. The facility Infection Preventionist will be identified by the Director of Nursing Services. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On the morning of 04/03/2024, conducted an interview with DON, also identified as the facility's IP, to review the facility's IPCP. DON stated her job roles is the current director of nursing and the infection preventionist. DON informed this surveyor of her intent to train a new registered nurse to assist her with the facility's IPCP. Inquired which staff are qualified to function as the infection preventionist and who were the individuals listed in the survey binder with completed infection preventionist training. DON replied, the individuals listed in the survey binder with completed infection preventionist training were corporate staff (not actual staff currently working as a registered nurse at the facility) and prior to her employment at the facility, a corporate staff was on-site as the infection preventionist and the others (in the survey binder) are corporate resources staff, consultants, as needed by the facility. DON stated the corporate resource staff also cover other infection preventionist positions, due to vacancy and vacations, at other facilities owned by the parent corporation. DON confirmed she is solely responsible for the facility's IPCP, and the duties are not shared with any corporate resource staff. DON stated corporate resource staff have access to the computer program used and will occasionally contact her to ask if she had seen something, but there is no delineation of duties. DON admitted to trying to maintain eight hours a day, Monday through Friday, 40 hours per week. When asked to estimate the amount of time she consistently spends on infection control, DON stated, 50 percent. On 04/04/2024 at approximately 12:30 PM, during an interview with the Administrator (ADM), confirmed DON has full responsibility for the IPCP program at the facility. ADM reported the facility has access to resources at corporate, but corporate resource staff do not complete any daily duties/tasks in an attempt to assist the DON in her role as the infection preventionist. The ADM confirmed the training documents in the survey binder were those of the corporate staff, and that there was no one else in the facility currently assisting the DON with IP duties. On 04/04/2024 at 10:30 AM, observed the CN11 drop a narcotic pill on the floor during a med pass. Because CN11 was the only licensed staff on the unit, she needed to request the DON's presence to waste the narcotic. Observed the DON assist with the process, witnessing the waste of the narcotic and the documentation. On 04/04/2024 at 12:00 PM, observed and interviewed the DON at the nursing station on Laulima. She confirmed she is covering the unit floor for the licensed staff who was at lunch. Due to the fact the facility has one licensed staff on each unit, the DON often needs to cover breaks and assist with tasks and resident care. Reviewed the job description of the Director of Nursing. The position summary read: The Director of Nursing will plan, organize, develop, and direct the overall operation of the facility's nursing department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, as may be directed by the Executive Director to ensure that the highest quality of care is maintained at all times. Essential Position Duties included, but not limited to: - The Director of Nursing (DNS/DON) is responsible for the delivery of nursing services to include planning, implementing, and evaluating the care plan of each resident to maximize resident quality of life and quality of care . (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- The Director of Nursing develops and evaluates with the health care team and Executive Director, resident care goals and policies in order to assure that adequate resources and services are provided to residents, reviews logs, and medical records on an ongoing basis ensuring the highest practicable care is being delivered. - Observes, mentors, and trains new and current staff . and holds staff accountable for duties assigned. - Perform other related duties as assigned. Reviewed the job description of the Infection Preventionist, last revised 8/7/2022. The position summary read: The Infection Preventionist evaluates the quality of resident care and outcomes as they relate to Healthcare Acquired Infections (HAI) and Community Acquired Infections (CAI) in accordance to Presents infection data and makes recommendations for actions. Monitors Employee compliance with infection control standards through . Prepares and presents education for the staff, residents, and families. Serves as a resource to all departments and personnel related to infection control practices. Essential Position Duties included, but not limited to: -Responsible for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services. -Responsible for collecting, analyzing, and providing infection data and trends to nursing staff and health care practitioners. -Identifying when and how isolation should be implemented for a resident including the type and duration of isolation, . -Accountable for surveillance of healthcare acquired and community acquired infections including outbreak investigates. -Adherence to the facility antibiotic stewardship. -Conduct routine facility rounds to evaluate staff compliance with hand hygiene, linen handling, standard precautions, transmission-based precautions, use of PPE, disinfection of reusable equipment, disposal of single-use items and appropriate aseptic technique. -Complete clinical reviews of documentation for newly prescribed antibiotics to ensure appropriate treatment, dose, duration, and indication .

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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 observation, interviews, and RR, the facility failed to ensure drug records are in order and an account of all controlled drugs is maintained and periodically reconciled. As a result of this deficient practice, there is the potential for diversion of controlled medication(s). Findings include: 1) On 04/03/24 at 09:21 AM, conducted a concurrent observations and interview of the controlled medication reconciliation for the medication cart with the RCM1. The facility implemented a Narcotic Count sheet (located in the medication cart binder) which is used by licensed nursing staff to document the reconciliation of controlled medication(s) between shift to account for all controlled mediations and to mitigate the diversion of controlled medications. Review of the facility's Narcotic Count sheet documented it was not signed/initialed on 04/01/24 and 04/02/24 for the On 0700-1900 and OFF 07/1900 portion of the sheet. Inquired with RCM1 regarding the blank portion of the Narcotic Count sheet. RCM1 confirmed the Narcotic Count sheet should have been signed with the off-going nurse and the on-coming nurse immediately after staff confirm the count of controlled medications listed on Narcotic Count sheet matches the actual count and both staff should initial/sign the form in the presence of each other, but staff did not initial/sign the Narcotic Count sheet. On 04/03/24 at 11:49 AM, conducted an interview with the DON. DON stated the Narcotic Count sheet is used to reconcile controlled medications between shifts, should be initialed/signed immediately after verifying the count is correct with another licensed nurse, and it should be initialed/signed in the presence of the licensed nurse the count was completed with as part of the facility's process to mitigate the diversion of controlled medications and confirmed staff did not implement the facility's procedure. DON stated the licensed staff responsible for not initialing/signing the Narcotic Count sheet was called in to sign it. Review of the facility's policy and procedure, Medication Administration, Controlled Substances, 01/23, documented the procedure, 7. At each shift change, a physical inventory of controlled medications, as defined by state regulations, is conducted by two licensed clinicians and is documented on an audit record. 2) On 04/03/24 at 09:25 AM, conducted a reconciliation of the narcotic medication for the medication with RCM1. RCM1 reported three residents was administered controlled medication(s) and the administration was documented on the electronic medication administration record (EMAR) but had not yet documented the administration on the resident's (individual) pharmacy count sheet (documents the count of the number/amount medication which should be stored in medication cart). RCM1 stated R41 was administered one tablet of Tramadol 50 mg, R5 received one tablet of Lacosamide 100 mg, and R30 was administered one tablet of Lorazepam 1 mg. All the controlled medications stored in the medication cart were reconciled and confirmed RCM1 did not sign the pharmacy count sheet for R41, R5, and R30 at the time the medication(s) were removed from the medication cart. (continued on next page)

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	125061	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kauai Care Center	9611 Waena Road Waimea, HI 96796

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/24 at 11:51 AM, conducted an interview with the DON regarding RCM not documenting the removal of the medication from the medication cart. The DON stated staff sign the pharmacy's count sheet after the resident takes the medication. Review of the facility's policy and procedure, Medication Administration, Controlled Substances, 01/23, documented the procedure, 4. When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record when removing dose from the controlled storage .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853 Based on interviews, observation, and RR, the facility failed to ensure a resident (R)12 is free from an unnecessary drug (antibiotic). R12 was prescribed an antibiotic (Levaquin) by a consultant at the time of an off-site office visit. Neither the prescribing consultant or facility provider documented adequate indications for the antibiotics use. As a result of this deficient practice, the antibiotic may be unnecessary and increase R12's resistance to antibiotics and put her at risk for adverse reactions to the medication. Findings include: R12 is a [AGE] year-old female with upper extremity weakness and right shoulder pain. She does not ambulate due to unsteady gate. R12 uses a wheelchair and requires one person assist for dressing, toileting, bathing, and transfers. Her diagnosis includes, but not limited to severe persistent asthma, muscle weakness, acute and chronic respiratory failure, hypertension, pulmonary hypertension (increased blood pressure in the arteries of lungs, which causes shortness of breath, and swelling of legs), anxiety disorder, seizure disorder and gastrointestinal hemorrhage. R12 has chronic shortness or breath and uses oxygen continuously via nasal cannula. On 04/01/2024 at 10:20 AM, observed R12 sleeping in her room. Her bed was against the wall, and she was sitting in the bed with several pillows behind her back propping her up with her back against the wall and legs off the side of the bed. She was sleeping and was on 3 liters (L) of oxygen (O2) by nasal cannula via concentrator located at her bedside. On 04/04/2024 at 11:00 AM, observed R12 in the activity/dining area in a wheelchair at a table. She had her oxygen on at 3L, with the concentrator next to her. On 03/26/2024, R12 went off site for a visit to a Pulmonologist. Reviewed the Pulmonologist hand written consult notes sent with R12 when she returned to the facility after the office visit. The notes included the following: Chief complaint: Shortness of breath and cough with green sputum. Findings, Assessment, Plan: + (positive for) wheezing, +edema, +JVD (jugular vein distention) . levaquin 500 mg. (milligrams) po (orally) daily x 10 days then D/C (discontinue). MD1's typed progress notes included: R12 is .here for follow up of shortness of breath. Since the last visit, R12 was hospitalized with pneumonia twice, the [sic] had Covid infection. She has a cough with green sputum, but has no hemoptysis (coughing up blood). She reports no aspiration symptoms . Past medical history included asthma. Assessment and Plan: Shortness of breath with hypoxia (below normal level of oxygen in your blood), with persistent symptoms in a patient with severe pulmonary restriction and reactive airway disease. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ROS (review of systems) included: No recent fever or chills. Visit Diagnosis included shortness of breath, uncomplicated severe persistent asthma, and hypoxemia. The Pulmonologist did not order a diagnostic chest x-ray or a culture and sensitivity prior to the start of the antibiotic. RR revealed R12 had the order for the antibiotic placed on 03/27/2024. The order summary read Levaquin Oral Tablet 500 mg (levofloxacin). Give 1 tablet by mouth one time a day for PNA (pneumonia) for 10 days. Reviewed R12's care plan, which revealed revisions on 03/27/2024 after the visit with pulmonologist. The Focus was ABT (antibiotic therapy) r/t (related to PNA (pneumonia). The goal included: Resident will have no adverse reaction from antibiotic therapy use. During an interview with the Infection Preventionist (IP), she said the facility uses the McGeer Criteria for Infection Surveillance. The IP said, although the licensed staff do not use a form or checklist, the criteria is posted in the nursing station. R12 had not been identified by the staff as having a potential new infection based on the McGeer criteria. The IP said she was familiar with R12, the antibiotic order, and said the pulmonologist did not want a chest x-ray or sputum culture and sensitivity (C&S) to identify the most effective antibiotic), but that the facility had done a C&S. The facility uses exception charting, which is a method of medical notation in which nurses only document notes if there are deviations from a patient's norm or baseline. Review of R12's nursing progress notes from 03/20/2024 to 03/26/2024, revealed there were no entries of deviation from R12's baseline. There were no notations of increased cough or colored sputum. Her oxygen saturation remained at baseline (96-99%) and there was no fever, increased respirations, or changes in her mental or functional status. On a second interview, the IP said she had been mistaken, and that on further investigation, the facility provider had given a verbal order for the sputum C&S, but nursing did not record or complete the test. The IP (DON) said she was trying to reach the Pulmonologist to inquire what the indications were for the antibiotic, and if there was a diagnosis of infection. The IP confirmed there was no diagnosis of pneumonia documented. RR revealed R12's last chest x-ray was taken on 02/28/2024 for shortness of breath. The findings included There are increased reticular opacities in both lungs (comparison chest x-ray 11/27/2023 and CT 12/14/2023.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 42160 Based on an interview and document review, the facility failed to establish a water management program as part of an infection prevention and control program to prevent the transmission of disease associated with water-borne pathogen. The facility was unable to demonstrate its measures to minimize the risk of Legionella and other water borne opportunistic pathogens in building water systems in a documented water management program. This program must be based on nationally accepted standards and include an assessment to identify where Legionella and other water borne pathogens could grow and spread and measures to prevent the growth of opportunistic water borne pathogens and how to monitor for pathogens. As a result of this deficiency, resident are potentially at risk for infections related to water-borne pathogens. Findings include: Definition of Legionellosis refers to two clinically and epidemiologically distinct illnesses: Legionnaires' disease which is typically characterized by fever, myalgia, cough, and clinical or radiographic pneumonia; and Pontiac fever, a milder illness without pneumonia (e.g., fever and muscle aches). Legionellosis is caused by Legionella bacteria. Legionella can grow and multiply in a building's water system, water containing Legionella can spread in droplets small which individuals can breathe in and develop Legionnaires' disease or Pontiac fever. On 04/04/24 at 11:36 AM, conducted a concurrent interview and RR with the Maintenance Staff (MS)3. Inquired with MS3 regarding the facility's water management program for facility assessment of the building's water system and potential areas Legionella can grow and multiply and how the facility monitors for Legionella water system and areas identified in the assessment. MS3 reviewed the facility's maintenance binder, then confirmed the facility did not complete an assessment of the building's water system and does not have a plan for monitoring the water system for the presence of Legionella and other opportunistic water-borne pathogens. MS3 stated he/she was unaware that facility needed to complete an assessment of their water system and monitoring for Legionella and other water-borne pathogens.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 39853 Based on observations, interviews and document review, the facility did not ensure the wrist blood pressure (BP) patient care monitor was used according to manufacturer's recommendations. Specifically, the monitor is recommended for in-home use only. To ensure accuracy, it should be used according to manufacturer's guidelines. This has the potential to affect any resident that had their BP taken with the wrist monitor. Findings include: On 04/03/2024 at 10:10 AM, observed a wrist blood pressure (BP) monitor on the top of the medication cart. At that time interviewed the Resident Care Manager (RCM), who was administering medications. She said they keep the piece of equipment on the cart and use it to check resident BP prior to administering hypertension medications with range limits. The unit is used on multiple residents and wiped down between residents. On 04/04/2024 at 10:00 AM, observed CN11 use the wrist BP monitor on R5 prior to administering her BP medication. On 04/03/2024 at 11:20 AM, during an interview with DON, inquired what the manufacturers recommendations were for use and cleaning the wrist strap. She stated they wipe down the monitor and strap after each use. DON said she thought the units were old and had not purchased any since she was hired. Request make for manufacturer guidelines. The DON provided the wrist blood pressure user guide which she located on the Internet at approximately 02:30 PM, later that day. The wrist blood pressure monitor (Model MDS4003) was manufactured by Medline Industries. Review of the User Guide dated 2019, included the following: Page 4: Indications for Use .It is intended for adult in-home use only. Page 6: Page titled Caution. Bullet one: This device is intended for adult, in-home use only. Bullet two: The device is not suitable for use on . patients with implanted electronic devices, patients ., premature ventricular beats, atrial fibrillation, peripheral, arterial disease and patients undergoing intravascular therapy . Page 7: .To verify the calibration of the automated sphygmomanometer, please contact manufacturer. Page 8: It is recommended that the performance should be checked every 2 years and after maintenance or repair. There was no process in place to check the performance of the wrist blood pressure monitor according to manufacturer's guidelines.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 42160 Based on observations and interviews, the facility failed to ensure a safe environment for residents, staff, and the public. Observation of the facility's industrial dryers used by the facility documented the lint traps were not cleaned and the facility's formed used to document staff cleaned the lint traps was blank, indicating staff did not clean it. Interviews with staff confirmed the environment was unsafe for residents, staff, and the public due to the fire hazard of the amount of lint contained in both industrial dryers. Also, the facility is physically located in a dry and hot climate which would make it easier for the fire to spread and affect the residents, staff, and public resulting in Findings include: On 04/04/24 at 11:24 AM, conducted a concurrent interview and inspection of the facility's laundry room and services with the Housekeeping/Laundry Supervisor (HLS). At 11:29 AM conducted an inspection of the lint traps for two of three industrial dryers used by the facility (the third dryer was out of order). HLS opened the bottom panel (where lint in collected) of dryer (D)1. As HLS opened the panel, lint was immediately observed due to a portion of the lint was partially connected to the opened panel. The entire lint screen was covered with lint which was approximately half an inch thick. HLS opened the panel for D2, there was lint on the bottom of the dryer and the entire lint screen was covered with lint which was approximately one inch thick and contained lint on the bottom of the dryer. HLS confirmed the lint catch for both dryers should have been cleaned because it is a fire hazard but had not been cleaned. At 11:31 AM, Laundry staff (LS)71 entered the laundry room, informed this surveyor he/she was not currently working in the laundry room on this day, but worked in the laundry room yesterday (04/03/24). LS71 stated the lint portion of the dryer should be cleaned after each use, because the lint can cause a fire and the facility climate the of the county is dry and hot, which would allow the fire to spread to surrounding structures quickly. At 11:33 AM, LS4 entered the laundry room and confirmed he/she was working in the laundry room this shift. LS4 initially stated the lint was being cleaned from the dryer after each use and was informed by HLS that both dryers were not cleaned and there was lint. Reviewed a form posted on the dryer which is used by staff to document when staff cleaned the lint with HLS, LS71, and LS4. HLS stated there is a form on the dryer that staff are supposed to sign/initial as an attestation that the lint trap of the dryers were cleaned. HLS, LS71, and LS4 reviewed the lint trap cleaning form and confirmed on 04/03/24 and 04/04/24, responsible staff did not sign/initial the form, indicating the dryer's lint trap had not been cleaned on those days.