STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125069	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hale Ola Kino by Arcadia	1314 Kalakaua Ave Second Floor Hon, 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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on observation, interview, and record review, although informed of concerns regarding an unsafe transfer and poor positioning in bed, the facility failed to identify and document the verbalized complaint as such, and failed to provide a prompt resolution of the complaint/grievance for one resident (Resident 131) and his family representative(s). As a result of this deficient practice, the resident experienced a decreased quality of life, feeling as if the concerns he and his family representatives voiced were not being taken seriously, or acknowledged. This deficient practice has the potential to affect all the residents at the facility who voice a concern. Findings include: Resident (R)131 is a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that include, but are not limited to, unspecified convulsions, left hemiplegia [paralysis on one side of the body] and left hemiparesis [one-sided muscle weakness] following a stroke, and constipation. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125069	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2024
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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/04/24 03:37 PM an interview was done at the bedside with R131 and his family representative (FR)1. Both reported that the first Sunday after being admitted (02/11/24), R131 was transferred from bed to a shower chair for a shower, but it didn't go well. FR1 described how the certified nurse aide (CNA)12 who initially tried to do the mechanical lift transfer alone seemed like he did not have a lot of experience with this type of transfer. He did not prepare R131 for the transfer by explaining the process before or during the procedure, and R131 was very scared. In addition, R131 stated that he felt that CNA12 was rough with him, describing the incident as he [CNA12] likes to push and shove. FR1 stated that the transfer seemed very unsafe, and after the shower was done, CNA12 and another CNA hand carried R131 back into bed in a manner that seemed equally unsafe. Dropping R131 perpendicularly (short-ways) onto the bed before he was properly positioned parallel (long-ways) to the bed. FR1 reported that again, CNA12 seemed inexperienced for this type of transfer. Observation of R131 at this time noted that he is quite tall. FR1 confirmed the observation by stating that R131 is over six feet tall, and his long legs made the transfer(s) even more frightening for them. FR1 continued on to explain that they complained to the Director of Rehab [Rehabilitation] (DOR) about the incident the next day. FR1 also stated that the Minimum Data Set Coordinator (MDSC)1 (who serves as the Admissions Coordinator, and in the absence of a Social Services Designee, acts as the Grievance Officer), spoke to them approximately a week after the incident. When they brought the incident up with him, MDSC1 appeared to blow it off, telling them, Well, we need to review some processes, but offered no apologies, explanations, or assurances that the matter would be looked into. Both FR1 and R131 agreed that they did not feel the incident was properly addressed or resolved, explaining that it felt like the facility had tried to say the incident was their fault for stating upon admission that R131's preference was to shower instead of having a bed bath. On 03/06/24 at 09:30 AM, a review of the Grievance Log for 2024, and a concurrent interview with the Administrator-in-Training (AIT), who also served as the Director of Nursing, confirmed that there was no documentation of R131's or his representative's complaint which had been verbalized and/or discussed with DOR and MDSC1. On 03/06/24 at 12:07 PM, an interview was done in the Therapy Room with DOR. DOR stated that after R131 and his representative(s) complained about the incident to her, she immediately reported it to the Hospitality Coordinator (HC) so that R131 could be taken off of the shower schedule. In addition, DOR reported that she also mentioned it in stand-up [staff meeting], but they [administrative staff and direct care staff] already knew. On 03/07/24 at 07:36 AM, during an interview with MDSC1 in the Breakroom, MDSC1 confirmed that while R131's representatives did bring the incident up with him, he did not document the discussion anywhere. A review of the facility's policy on Grievance Management, revised 1/2023, revealed the following: 1. Any complaint may be directed to any staff member . who will assume responsibility for communicating the complaint to the appropriate individual for timely investigation and resolution. A review of the facility's undated Grievance Management Guidelines noted the following: The administration documents and investigates all grievances/complaints to ensure reasonable satisfaction and accommodation and to improve services where necessary or practical.

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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** 38870 Based on interview and record review, the facility failed to develop and implement a person-centered comprehensive care plan for one Resident (R)82 of four in the sample. R82's care plan was generalized, written as the resident instead of resident's name; the interventions for pain management were not followed as written on the care plan. The deficient practice placed the resident with ineffective pain control, cross reference (cr) to F697 pain management. Findings include: R82 is a [AGE] year-old male admitted to the facility on [DATE] for rehabilitation services after suffering from a fall with a lumbar fracture, cr to F697 pain management. Electronic health record (EHR) reviewed. Minimum data set (MDS) with Assessment reference date (ARD) 02/26/2024 reviewed. Active Diagnoses: Includes musculoskeletal wedge compression fracture of third lumbar vertebrae. Other low back pain and muscle weakness. Section J - Health Conditions: Pain Assessment interview. Pain Presence- Yes. Pain frequency: 2. Occasionally. Pain intensity: 2. Moderate. Care plan reviewed. Focus: Alteration in comfort related to acute Pain/ chronic Pain - wedge compression fracture of lumbar three vertebra. Complaint of generalized pain. Low back pain. Goal: Resident will report satisfactory pain control. The following interventions/tasks were not implemented for R82: -Assist as needed to reposition for comfort .assessment of pain: characteristics of pain; location, severity on a scale of 1-10, type, frequency, precipitating factors, relief factors frequency, including as needed. -Offer analgesics according to physician order. Acetaminophen. Medication administration record (MAR) and pain log reviewed simultaneously, see F697 pain management. Acetaminophen 325 mg Give two tablets by mouth every four hours as needed for generalized pain. Was not documented as given on 03/01/24 to 03/06/24. Review of the pain log revealed that the pain level and non-pharmacological interventions were not documented. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the director of nursing (DON) and MDS Nurse on 03/07/24 at 08:14 AM in the staff break room. The surveyor asked the following questions about pain management: How are the nurses ensuring the residents interventions for pain management are being followed? When are they expected to rate the resident's pain on the pain scale, is it when they encounter the resident, do an assessment, or give medications? The DON stated that the nurses rate the resident's pain when they make their observations with the resident. They look at the resident and if the resident looks like they're in pain, they will document the pain level and can medicate them. They don't normally ask them what their pain level is on the pain scale. The residents who are receiving physical therapy are pre-medicated and the pain level is measured based on how they are able to participate in therapy.

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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** 43245 Based on interview, and record review, the facility failed to adequately monitor, care plan, and manage, an elevated risk of constipation for 1 of 1 resident (R131) sampled. As a result of this deficient practice, Resident (R)131 experienced abdominal discomfort and difficulty defecating. This deficient practice has the potential to affect all the residents at the facility at risk of constipation. Findings include: Resident (R)131 is a [AGE] year-old male admitted to the facility on [DATE] with admitting diagnoses that include, but are not limited to, unspecified convulsions, left hemiplegia [paralysis on one side of the body] and left hemiparesis [one-sided muscle weakness] following a stroke, and constipation. On 03/05/24 at 09:18 AM, during an interview with R131's Family Representative (FR)1, FR1 reported that R131 had hard stools that he has difficulty pushing out every time he goes. FR1 continued on to explain that R131 had felt constipated the other day and had asked for a suppository, but was told that it was only for no bowel movements after three days. A review of R131's nursing progress notes revealed a Clinical Admission note from 02/06/24 at 04:05 PM, documenting Constipation noted. Date of last BM [bowel movement]: 02/01/2024. Despite this, and an admitting diagnosis of constipation, review of R131's electronic health records revealed he was not started on a routine medication for constipation until 02/20/24. Stimulant laxative plus [with stool softener] tablet . one tablet . two times a day for constipation . This medication was increased to two tablets two times a day on 02/28/24. Further review of R131's medication orders revealed the following as needed medications for constipation: 02/06/2024 Lactulose Solution, 15 ml (milliliters) as needed for constipation. May administer if no BM [bowel movement] in 3 days. 02/06/2024 Bisacodyl Suppository, 10 MG (milligrams) One suppository rectally for constipation, to be used as needed if Lactulose is ineffective. Review and reconciliation of medication administration record (MAR) and point-of-care log for bowel movements noted Lactulose had been administered on 02/15/24 despite a bowel movement documented on 02/14/24. In addition, although the Lactulose had only been administered once since admission, the Bisacodyl suppository was documented as given on 02/20/24 and 02/27/24 despite bowel movements documented on 02/19/24 and 02/25/24. On 03/06/24 at 09:18 AM, an interview was done with the Director of Nursing (DON) outside her office. When asked about the facility's bowel protocol regarding problems with constipation, the DON stated the facility has no bowel protocol because each doctor has their own treatment preferences. DON continued on to state that staff should be following whatever the doctor's orders are. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/07/24 at 09:33 AM, a review of R131's comprehensive care plan noted no care plan initiated specifically for the constipation problem identified on admission. It had been added into an Alteration in Comfort care plan beneath acute pain/chronic pain related to rhabdomyolysis (a condition where muscle tissue breaks down often resulting in muscle aches) and gout (a form of arthritis that causes severe pain), and c/o [complaints of] generalized pain, which listed constipation and abdominal pain. The care plan referenced the as needed medications but was not revised when the routine medication (laxative plus stool softener) was added on 02/20/24 or when it was increased on 02/28/24.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on observation, interview, and record review, the facility failed to ensure residents were free from accidents hazards, both in the Therapy Room, as evidenced by Resident 23 sustaining an injury on an exposed end of the wooden parallel/balance bars, as well as during transfers for Resident 131. This deficient practice has the potential to affect all residents using the Therapy Room or requiring assistance during transfers. Findings include: 1) Resident (R)23 is a [AGE] year-old female admitted on [DATE] with admitting diagnoses that include, but are not limited to, unspecified convulsions, history of syncope (fainting) and collapse, unspecified pain and shortness of breath, muscle weakness, and difficulty in walking. On 02/08/24, the facility conducted a Brief Interview for Mental Status (BIMS) exam and found R23 to be cognitively intact with a score of 15 out of 15. On 03/04/24 at 09:13 AM, during an interview with R23 at her bedside, observed she was wearing a geri sleeve skin protector on her left forearm. When questioned about it, R23 removed the geri sleeve to reveal a wound, approximately 1.5 inches in diameter, covered with four steri-strips that varied in length. R23 stated that she obtained the wound when she slipped while using the wooden balance bars in the Therapy Room, skinning herself on the exposed end approximately 2 weeks ago. R23 stated it is very dangerous; they need to cover it up. On 03/04/24 at 10:47 AM, observations were done in the Therapy Room. Wooden parallel bars noted in the corner of the small and cluttered room. The parallel bars were made up of two square lengths of wood with edges that were rounded at the lengths but not on the uncovered ends. On 03/06/24 at 11:55 AM, reviewed the injury report for R23's left forearm injury, which occurred on 02/24/24. On the injury report, Registered Nurse (RN)4 documented, Per resident said skin tear is sustained while in the therapy room by the parallel bar . Area is approximately 8x3 cm [centimeters] . On 03/06/24 at 12:06 PM, an interview was done in the Therapy Room with the Director of Rehab (DOR) and Physical Therapist (PT)2. DOR stated that she was not present when R23's injury occurred, but she had heard about it. Believed R23 had injured herself on the length of the bar. PT2 reported that he was the therapist working with R23 at the time, and that R23 had been doing sit-to-stand exercises at the end of the parallel bars when he tried to boost her up in her wheelchair because she was slipping down. PT2 described how he had instructed R23 to let go of the railing/parallel bar, but she didn't listen, so when he boosted her up, she scratched her arm on the bottom corner of the end of the left railing/bar. DOR stated that she was not aware that was how the injury happened. PT2 confirmed that RN4, who had completed the injury report, was not present when the injury occurred, nor did she ask PT2 how it happened. Concurrent observation of the parallel bars at this time noted that the ends remain exposed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/07/24 at 07:15 AM, observations in the Therapy Room confirmed that the ends of the parallel bars remained exposed and unprotected. On 03/07/24 at 07:27 AM, an interview was done in the Break Room with the Director of Nursing (DON) and Minimum Data Set Coordinator (MDSC)1. When asked why R23's injury report was completed by someone who was not a witness to the incident, DON answered that is not part of the process right now [to get an injury report from the staff who witnessed]. Both agreed that in this case, it would have been helpful to know exactly how the injury occurred so that actions could have been taken to ensure further injuries did not occur in a similar fashion. 2) Resident (R)131 is a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that include, but are not limited to, unspecified convulsions, left hemiplegia [paralysis on one side of the body] and left hemiparesis [one-sided muscle weakness] following a stroke, and constipation. On 03/04/24 03:37 PM, an interview was done at the bedside with R131 and his family representative (FR)1. Both reported that the first Sunday after being admitted (02/11/24), R131 was transferred from bed to a shower chair for a shower, but it didn't go well. FR1 described how the certified nurse aide (CNA)12 who initially tried to do the mechanical lift transfer alone seemed like he did not have a lot of experience with this type of transfer. He did not prepare R131 for the transfer by explaining the process before or during the procedure, and R131 was very scared. In addition, R131 stated that he felt that CNA12 was rough with him, describing the incident as he [CNA12] likes to push and shove. FR1 stated that the transfer seemed very unsafe, and after the shower was done, CNA12 and another CNA hand carried R131 back into bed in a manner that seemed equally unsafe. Dropping R131 perpendicularly (short-ways) onto the bed before he was properly positioned parallel (long-ways) to the bed. FR1 reported that again, CNA12 seemed inexperienced for this type of transfer. Observation of R131 at this time noted that he is quite tall. FR1 confirmed the observation by stating that R131 is over six feet tall, and his long legs made the transfer(s) even more frightening for them. A review of R131's Physical Therapy Evaluation, done by PT2 on 02/06/24, revealed that regarding R131's functional mobility assessment for chair-to-bed and bed-to-chair transfers, R131 had been assessed as Dependent, meaning requiring 100% assistance or 2 or more helpers for transfer. A review of R131's Occupational Therapy Evaluation, done by DOR on 02/06/24, revealed that regarding R131's Functional Skills Assessment for transfers, R131 had been assessed as Total Assist, meaning requiring 76-99% assistance. On 03/07/24 at 11:30 AM, an interview with DOR was done in the Therapy Room. When asked about his PT/OT evaluations, DOR agreed that given R131's PT Dependent and OT Total Assist determinations, she would not have recommended any transfers be attempted without therapy staff present. DOR confirmed that there were no therapy staff present when CNA12 transferred R131 out of bed and back on 02/11/24, and they were not consulted about R131's mobility status prior to the transfer attempt. A review of the facility's policy on Safe Lifting and Movement of Residents, revised on 01/26/24, revealed the following: Manual lifting of residents shall be eliminated when feasible. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing staff, in conjunction with rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. A review of CNA12's training record for the past year revealed he had not completed the Transferring Safely training component. In addition, it was noted that CNA12's mechanical lift transfer competency was completed on 04/16/23 (almost a year ago), and did not specify which of the 2 very different mechanical lifts the facility used CNA12 had been tested on . On 03/07/24 at 07:36 AM, an interview was done with DON in the Break Room. DON confirmed that CNA12 had not completed all of his required trainings in the past year, including Transferring Safely. When asked about his hours, DON reported that CNA12 only works on the weekends.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38870 Based on observation, interview and record review, the facility failed to recognize and evaluate when the resident experienced pain; and manage pain consistent with the comprehensive assessment, the plan of care, current professional standards of practice, and the resident's goals for one resident (R) 82 in the sample. R82's pain level was not consistently evaluated by the nursing staff, and analgesics were not available to the resident as ordered by the physician. The deficient practice resulted in increased pain for R82. Findings include: R82 is a [AGE] year-old male admitted to the facility on [DATE] for rehabilitation services after suffering from a fall that resulted in a lumbar fracture. During an observation on 03/04/24 at 11:05 AM in R82's room who was observed sitting in the Geri chair next to his bed. The surveyor asked him how he was doing today. R82 stated terrible when I was living at home, I slipped and fell on the floor on my tailbone. I have a fracture in my spine and went to the hospital for a while then came over here. I am able to walk with a therapist and walker. I don't think I have the mobility to move on my own, I have a lot of pain. The surveyor asked him if he is getting any medication for his pain. R82 said, when I call them, they bring a pill. They aren't giving it regularly, and only when I request it. When it hurts. I have to request it. I think I'm going to need to go home with more medicine. Random observations of license practice nurse (LPN)4 providing care for R82 on 03/05/24 between 08:45AM and 11:00 AM. Did not observe LPN4 asking R82 what his pain level was. Observation on 03/06/24 at 08:32 AM, observed R82 sitting in his wheelchair in his room at the bedside with the breakfast tray on his table. None of the breakfast on the tray had been eaten except for a few bites of fruit. When asked how you are this morning, with a frown he stated, I'm not very good. Observation on 03/06/24 at 09:36 AM observed licensed practice nurse (LPN)1 take R82's blood pressure and turn to walk out of the room. Noted that LPN1 did not ask R82 about his pain level. The physical therapist (PT) walked into the room with another resident and asked if LPN1 could give R82 his pain medication prior to his PT appointment. Electronic health record (EHR) reviewed. Minimum data set (MDS) with assessment reference date (ARD) 02/26/2024 reviewed. Active Diagnosis: Includes musculoskeletal wedge compression fracture of third lumbar vertebrae. Other low back pain and muscle weakness. Section J - Health Conditions: Pain Assessment interview. Pain Presence- Yes. Pain frequency: 2. Occasionally. Pain intensity: 2. Moderate. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care plan reviewed, cross reference to F656 develop/ implement comprehensive care plan . Focus: Alteration in comfort related to Acute Pain/ Chronic Pain - Wedge compression fracture of third lumbar vertebra. Complaint of low back pain. Registered nurse (RN) Interventions/ Tasks; evaluate pain. Establish a pain management treatment plan. Offer analgesics according to physician order. Acetaminophen. Medication administration record (MAR) and pain log reviewed simultaneously: R82 received the following routine pain medications/ analgesics on the following dates: -Lidocore External Patch to back daily at 0600 on 03/01/24 to 03/06/24. -Oxycodone oral tablet 2.5 milligram (mg) 1 hour prior to therapy on 03/01/24, 03/02/24, -03/03/24,03/06/24. the following as needed analgesics: -Acetaminophen 325 mg Give 2 tablets by mouth every 4 hours as needed for generalized pain was not given on 03/01/24 to 03/06/24. Review of the pain log revealed that the pain level and non-pharmacological interventions were not documented. Interview with the director of nursing (DON) and MDS Nurse on 03/07/24 at 08:14 AM in the staff break room. The surveyor asked the following questions about pain management: How are the nurses ensuring the residents interventions for pain management are being followed? When are they expected to rate the residents pain on the pain scale, is it when they encounter the resident, do an assessment, or give medications? The DON stated that the nurses rate the residents pain when they make their observations with the resident. They look at the resident and if the resident looks like they're in pain, they will document the pain level and can medicate them. They don't normally ask them what their pain level is on the pain scale. The resident's who are receiving physical therapy are pre-medicated and the pain level is measured based on how they are able to participate in therapy. During an interview with the staff development manager/infection preventionist (SDM/IP) on 03/07/24 at 10:47 AM. The surveyor asked how do the nursing staff evaluate and monitor the resident for presence of pain? The SDM/IP responded; they rate the pain level on the pain log. During an interview with LPN4 on 03/07/24 at 2:30PM the surveyor asked how pain management is conducted for residents who have pain. She responded that we ask the resident what the pain level is every shift and give the resident the medication. Normally they won't ask a resident what the pain level is for a routine order. Reviewed the facility pain management guideline (No revision date). General guidelines. The pain management program is based on .commitment to appropriate assessment and treatment of pain, based on professional standards of practice .3. Pain management is a multidisciplinary care process that includes the following: Recognizing the presence of pain .Identifying and using specific strategies for different levels and sources of pain. Monitoring the effectiveness and modifying approaches, as necessary.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on observation, interview, and record review, the facility failed to adequately assess for and identify past traumas experienced by 1 of 1 residents (Resident 132) sampled for Trauma-Informed Care. As a result of this deficient practice, Resident 132 did not have her triggers identified, placing her at increased risk of re-traumatization, and was hindered from attaining her highest practicable mental and psychosocial well-being. Findings include: Resident (R)132 is a [AGE] year-old female admitted on [DATE] with admitting diagnoses that include, but are not limited to pain, muscle weakness, difficulty in walking, and history of falling. On 02/28/24, the facility conducted a Brief Interview for Mental Status (BIMS) exam and found R132 to be cognitively intact with a score of 15 out of 15. On 03/05/24 at 08:18 AM, during an interview with R132 at her bedside, she described how she was experiencing post-traumatic stress from the incident(s) that took her to the hospital and then here to the skilled nursing home. R132 shared that immediately prior to being hospitalized and subsequently transferred here, she experienced terrifying visual and auditory hallucinations of people cutting her open, and digging around in her insides. As she described the traumatic event, R132 was visibly upset, clenching her eyes tightly closed at some points, her hands shaking, and her voice trembling. After she arrived at the facility, R132 stated that a staff member came in who looked like one of the people who cut her open, and I got so scared I thought I was going to have a heart attack! R132 continued on to state that she finds the background noise on the staff walkie-talkies to be unnerving and startling to her at times as well. She couldn't explain why, but it reminds her of her terrifying dreams. When asked if anyone at the facility had spoken to her about traumatic events in her life before, R132 stated, no. A review of R132's electronic health record (EHR) notes a Trauma Informed Care Assessment completed by Minimum Data Set Coordinator (MDSC)2 on 02/28/24. The assessment consists of two questions. If the resident answers no to question 1, the second question is not asked. R132's assessment has no marked as the answer to question 1. On 03/06/24 at 10:55 AM, an interview was done with MDSC2 in the Break Room. MDSC2 confirmed that in the absence of a social services designee, she usually conducts the trauma-informed care assessment as part of the admission process. Stated that she usually reads question 1 directly off the paper, but does not always read all of the examples given. MDSC reported that she does not remember R132's assessment specifically, but knows that she did it. On 03/06/24 at 01:50 PM, during an interview with R132 at her bedside, R132 repeated that she does not remember any staff member asking her about any traumatic events since she was admitted . Stated that if anyone had, she would have answered yes, because that [the hallucinations] was SO traumatic! (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/07/24 at 08:39 AM, during an interview at her bedside, R132 stated that she has been having nightmares related to her hallucinations. Reported that she had one last night, not as bad as hallucinations but scary just the same.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 43245 Based on observation, interview, and record review, the facility failed to ensure staff competency in safe transfers and perineal care (peri care) for two residents in the sample (Residents 131 and 13). This deficient practice placed the residents at risk for avoidable injuries and decreased quality of care, and has the potential to affect all the residents at the facility requiring assistance with transfers and/or peri care. Findings include: 1) Cross-reference to F689 Accident Hazards. Based on interview and record review, the facility failed to ensure staff were trained for safe transfers as evidenced by an unsafe transfer of Resident (R)131 placing him at risk for avoidable injuries. 2) On 03/04/24 at 03:21 PM, observations were done of Certified Nurse Aide (CNA)11 performing perineal care (peri care) on Resident (R)13 after a bowel movement in her adult incontinence brief. After donning a pair of gloves, CNA11 prepared to clean R13 with two dry 4x4 disposable cloths and one 4x4 disposable cloth moistened with water. As he wiped her gluteal fold, CNA11 was observed having difficulty wiping with the dry cloths as they were not moving smoothly across the skin. When asked if R13 had a peri bottle (to be filled with warm water and used for rinsing), CNA11 answered that although the facility did have them, R13 did not. As CNA11 rolled up the dirty brief to move it out from under her, a piece of R13's stool rolled out of it onto the disposable bed pad. CNA11 picked up the feces in his right gloved hand and threw it into the trash can. Wearing the same gloves, and with his right hand, CNA11 proceeded to grab three additional disposable cloths from R13's bedside cabinet, which he used to finish wiping her perineal area. Still wearing the same gloves, CNA11 put a clean brief on R13, positioned a pillow under her knees, grabbed her sheet and blanket, and was about to pull them up over R13 when Surveyor reminded him that he should change gloves when going from dirty to clean, and pointed out that he had transferred feces onto R13's sweatshirt with his dirty gloves. CNA11 apologized, doffed the dirty gloves, and donned a new pair with no hand hygiene in between. CNA11 then proceeded to change R13's dirty sweatshirt. Surveyor asked where the alcohol-based hand rub was located, CNA11 pointed to the dispenser by the door. Surveyor reminded him about hand hygiene between glove changes, CNA11 apologized and stated he forgot. On 03/06/24 at 12:48 PM, an interview was done with the Infection Preventionist (IP) in the Break Room. IP stated that she is also responsible for staff development and does all the training. After sharing the peri care observation with her, IP confirmed that CNA11 should have used only moistened 4x4s to clean up feces, should have changed his gloves when going from dirty to clean, and should have performed hand hygiene before and after the procedure in addition to between glove changes.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 43245 Based on observation, interview, and record review, the facility failed to implement a food and hydration program that recognizes and addresses the preferences of each resident. This is evidenced by a failure to provide fresh water throughout the day, despite repeated requests, to one resident (Resident 132), and a failure to offer and provide an alternate menu item when residents found their meal tray unappetizing. This deficient practice has the potential to affect all residents at the facility. Findings include: 1) On 03/04/24 at 09:56 AM, a concurrent observation and interview was done with Resident (R)132 at her bedside. R132 eating her breakfast, stated that last week when she went to the bathroom her urine was very dark like that [pointing to color of the brown bedside table] and burned. When she reported it, she was told she needed to drink more water. Water pitcher on the bedside table noted to be completely empty. At 11:36 AM, observation made that R132's water pitcher still completely empty. R132 stated that she did ask for water several times and was told by multiple staff members that they would bring it, but no one has provided it yet. At 12:11 PM, observed R132 eating lunch, her water pitcher still empty. R132 reported that she had one small cup of water on her lunch tray and asked again for her water pitcher to be filled but no one had returned to do that yet. Surveyor went out to the hallway to find staff to provide water. Found Licensed Practical Nurse (LPN)4 across the hall in front of a medication cart. When asked who was able to provide water to the residents, LPN4 responded that the Certified Nurse Aides (CNAs) are responsible to get water for the residents. When asked if they don't have water, how can a resident get water? LPN4 responded, from the pantry. LPN4 did not ask or seem concerned with which resident might need water. When Surveyor returned to the room to speak to R132, she also reported that once she did not like what she was served for her meal, stating, How do I know I won't like it until I get it, and she asked for saimin. Staff member told her that it was too late, she had to pre-order/pre-select the alternate menu items. R132 stated that is not what her understanding was regarding the alternate menu. On 03/06/24 at 09:02 AM, observed R132 eating breakfast with her water pitcher standing empty on her bedside table. R132 reported that it was last filled yesterday afternoon after she specifically asked for it to be filled. On 03/06/24 at 10:04 AM, an interview was done with the Dietary Supervisor (DS) outside the Administrator's office. When asked about the process of ordering from the alternate menu, DS stated that the alternate menu is available at all times, and no resident should be told no or that it was too late to order. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/06/24 at 02:00 PM, observed R132's water pitcher standing empty on her bedside table. R132 stated that again, she had asked multiple staff members for water, but no one seemed to have the time to fill her pitcher. On 03/06/24 at 12:55 PM, an interview was done in the Break Room with the Infection Preventionist (IP) who was also responsible for staff development, and conducted all staff trainings. Regarding hydration, IP reported that the residents' water pitchers are filled daily in the afternoon, and also during nourishment rounds conducted at 10:00 AM, 3:00 PM, and 8:00 PM. IP continued on to state that if a resident requests water however, anyone should be able to get them fresh water. On 03/06/24 at 02:00 PM, observed that R132's water pitcher was still empty. R132 confirmed that no one had filled it all morning, despite repeated requests from her. A review of R132's comprehensive care plan revealed under the Pain care plan: Offer/encourage fluids if not contraindicated due to constipating effects of pain medication. Under the Risk for Infection care plan, noted the following goal: Resident will remain hydrated. A review of the facility's undated policy on Hydration Management revealed the following: Fluids are available twenty four [sic] (24) hours per day. All residents have access to fluid stations/hydration carts. Staff assist prn [as needed]. 38870 2) Interviewed three residents (R)4, R14 and R18 at a resident council meeting on 03/06/24 at 12:22 PM. The surveyor asked the residents if the facility provides them with another food choice if they don't like the meal they receive. R14 stated, they usually tell you that you already ordered the food, and you don't get another choice. The surveyor asked the residents how is the food, it is good? Is it kept warm? R4 stated that the food is not so great, the fish is tough, they cook it too long. All three residents agreed the food could be better. Interview with the registered dietician (RD) on 03/06/24 at 1:39 PM. The surveyor asked the RD if the residents don't want the meal they receive, do they have the option of getting something else? The RD explained that yes, the residents have been told that they can have an alternate menu option if they don't like the meal that they receive or want something else. The RD stated that the dietary staff were recently reminded to offer those residents an alternate option and clarified that it doesn't matter if the resident received a meal that they ordered or not. Another option is always available to them. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the head chef (HC) from the kitchen on 03/07/24 at 1:55 PM. The surveyor shared the discussion with residents in the sample and at the resident council meeting who shared who shared a dislike of the food or the way it was cooked. He explained that it is challenging to cook the food downstairs in the kitchen and then keep it hot during transport upstairs without having to reheat the food.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38870 Based on observation and interview, the facility failed to store food in accordance with professional standards. The walk-in refrigerator contained boxes of food sitting on the floor. The deficient practice has the potential to affect many residents living in the facility who eat foods prepared in the kitchen. Findings include: During a return visit to the kitchen on 03/06/24 at 12:04 PM, observation in the walk-in refrigerator/ freezer on B1 floor noted several cardboard boxes of food resting on metal trays on the floor in the walk-in refrigerator. Verified with the Dietary supervisor (DS) that the boxes of food are required to be stored off the floor. Verified that the food inside the walk-in fridge is for the residents who dine in the facility (since the main kitchen provides food for the assisted living facility within the building. The DS notified another kitchen staff in the area to move the food off of the floor. The DS also notified the Kitchen manager. Interview with the head chef (HC) from the kitchen on 03/07/24 at 1:55 PM. The surveyor shared survey findings and the walk-in refrigerator/ freezer where boxes of food were found on the floor. HC confirmed that the items had been placed up on the shelves in the cooler and that he wasn't sure why they were placed on the floor. Reviewed the Food Handling Policy. 5. Food must be stored six (6) inches above the floor.