STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Islands Skilled Nursing & Rehabilitation	1205 Alexander Street Honolulu, HI 96826

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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** Based on observations, interviews, and record review, the facility failed to ensure the right to a dignified existence for four of 15 sampled residents (Resident (R)19, R9, R13 and R16) was protected. Specifically, staff were standing over R9, R13 and R16 while assisting them with their meals, and R19's urinary catheter bag was not covered. These deficient practices placed the residents at risk of embarrassment, decreased enjoyment of their environment, and decreased psychosocial well-being with potential negative effects such as decreased social interaction and social isolation. Findings include: 1) On 04/27/25 at 11:52 AM, observed Certified Nurse's Aide (CNA)9 assist R9 with lunch. R9 was in bed, supine position with head elevated. CNA9 placed the meal tray on the bedside table that was on the right side of the bed. CNA9 was positioned with the bedside table on her left and R9's bed on her right. CNA9 was standing over R9 as she assisted him with his meal. 2) On 04/27/25 at 11:56 AM, observed CNA11 assist R13 with his pudding and thickened juice. R13 was in a supine position in bed with the head elevated. CNA11 was standing over R13 as she assisted him with his meal 3) On 04/27/25 at 12:05 PM and 04/28/25 at 07:38 AM, observed CNA11 assist R16 with his meals. Both days, R16 was in bed with his head elevated and CNA11 was standing over him while assisting him with his meals. Review of facility policies titled Meal Supervision and Assistance and Promoting/Maintaining Resident Dignity conducted. Both policies did not mention if staff need to be sitting with the residents or be at eye level when assisting with their meal. On 04/29/25 at 03:56 PM, a concurrent interview and record review was conducted with the Interim Director of Nursing (IDON) in the conference room. Reviewed policy for promoting dignity and assisting residents with meals. IDON acknowledged that both policies do not include instructions for the staff to be sitting with the resident or be at eye level when assisting them with their meal. IDON added that the staff take into account the preference of the resident. When asked if all the residents are able to communicate their preference, IDON said, The staff just stand, that's how the staff do it. (continued on next page)

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	4) On 04/27/25 at 10:19 AM, initial screening of the residents was being conducted. Observed R19 lying in bed with head slightly elevated and turned to her right facing the door. R19 had a urinary catheter connected to a collection bag that was hung on the right side of the bed and was visible from the hallway. The collection bag did not have a privacy cover. Review of R19's Electronic Health Record (EHR) was conducted. R19 was admitted to the facility on [DATE] for long-term placement. Diagnoses included but not limited to hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction (stroke) and aphasia (loss of ability to communicate). Under Orders, with a start date of 11/17/24, Foley - Ensure Foley Catheter Privacy Bag is in Place. On 04/29/25 at 04:28 PM, an interview was conducted with IDON in the conference room. IDON confirmed that all urinary catheter collection bags are to be in a privacy cover at all times.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to provide a clean and homelike environment. Observed a buildup of dust on the back of the ceiling mounted televisions in five rooms. As a result of this deficient practice, there is the potential to cause adverse health conditions to the residents and affect their overall mood and psychosocial well-being. Findings include: On 04/27/25 at 10:39 AM, initial screening of the residents was being conducted in room [ROOM NUMBER]. Observed back of ceiling-mounted television for Resident (R)2 had a buildup of dust. Upon closer inspection of all four televisions in the room, observed all had a buildup of dust on the back and on the wires connected to them. Asked R2 how often the staff clean the backs of the television. R2 said he has not seen any staff clean them. On 04/27/25 at 10:47 AM, screened two residents in room [ROOM NUMBER] and observe the back of both televisions in the room with a buildup of dust. Both residents in the room had a tracheostomy (breathing tube inserted into an opening created in the windpipe through the neck). On 04/27/25 at 12:03 PM, observed the back of the ceiling mounted televisions in rooms 302, 303 and 305 had a buildup of dust. Residents in rooms [ROOM NUMBERS] had a tracheostomy. Pictures were taken of the back of the televisions. On 04/29/25 at 04:31 PM, an interview was conducted with the Administrator and Interim Director of Nursing (IDON) in the conference room. Asked Administrator how often the contracted housekeeping staff clean the rooms. Administrator said they come everyday to service the rooms. When asked if high dusting is included in the service agreement, Administrator said, Yes. Showed Administrator and IDON pictures of the back of the televisions taken on 04/27/25, both acknowledged that there was a buildup of dust, and it should be cleaned more often. Administrator added that the Environmental Services Supervisor (EVS) oversees the contracted housekeepers and would know more details on the cleaning schedule. On 04/30/25 at 06:49 AM, an interview was conducted with EVS in the conference room. Showed EVS pictures of the back of the televisions taken on 04/27/25. EVS acknowledged there was a build up of dust. EVS said the housekeepers perform high dusting once a month but were not able to do this task recently because they do not have a duster with a long handle to reach the back of the televisions.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to accurately assess one (Resident 18) of four residents reviewed for limitations of range of motion. The deficient practice puts the resident at risk of not having an accurate assessment and proper treatment to maintain his range of motion. Findings Include: Record review of R18's Electronic Health Record (EHR) on 04/28/25 revealed he is [AGE] years old, admitted to the facility on [DATE] and his diagnoses include, but are not limited to, dysphagia, oropharyngeal phase; type 2 diabetes mellitus without complications; unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; and tracheostomy status. Review of R18's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/14/24 revealed under section GG - Functional Abilities and Goals was coded as 0 - No impairment to his upper and lower extremities. Review of R18's MDS with ARD of 12/22/24 shows R18 was coded as 2 -Impairment on both sides of his upper and lower extremities. Review of R18's MDS with an ARD of 03/24/25 under section GG - Functional Abilities and Goals was coded as 2 impairments of both sides of R18's upper and lower extremities. On 04/30/25 at 10:16 AM Interviewed Certified Nurse Aide (CNA)5 who was assigned to work with R18. Inquired if CNA performs passive range of motion with R18 and CNA5 stated R18 is able to help when he turns on his right side. On 04/30/25 at 10:41 AM interviewed off site MDS Coordinator on the phone. Inquired about R18's coding for MDS with ARD of 06/21/24, 12/22/24 and 03/24/25 with change in R18's section GG - Functional Abilities and Goals was coded as 2 impairments of both sides of R18's upper and lower extremities for 12/22/24 and 03/24/25. Inquired why when the resident is able to assist turning on his right side. MDS coordinator stated she did not do the 12/22/24 assessment and will pull this information and review it and provide surveyor with an answer. On 04/30/25 at 01:10 PM Administrator delivered a copy of the explanation supplied from the MDS Coordinator for R18's coded impairments. MDS Coordinator reviewed R18's MDS with ARD of 12/22/24 section GG 115. Functional Limitations Range of motion and reported based on gathered information for this ARD coding appears to be correct. MDS coordinator reviewed R18's MDS with ARD of 03/24/25 and wrote Discussion with Therapy Department r/t (related to) review which indicates (per the reading of their notes). Impaired strength to both sides/ upper extremities. No contractures. Rt Arm with Impairment in ROM (range of motion). Lt Arm w/o/ impairment. Upon review this appears to be an coding error on the MDS and should have been coded as = 1 (Impairment on one side). MDS Modification of the ARD: 03/24/25 to correct coding - completed 04/30/25. Care plan for this resident has been updated .

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a baseline care plan for Resident (R)33's hyperglycemia (high blood sugar) and use of insulin to control it. The deficient practice could affect all the residents at the facility receiving insulin if a baseline care plan is not developed and implemented to provide effective and person-centered care. Findings Include: On 04/27/25 at 01:58 PM a family interview was conducted at R33's bedside. Inquired if R33 is receiving insulin and Family Member (FM) stated yes he started receiving insulin and his blood sugars have been good. Inquired if resident is diabetic and FM stated no that he started getting insulin when he was in the hospital. Record review of R33's Electronic Health Record (EHR) revealed he was admitted to the facility on [DATE] and his diagnoses included, but not limited to, shock, unspecified, cardiac arrest, cause unspecified, and tracheostomy status. Review of R33's list of diagnoses, in his EHR, did not reveal a diagnosis of diabetes mellitus or hyperglycemia. Review of R33's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/14/25 did not show a coded diagnosis of diabetes mellitus or hyperglycemia. The MDS did reveal R33 was coded as getting insulin for the past 7 days since admission under section N. - Medications. Review of R33's medication orders showed an order for Insulin Glargine Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 12 unit subcutaneously two times a day for DM which was ordered on 04/07/25. Review of R33's care plan, that was initiated on 04/07/25, did not find a baseline care plan for diabetes mellitus, hyperglycemia and use of insulin to control blood sugar levels. On 04/29/25 at 03:23 PM interviewed Interim Director of Nursing (IDON) in the conference room and asked if a resident is receiving insulin if they would have a diabetes diagnosis and she confirmed this. Inquired about R33 as he does not have a diagnosis of DM. IDON looked at R33's EHR and stated she will investigate this and get back to surveyor on this matter. On 04/29/25 at 03:47 PM a phone interview was conducted with the IDON. IDON stated she found R33's doctor's note that states resident is receiving insulin for hyperglycemia. Shortly afterwards, at 03:50 PM IDON came to the conference room and shared R33's attending physician's note. Concurrent review of the note provided revealed it was R33's admission History and Physical Note dated 04/08/25. R33's attending physician wrote under Assessment/Plan (R73.9) Hyperglycemia Plan: no hx (history) DM. On Lantus 12u (units) bid (twice a day) on TF (tube feeding). Accuchecks (blood sugar tests) under 150's. Continued review of R33's EHR with IDON. Inquired if R33 had a diagnosis of hyperglycemia or DM on his list of diagnosis page and IDON confirmed she did not see it listed on resident's diagnosis page. Inquired if R33 had a baseline care plan for hyperglycemia and use of insulin to control R33's blood sugar levels and IDON denied this.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review and interview the facility failed to develop and implement comprehensive person-centered care plan (CP) for two of 20 residents sampled for care plan review, Residents (R) 3 and 14. 1. R3 did not have a CP to address his need for bed rail use and interventions to keep him safe. 2. R14 did not have a CP to address his declining Range of Motion (ROM) and interventions that would be used such as Range of Motion exercises to maintain his ROM. Findings Include: 1) On 04/27/25 at 12:13 PM observed R3 lying in his bed and noticed his upper right bed rail was not on the bed. Inquired of Environmental Services Manager (ESM) if he knew where the bed rail was and he said he would search for it, stated he thinks resident's wife removed it. On 04/28/25 at 01:30 PM ESS notified surveyor staff found R3's bedrail in his bathroom and put it back on his bed. On 04/29/25 at 04:32 PM observed R3 in his bed and both side rails were on his bed. Record review of R3's Electronic Health Record (EHR) on 04/30/25 revealed R3 had a signed Bed Rails Consent form to use bed rails. Review of R3's CP found there was nothing for bed rail use. On 04/30/25 at 02:10 PM a phone interview was conducted with the Interim Director of Nursing (IDON). IDON confirmed R3 did not have a CP for bed rail use and she said she will add it to the CP. 2) Review of R14's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/25/24 revealed resident was coded as having no impairment to his upper extremities and has an impairment to his lower extremities. Review of R14's MDS with an ARD of 01/25/25 states resident has an impairment to resident's upper and lower extremities. 04/29/25 04:01 PM interviewed IDON in the conference room, and asked who does Range of Motion (ROM) with residents and she stated if the resident has therapy they will do with Physical Therapy (PT) or Occupational Therapy (OT) otherwise it's with the Certified Nurse Aides (CNAs). IDON stated it is stretching and moving the arms and legs, Passive Range of Motion when CNAs are changing the residents clothes or moving them in bed , there is no set number of exercises. Reviewed R14's CP with IDON and she confirmed there was nothing in R14's CP that addresses his ROM needs. On 04/30/25 at 11:39 AM IDON came to the conference room to share the intervention was added to R14's CP today to Provide gentle range of motion as tolerated with daily care. by Rehab Director because Rehab Director told IDON she forgot to add it to the CP. IDON confirmed this should have been added previously.

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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. Based on record review and interview the facility failed to follow Resident (R) 22's care plan and facility policies/protocols for the prevention/treatment of skin breakdown for one resident of three resident sampled for pressure ulcer/injury. The deficient practice puts the residents at risk for worsening of a pressure ulcer. Findings Include: Record review of R22's MDS with an ARD of 09/20/24 revealed resident was coded for a stage 3 pressure ulcer (PU) that was facility acquired. R22's PU is now coded as a stage 4 PU in the MDS with an ARD of 12/21/24 and continued to have the stage 4 PU for the MDS with an ARD of 03/19/25. Review of R22's care plan revealed she had the following Follow facility policies/protocols for the prevention/treatment of skin breakdown. which was initiated on 05/31/24 and last revision done on 04/10/25. On 04/29/25 at 04:01 PM interviewed Interim Director of Nursing (IDON) in the conference room and reviewed the turning logs for R22. On R22's Turning Schedule Log for 04/21/25 and 04/23/25 at 1 PM R22 was documented on her right and at 3 PM was documented on her right. On 04/22/25 at 1 PM R22 was documented on her left and at 3 PM R22 was documented on her left. IDON confirmed the staff should have turned the resident. IDON did state R22's fiance also moves the resident and that might be why the resident was documented on the same side.

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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** Based on observation and interview the facility failed to provide an environment free of accident hazards for one of one residents sampled for Accident Hazards, Resident (R) 3. R3's upper right bed rail was removed from his bed which staff were unaware of. This deficient practice could put all residents at the facility, who are dependent upon staff for care, and have bed rails at risk for accidents. Findings Include: On 04/27/25 at 12:13 PM observed R3 resting in his bed. At this time noticed R3's upper right bed rail was missing from his bed. Inquired with Environmental Services Supervisor (EVS), who happened to be in the hallway outside of R3's room, where R3's bed rail could be. EVS went to R3's bed and confirmed the bed rail was missing and stated he would search for it and stated he thinks R3's wife removed it. Record review of R3's Electronic Health Record (EHR) revealed he was admitted to the facility on [DATE] with diagnoses that included, but not limited to, personal history of malignant neoplasm of brain (cancerous brain tumor), dependence of supplemental oxygen, other reduced mobility, contracture of muscle (occurs when your muscles, tendons, joints, or other tissues tighten or shorten causing a deformity) multiple sites, and tracheostomy status. Review of R3's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/22/25 revealed under section GG - Functional Abilities and Goals R3 has impairments of range of motion to both his upper and lower extremities, is totally dependent on staff for his personal hygiene and movement. Continued record review found R3 has a signed Bed Rails Consent form which states the possible benefits is *Prevention of falls which might result in injury or death. On 04/28/25 at 08:24 AM observed R3 resting in is bed with both upper bed rails up on his bed. On 04/28/25 at 01:30 PM EVS notified surveyor staff found R3's bed rail in his bathroom and put it back on his bed.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on staff interviews, record review and review of policy, the facility failed to act on a Pharmacist Medication Regimen Review (MRR) recommendation for one resident (R) 2 of five residents sampled for Unnecessary Medication Review. As a result of this deficiency, the facility put R2 at risk for complications related to medications. Findings include: Review of Electronic Health Record (EHR) revealed R2 admitted with diagnosis including Paraplegia, Depression, Anxiety, Hypertension, Pulmonary Embolism. Current medications Apixaban (to prevent blood clotting), Mirtazapine (for depression), Morphine Sulfate (for pain), Oxycodone (for pain), Sertraline (for depression). Review of Pharmacist MRR dated 02/28/25, read please consider the following labwork: Primidone level, Phenobarbital level, Magnesium level. There was no documentation that showed this was communicated to the physician. Staff interview on 04/30/25 at 02:20 PM, Interim Director of Nursing (IDON) acknowledged that the recommendation previously mentioned was not communicated to the physician. IDON said that during that time, the Director of Nursing position was vacant and the MRR was not communicated because of that. Facility policy on Medication Monitoring, Medication Regimen Review and Reporting read; Policy, MRR of Drug Regimen Review is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes review of the medical record in order to prevent, identify, report and resolve medication-related problems, medication errors or other irregularities. The MRR also involves collaborating with other members of the IDT, including the resident, their family, and/or resident representative . The consultant pharmacist reviews the medication regimen and medical chart of each resident at least monthly to appropriately monitor the medication regimen and ensure that the medications each resident receives are clinically indicated. Identification of irregularities may occur by the consultant pharmacist utilizing a variety of sources including medication administration records, prescriber's orders, progress notes, nurse's notes, the Resident Assessment Instrument, Minimum Data Set, laboratory and diagnostic test results, behavior monitoring information and information from the nursing care center staff and other health professionals involved in the resident's care . Resident specific MRR recommendations and findings are documented and acted upon by the nursing care center and/or physician . The nursing care center follows up on the recommendations to verify that appropriate action has been taken. Recommendations should be acted upon within 30 calendar days of per facility specific protocols .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 2) On 04/29/25 at 08:13 AM observed medication cart two near nurse's station with keys left unattended in a disposable cup on top of the medication cart. Inquired of Registered Nurse (RN) 7 if the medication cart keys are supposed to be left on the medication cart and she stated, they told us to put them there. Inquired of RN7 who she meant and she stated manager. Inquired if RN7 is supposed to keep the keys on herself and she stated no that they were told to put the keys near the cups on top of the medication cart or the side of the cart near the medication cups and hide them. Inquired if the set of keys includes the narcotic key and she confirmed it does. Inquired of RN7 if she knew what the facility policy states regarding medication cart keys and she stated she had not seen it. At this time reviewed the medication cart Narcotic Endorsement Log and found there were two blank slots for 04/13/25 when the oncoming nurse for 0700-1900 shift and off going nurse for 1900-0700 shift did not initial confirmation of reconciliation of narcotic count. Inquired of RN7 why this occurred and she stated someone did not sign. On 04/29/25 at 12:05 PM interviewed Interim Director of Nursing (IDON) at the nurse's station on the second floor. Inquired if the medication cart keys are to be kept with the nurse or left on the medication cart and IDON stated with the nurse. Requested a copy of facility's policy on medication administration. Review of facility policy titled Narcotic & Pain Patch that was reviewed on 02/26/25 states Policy: It is the policy of this facility to maintain records of all narcotic and pain patches at the time of receiving in the facility until destruction. Policy Explanation and Compliance Guidelines: . 3. Both nurses will sign the shift change log verifying the count is accurate at the time of reconciliation. 4. Medication cart keys are to be kept with the RN at all times. 3) On 04/29/25 at 08:36 AM medication cart check was done with RN7, near the nurse's station. Observed a vial of Humulin R insulin that was labeled it was opened on: 01/23/25 and to discard by: 02/23/25. Showed the label to RN7 who confirmed the medication should have been thrown away. RN7 stated R5 has not been given it in awhile because her sliding scale is in good control. RN7 stated she checked the refrigerator and there was no refill of this medication for R5 and she would have to contact the pharmacy to get a new one. Record review of R5's medication administration record revealed she had been given 4 units of Humulin R insulin at 0600 (06:00 AM) on 04/09/25, 04/10/25 and 04/12/25 when her blood sugar was between 201-250. Based on observations, interviews and record reviews, the facility failed to: 1. Ensure all medications and blood glucose testing supplies were labeled in accordance with professional standards. Proper labeling is necessary to promote safe administration practices and decrease the risk for medication errors. Proper labeling of blood glucose testing supplies is necessary to ensure the efficacy of the supplies used to test the blood glucose meter for accuracy. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Assure only authorized personnel had access to the medication cart keys and assure nurses were doing the change of shift count of narcotics at the end of each shift and signing the narcotic endorsement log after it was reconciled. 3. Dispose of insulin for one resident, Resident (R) 5, by the discard date. These deficient practices have the potential to affect all residents in the facility. Findings include: 1) On 04/29/25 at 08:46 AM, inspected medication cart two with Registered Nurse (RN)5. Observed glucometer (device used to measure glucose in the blood), test strips and control solutions that were kept in the top drawer of the cart. Both control solutions and test strips canister did not have a label with the open and discard dates. Asked RN5 how often do they test the glucometer for accuracy and function. RN5 said they test it once a day and it is done by the night shift staff. When asked if the test strip and control solutions in the cart were being used to test the glucometer, RN5 said, Yes. Asked RN5 if she can tell when the test strips and control solutions were opened, RN5 inspected them and confirmed she was not able to since they were not labeled. RN5 added she will discard them and get a new set. Review of the glucometer user's guide stated, . Record the date on the bottle when opening a new bottle of control solution. Discard any unused control solution three months after the opening date . For vial test strips, records the date on the bottle when you open a new bottle of test strips. Discard any unused test strips six months after opening.

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	125067	A. Building B. Wing	04/30/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure the ice machine was kept in clean and sanitary condition in accordance with professional standards for food service safety. This deficient practice placed the residents at risk for foodborne illness. Findings include: On 04/27/25 at 09:10 AM, initial tour of the kitchen was conducted with Kitchen Manager (KM). Opened door to ice machine and observed a grayish-green buildup under the area where ice is dispensed. KM acknowledged that the ice dispenser had a buildup of a grayish-green residue. Used a dry paper towel to wipe the area and was able to remove some of the residue. KM said the ice machine was recently serviced on 03/31/25 by an outside vendor but did not notice the buildup under the dispenser. KM presented log where monthly inspection of the ice machine is documented, next service is scheduled on 04/30/25. KM said he will ask the staff to clean the dirty dispenser today and add this task on the weekly log.

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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** Based on record review and interview the facility failed to correctly fill out an accurate Physician Orders for Life Sustaining Treatment (POLST) for one of three residents reviewed for Advance Directives, Resident (R) 18. Findings Include: Record review of R18's Electronic Health Record (EHR) revealed he was admitted to the facility on [DATE] and his diagnoses include, but not limited to, dysphagia, oropharyngeal phase, type 2 diabetes mellitus with other skin complications, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and tracheostomy status. Continued record review revealed R18's EHR did not have an Advanced Health Care Directive appointing an agent as his Power of Attorney to make health care decisions should he become unable to. Review of R18's POLST, that was prepared on 06/18/24, revealed under section D Signatures and Summary of Medical Condition, the Legally Authorized Representative (LAR) box was marked with an X. Instructions stated, If LAR is checked, you must check one of the boxes below: and Agent designated in Power of Attorney for Healthcare was marked with an X. On 04/28/25 at 04:05 PM requested a copy of R18's Advanced Health Care Directive (AHCD) from Administrator. On 04/29/25 at 12:22 PM Administrator provided a copy of facility admission form that R18 or his representative signed stating they do not wish to complete an Advanced Directive and do not wish to complete a POLST at that time dated 06/15/24. On 04/29/25 at 01:48 PM interviewed Social Worker (SW) in her office. Inquired if R18 had an AHCD and SW confirmed R18 did not have an AHCD. Inquired about R18's POLST that states R18's wife is his Agent designated in Power of Attorney for Healthcare. SW reviewed R18's POLST and stated this was a mistake that Surrogate selected by consensus of interested persons (Sign section E) box should have been marked. Review of POLST revealed R18's wife had signed section E per POLST instructions. Inquired of SW for a copy of R18's surrogate form and letter from his doctor identifying resident as not have capacity to make his own health care decisions. SW stated she did not have this. Inquired if the facility has a process in place for this type of situation, when a surrogate would need to be named to make health care decisions for the resident without capacity and SW stated the facility does not have a process in place for initiating a surrogate for the residents if/when this is needed. SW confirmed R18's wife is not his Healthcare POA as checked off on his POLST and she stated she would work on getting it fixed with the resident's wife.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review and interview the facility failed to submit their staffing information based on payroll data for direct care staffing (including information for agency and contract staff) for fiscal quarter 3 of 2024 (April 1 - June 30), to the Center of Medicare and Medicaid Services (CMS) on the schedule specified by CMS. Findings Include: Review of the CMS Payroll-Based Journal (PBJ) Staffing Data Report [NAME] Report 1705D for fiscal year Quarter 3 of 2024 (April 1 - June 30) revealed the facility Triggered for Failed to Submit Data for the Quarter which states Triggered = No Data Submitted for Quarter. On 04/30/25 at 02:30 PM an interview was conducted with the Administrator and Interim Director of Nursing (DON) in the Administrator's office. Inquired if the facility had submitted the required staffing information based on payroll data to CMS. Administrator stated there were two instances when the facility was not able to submit the PBJ information on time and he stated once you miss the deadline you are not allowed to turn anything in.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 5) On 04/27/25 at 11:10 AM observed R31 resting in his bed. At this time observed R31's indwelling urinary catheter tubing and urinary bag, which was covered with a privacy bag, resting on the floor next to R31's bed. Record review of R31's Electronic Health Record revealed he was admitted to the facility on [DATE] and his diagnoses include, but are not limited to, chronic pulmonary edema, persistent vegetative state and neuromuscular dysfunction of bladder, unspecified. Review of R31's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/25/25 revealed he was coded for having a urinary catheter and he is totally dependent upon staff for his care. On 04/30/25 at 02:18 PM a phone interview was conducted with the Interim Director of Nursing (DON). Inquired if it was okay for residents with a urinary indwelling catheter and the urinary bag to rest on the floor. Interim DON confirmed nothing of the Foley (urinary indwelling) catheter system should be resting on the floor. Based on observations, interviews, and record reviews, the facility failed to implement infection prevention and control measures when providing care for residents. The facility did not ensure that staff perform hand hygiene between glove changes and wearing applicable personal protective equipment (PPE) when providing care to a resident on Enhanced Barrier Precautions (EBP). The facility failed to assure one of two residents sampled for Urinary Catheter or UTI, Resident (R) 31, had their indwelling urinary catheter tubing and urinary bag which was covered with a privacy bag were kept up off of the floor. This deficient practice placed the residents at risk for the potential spread of infections and communicable diseases. Findings include: 1) On 04/27/25 at 09:36 AM during the initial screening of residents, observed Licensed Practical Nurse (LPN)1 administer medications to R136. LPN1 was wearing a gown, gloves and mask as she entered the room and placed the medications to be administered on the bedside table. LPN1 administered eye drops, removed gloves and donned a new pair of gloves. LPN1 did not perform hand hygiene prior to donning new pair of gloves. LPN1 then administered the rest of R136's medications though his gastrostomy tube (feeding tube surgically placed through the abdomen into the stomach). 2) On 04/29/25 at 11:50 AM, observed Registered Nurse (RN)5 change the dressing to R12's pressure ulcer to buttocks. RN5 gathered all the supplies needed for the dressing change and placed them on the bedside table with a barrier. RN5 was wearing gloves, gown and a face mask. After removing the old dressing, RN5 discarded it into the trash can that was next to the bed, removes her gloves and donned a new pair of gloves. RN5 did not perform hand hygiene between glove change. Review of facility policy titled Hand Hygiene stated, . The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. On 04/29/25 at 03:56 PM, and interview was conducted with the Infection Preventionist (IP) in the conference room. IP confirmed the staff are trained to perform hand hygiene between glove changes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) On 04/27/25 at 09:57 AM, observed LPN1 administer medication to R12 through her gastrostomy tube. R12 was on EBP due to the use of a gastrostomy tube. LPN1 placed the medications on the bedside table, checked the gastrostomy tube placement, and administered medication. LPN1 had gloves on but was not wearing a gown. 4) On 04/27/25 at 12:23 PM, observed LPN1 flushing R19's gastrostomy tube after the feeding formula was completed. R19 was on EBP for the use of a gastrostomy tube. LPN1 had gloves and mask on but was not wearing a gown. Review of facility policy titled Enhanced Barrier Precautions stated, Enhanced barrier precautions . employs targeted gown and gloves use during high contact resident care activities. for residents with any of the following . indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes . even if the resident is not known to be infected or colonized . care activities include . Device care and use . On 04/29/25 at 03:56 PM, an interview was conducted with the IP in the conference room. IP confirmed that staff are to wear gown and gloves when administering medications to a resident with a gastrostomy tube.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, staff interview and policy review, the facility failed to keep record of dryer lint removal and cleaning. As a result of this deficient practice, the facility did not show that there was any dryer lint removal and/or cleaning being done. Findings include: During observation of the dryer lint traps on 04/30/25 at 10:00 AM, observation was done mid-cycle, and the lint traps had a thin layer of lint. Staff interview on 04/30/25 @ 10:05 AM, Environmental Services Director (EVS Dir) revealed that they recently stopped keeping record of dryer lint removal and cleaning but later said that they would start to keep the records again. Review of facility policy on Laundry read; Policy, the facility launders linens and clothing in accordance with current CDC guidelines to prevent transmission of pathogens . Laundry equipment will be used and maintained according to manufacturer's instructions . Dryer vents will be checked daily to ensure lint is removed properly and completely. Dryer vents are washed monthly .