STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	655000	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guam Memorial Hospital Authority	449 N Sabana Dr Barrigada, GU 96913

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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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure that staff provided care in a manner that promoted dignity and respect for two of 19 residents (Resident(R)5 and R12) during dining observation. A Certified Nursing Assistant (CNA) was observed standing over R5 and R12 while assisting the residents with their meals. This failure had the potential to negatively impact the residents.Findings:For R12:On 08/18/2025 at11:38 AM, R12 was observed in bed with the head of the bed elevated to approximately 90 degrees, Bed was in low position. CNA5 was observed assisting R12 with lunch while standing over the resident. R12's eye level was observed at approximately the level of CNA5's chest. After a few spoonfuls of food, R12 stated she was done.For R5:On 08/18/2025 at 11:49 AM, R5 was observed in bed with the head of bed elevated to approximately 45 degrees after CNA5 adjusted the bed at the resident's request. CNA5 was observed spoon-feeding R5 while standing over the resident. At that time, R5's eye level was approximately at the level of CNA5's chest. After receiving three spoonfuls of food, R5 stated he was done.On 08/18/2025 at 12:00 PM, an interview was conducted with CNA5, who verified the above observations with R5 and R12. CNA5 stated that she knew she was expected to sit when assisting residents with meals so that she could .better accommodate the resident [sic] and see if they are swallowing well. CNA5 stated this practice was part of her training and did not provide an explanation for why she did not follow it at that time.On 08/22/2025 at 2:25 PM, an interview was conducted with the Director of Nursing (DON), who was informed of the observations. The DON acknowledged the findings and stated that her expectation is for CNAs to take time to sit down when assisting residents with meals and to maintain eye level with residents.According to the facility's policy titled Feeding, long-term care revised November 18, 2024, In long-term care facilities, creating a pleasant dining experience is also important. Mealtime affords an opportunity for social interaction and stimulation. Feeding a resident in a respectful and patient manner, engaging in pleasant conversation, and offering undivided attention help enhance the resident's nutritional status and psychosocial well-being.Position a chair next to the resident's bed so you can sit comfortably if you need to provide cues or maximal assistance with feeding.Face the resident during feeding, make eye contact, and use gentle tone of voice (shown below [photo depicting a staff member seated in a chair next to a resident while assisting the resident with a meal]).

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 0561 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. (continued on next page)

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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 0561 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to honor the rights of one of one resident (Resident(R)28) reviewed for choices to make decisions about their care. Specifically, staff failed to provide showers for R28 prior to going to dialysis treatments due to lack of available linens.This failure resulted in R28 experiencing psychosocial harm as exhibited by decreased engagement in social activities, apathy and withdrawal, and refusal of care. Findings:On 08/18/25 at 10:58 AM, R28 was observed lying in bed in her room, watching television. R28 was alert and stated she wanted to share her concerns; however, she is going to dialysis so would like to speak the next day. Transport arrived after a couple of minutes. On 08/19/25 at 09:35 AM, a follow-up interview was conducted with R28, inside her room. R28 stated the facility had been short of linens. R28 reported that she goes to dialysis three times a week and, on dialysis days, she prefers to take a shower. However, on most days, staff told her that there were no linens available, so showers could not be provided. Instead, the Certified Nursing Assistants (CNAs) would provide a wipe down. R28 stated this occurred frequently, like yesterday, I only got a wipe down.I am also speaking for other residents, because if it's just a wipe down, you still get sticky. R28 stated when she returns from dialysis, she becomes irritated because she feels more uncomfortable. R28 further stated that when she is irritated, she does not want to do anything and will refuse to eat or take her medications. R28 stated if it's not dialysis days, it's okay I just wash down there.but not during dialysis.Review of the electronic health record (EHR) revealed R28 is a [AGE] year-old resident readmitted to the facility on [DATE], with diagnoses including end stage renal disease on hemodialysis, sacral pressure ulcer, and seizure disorder.Review of the Minimum Data Set (MDS, a standardized assessment tool) with assessment reference date of 08/04/25, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating R28 had no cognitive impairment. R28 required substantial/maximal assistance from staff for shower/bathing and personal hygiene.Review of the Physician Progress Note dated 08/06/25, revealed documentation of R28's refusal of care and medication. The note showed, In reviewing nursing notes patient has had multiple refusals of medications and care plan for her wound care. This is not specific to Depakote or to midodrine. Referred to Guam behavioral [sic] Health. Patient seen by Guam behavioral [sic] Health. Seen by psychiatry. Diagnosis of MDD [Major Depressive Disorder] Increase risperidone to .5 mg b.i.d.[twice a day]. On 08/19/25 at 01:17 PM, an interview was conducted with Certified Nursing Assistant (CNA) 1, who stated R28 goes to dialysis on Monday, Wednesday, and Friday and likes to take showers before going to dialysis. CNA 1 stated R28 receives shower from the night shift staff early in the morning on dialysis days. CNA 1 stated that R28 is picked up by transport at around 11 AM and comes back in the afternoon shift (3:00 PM to 11:00 PM). On 08/19/25 at 01:31 PM, an interview was conducted with CNA 3, who stated that R28 likes to go out and participate in group activities. CNA 3 stated, however, that there are days when R28 suddenly becomes quiet, does not want to do anything, and refuses to eat.Review of the SNU shower schedule showed R28 was scheduled to receive showers on the night shift (11:00 PM to 07:00 AM) every Sunday, Tuesday, and Thursday. Shower is given early the following morning (Monday, Wednesday, and Friday).Review of the night shift's SNF CNA Patient Care (CNA's shower documentation) for August 2025 revealed that showers were not provided to R28 on 8/1, 8/4, 8/8, 8/13 and 8/18/25 as scheduled.On 08/21/25 at 10:38 AM, an interview was conducted with Registered Nurse (RN) 2, who stated she was aware that residents, including R28, were not consistently provided showers due to lack of linens. RN 2 stated, sometimes they [CNAs] report to me they cannot shower the resident because there are no linens, or sometimes we cannot change the bed because there are no linen, so sometimes I tell them just to change the lifter [lift sheet]. RN 2 verified that after R28 returns from dialysis, she often hears reports from nurses and CNAs that the resident refuses care and refuses to eat.On 08/21/25 at 03:34 PM, a telephone interview was conducted with CNA 2, who stated she worked the night shift and was regularly assigned to R28. CNA 2 explained that R28 receives her showers in bed, meaning her body and hair are washed while she remains in bed, which requires the linens to be changed afterward. CNA 2 stated that R1 prefers to have showers early morning on her dialysis days, which are Monday, Wednesday, and Friday. CNA 2 verified that on 08/08 and 08/13/25, where she documented a shower did not occur; it was because there were no linens available. CNA 2 stated that when showers are done in bed, both towels and linens are needed, but most of the time these were not available. In those instances, CNA 2 stated they would provide only a wipe-down and perineal care. CNA 2 stated that

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 5 of 5 residents (Resident[R]1, 5, 7, 13, 15) reviewed for advance directives were provided with information about advance directives. In addition, the facility failed to obtain and maintain a copy of the advance directive in the medical record so that it was readily retrievable by any facility staff. The facility did not develop policy and procedure to implement advance directives.This failure put the resident at risk for not having his wishes for treatment known and had the potential for the resident's decision regarding his healthcare and treatment options not being honored. For R5: Review of face sheet (admission record) revealed R5 was admitted to the facility 12/12/24. Review of the Minimum Data Set (MDS, a standardized assessment tool) with assessment reference date of 06/19/25, revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating R5 had no cognitive impairment. Review of the hospital’s Advance Directive Acknowledgement Form dated 12/12/24, revealed the section “Has An Advance Directive” was completed by R5’s representative. The boxes indicating “I have Advance Directive: Durable Power of Attorney for Health Care” and “I have brought in a copy and provided it to hospital staff to go into my medical record” were both checked. However, review of the electronic health record (EHR) and the physical chart did not show a copy of R5’s Durable Power of Attorney for Healthcare on file. 08/20/2025 10:50 AM, an interview and concurrent medical record review was conducted with Registered Nurse (RN) 2. RN 2 reviewed both the EHR and R5’s physical chart and verified there was no copy of R5’s Durable Power of Attorney for Healthcare on file. For R15: Review of Face sheet (admission record) revealed R5 was admitted to the facility 06/15/25. Review of the Minimum Data Set with assessment reference date of 06/22/25, revealed resident was rarely/never understood so staff assessment for mental status was completed, which revealed R15’s cognitive skills for daily decision making was moderately impaired. Review of Advance Directive Acknowledgement Form dated 06/15/25, revealed the section “Does Not Have An Advance Directive” was completed. The boxes indicating “I been given written materials about my right to make decisions about my medical treatments” and “I choose not to have an Advance Directive but I understand that I can make one during my hospital stay or anytime in the future” were both checked. This document was signed by R15 using a thumbprint. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/20/2025 10:41 AM, an interview was conducted with Registered Nurse (RN) 2, who verified R15 had no capacity to make decisions. When asked if R15 would have been able to understand and read the information provided to him at the hospital regarding advance directives, RN 2 stated, “No.” RN2 stated that the Advance Directive Acknowledgement Form was completed at the hospital. RN2 further explained that when a resident is admitted to the Skilled Nursing Unit (SNU), staff do not request a copy of the advance directive nor provide information regarding advance directives. RN 2 stated she did not know who was responsible for advance directives in the SNU. On 08/21/2025 1:34 PM, an interview was conducted with Licensed Social Workers (LSW) 1 and 2. Both LSW stated they do not handle advance directives. When asked who is responsible for advance directives in the SNU, both did not have an answer. LSW 1 verified that R15 had no capacity to make decisions, yet was made to sign (thumbprint) the Advance Directive Acknowledgement Form, and also thumbprinted his consent to treat and consent for admission. LSW1 explained that she attempted to complete the social summary with R15, but was unable to do so because “he doesn’t speak.” LSW2 verified that R5 had a durable power of attorney for healthcare and she had kept a copy in her office. LSW2 stated she was not aware that she had maintain a copy in the medical record readily accessible for all staff and having kept it in her office would not make it accessible to staff, since the office is not open 24 hours a day, 7 days a week. Findings: R7 Review of R7’s medical record indicated, R7 was re-admitted in the facility after hospitalization on 08/01/25 with diagnoses including recurrent urinary tract infection (UTI) and stage IV decubitus ulcer (severe form of skin damage). On 08/18/25 at 02:25 PM, observed the R7 in bed turned on his left side, eyes opened but not tracking and did not respond to questions. On 08/19/25 at 10:25 AM, R7’s Advance Directive Acknowledgement Form ADAF reviewed with Licensed Practical Nurse (LPN) 1. ADAF revealed that R7’s right index thumbmark in the form dated 08/01/25. LVN1 stated that the thumbmark means “[R7’s] signature acknowledging that [R7] was given an Advance Directive brochure and [R7] understood and choose not to have one [AD].” LVN1 stated that R7 is non-verbal “but I don’t think he will understand the conversation about [AD].” Per LVN1, AD is completed at the hospital prior to resident’s discharge. LVN1 did not offer an answer when asked whether the facility verifies the accuracy of the information indicated in the ADAF. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/21/25 at 09:59AM, the Director of Nursing (DON) stated, “We don't do Advance Directive here [in the facility]. It's done by Patient Registration staff [in the hospital] and the staff there will be the one to explain the Advance Directive to the resident. When the resident arrives here [in the facility], the Social Worker will refer residents to legal services if they want DPOA [Durable Power of Attorney].” The DON further explained, “[R7’s] mother claims that she's the DPOA but did not provide us a copy of DPOA. The mother is the one signing for consent if needed a procedure. The mother of [R7] should be the one to receive the info [information] for Advance Directive and sign the acknowledgement form because she can comprehend and she's the one making the decision.” DON stated that R7 does not have the capacity to engage in conversation and does not have a capacity to understand Advance Directive information. In an interview on 08/21/25 at 1:41 PM, Licensed Social Worker (LSW) 2 stated that R7’s “Mother is the DPOA, but no documentation. I don't handle Advance Directive.” LSW1 stated that they will follow up the DPOA documentation for R7’s mother. R13 Review of R13 medical records indicated, R13 was admitted in the facility after hospitalization on 02/13/24 with diagnoses including hypertension, diabetes mellitus, and eye blindness. Review of ADAF form dated 02/13/24 revealed R13’s right index thumbmark indicating that R13 received “written materials about my right to make decisions about my medical treatments.” The form also has an x mark indicating that R13 “chose not to have an [AD].” In an interview on 08/21/25 at 10:19AM, the DON stated that “it’s not appropriate” for R13 to receive AD brochure “because she cannot read. [R13] is visually impaired.” The DON further stated, “[R13] has a daughter. The information should be given to the daughter.” In an interview on 08/21/25 at 1:58 PM, LSW1 and LSW2 stated that R13 could not read because “[R13] is legally blind since early May last year [2024].” LSW2 added that R13 is still able to make her own decisions. R1 R1 was admitted to the facility on [DATE] with diagnoses including acute renal failure, hypertension, and stroke. Review of R1's record revealed ADAF dated 06/27/25 indicated that R1 signed that he has an AD and DPOA for health. R1 also signed the portion of the form indicating that he did not have an AD. In an interview on 08/19/25 at 1:22 PM, while reviewing R1’s ADAF, LPN1 stated that the form was “confusing.” LPN1 stated that she looked at R1’s electronic and paper medical records and confirmed that the facility did not have a copy of R1’s AD. LVN1 explained that “Admitting nurse does the process of admission with resident. For Advance Directive, I never talk to a patient or family member.” (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/21/25 at 10:24 AM, the DON stated, “[R1] makes his own decision. He doesn’t have DPOA. I know he's been making the decision.” The DON acknowledged that the facility does not have a copy of DPOA documentation. In an interview on 08/21/25 at 2:02 PM, LSW1 stated that “[R1’s] brother is the POA.” LSW1 stated she has the DPOA documentation in her office and added, “[R1] is competent. He still can make decisions for himself.”

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an adequate supply of bed and bath linens to meet the care needs of 19 of 19 residents residing in the Skilled Nursing Unit (SNU). This failure resulted in residents not receiving scheduled showers and having unchanged bed linens. The lack of adequate linens had the potential to compromise resident dignity, comfort, and hygiene, and increased the risk for skin breakdown and infection.Findings:On 08/19/25 at 09:35 AM, an interview was conducted with Resident (R) 28, the facility's Resident Council President, inside her room. R28 stated the facility had been short of linens. R28 reported that she goes to dialysis three times a week and, on dialysis days, she prefers to take a shower. However, staff informed her that there were no linens available, so showers could not be provided. Instead, the Certified Nursing Assistants (CNAs) would provide a wipe down. R28 stated, like yesterday, I only got a wipe down.I am also speaking for other residents, because if it's just a wipe down, you still get sticky. (Cross reference to F561)On 08/19/25 at 01:17 PM, an interview was conducted with CNA 1, who stated that the facility frequently experienced problems with the availability of linens. CNA 1 explained that deliveries were not made daily and were often insufficient. CNA 1 stated, we haven't had face towels, body towels, thin sheets.we have the thicker sheets [thicker cotton blankets with waffle weave], sometimes we use those as bed sheets, they are uncomfortable.we have no choice. CNA 1 stated that staff occasionally donated pillowcases and bath towels or asked family members to bring towels from home. CNA 1 further stated that when towels and sheets were unavailable, staff were unable to provide showers and instead offered residents wipe downs or sponge baths, and would still need wash cloths and towels. CNA 1 stated some residents requested showers, but they had to explain that we are short of linen.Review of the linen delivery receipts and the facility census for June 2025, showed the following:- On June 1-2, 2025, the census was 18 residents. No linen deliveries were recorded.- On June 3, 2025, the census was 18 residents. Delivery included 18 flat sheets, 5 bath towels, and 4 pillowcases.- On June 4, 2025, the census was 18 residents. No linen deliveries were recorded.- On June 5, 2025, the census was 18 residents. Delivery included 40 flat sheets and 6 bath towels. No pillowcases were delivered.- On June 6, 2025, the census was 18 residents. No linen deliveries were recorded.- On June 7, 2025, the census was 18 residents. Delivery included 30 flat sheets and 13 pillow cases. No bath towels delivered.- On June 8, 2025, the census was 18 residents. No linen deliveries were recorded.- On June 9, 2025, the census was 17 residents. No linen deliveries were recorded.- On June 10, 2025, the census was 16 residents. Delivery included 50 flat sheets, 5 bath towels, and 14 pillowcases.- On June 11, 2025, the census was 15 residents. No linen deliveries were recorded.- On June 12, 2025, the census was 16 residents. Delivery included 10 flat sheets, 4 bath towels, and 10 pillowcases.- On June 13, 2025, the census was 17 residents. No linen deliveries were recorded.- On June 14, 2025, the census was 17 residents. Delivery included 20 flat sheets and 7 pillow cases. No bath towels delivered.- On June 15-16, 2025, the census was 18 residents. No linen deliveries were recorded.- On June 17, 2025, the census was 18 residents. Delivery included 10 flat sheets and 10 pillow cases. No bath towels delivered.- On June 18, 2025, the census was 18 residents. No linen deliveries were recorded.- On June 19, 2025, the census was 18 residents. Delivery included 20 flat sheets, 5 bath towels, and 15 pillowcases.- On June 20, 2025, the census was 18 residents. No linen deliveries were recorded.- On June 21, 2025, the census was 18 residents. Delivery included 10 flat sheets and 15 pillow cases. No bath towels delivered.- On June 22-23, 2025, the census was 18 residents. No linen deliveries were recorded.- On June 24, 2025, the census was 18 residents. Delivery included 15 flat sheets, 3 bath towels, and 20 pillowcases.- On June 25, 2025, the census was 18 residents. No linen deliveries were recorded.- On June 26, 2025, the census was 18 residents. Delivery included 15 flat sheets, 5 bath towels, and 20 pillowcases.- On June 27, 2025, the census was 18 residents. No linen deliveries were recorded.- On June 28, 2025, the census was 20 residents. Delivery included 15 flat sheets and15 pillowcases. No bath towels delivered.- On June 29-30, 2025, the census was 20 residents. No linen deliveries were recorded.Review of the linen delivery receipts and the facility census for July 2025, showed the following:- On July 1, 2025, the census was 20 residents. Delivery included 20 flat sheets and 20 pillowcases. No bath towels were delivered.- On July 2, 2025, the census was 20 residents. No linen deliveries were recorded.- On July 3, 2025, the census was 20 residents. Delivery included 15 flat sheets, 20 pillowcases, and 5 bath towels.- On July 4, 2025, the census was 20 residents. No linen deliveries were recorded.- On July 5, 2025, the census was 20 residents. Delivery

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, and record review, the facility failed to ensure 1 of 5 residents (Resident(R)6) reviewed for unnecessary medications was free from unnecessary psychotropic drug use. Specifically, R6's antipsychotic medication was increased on 10/23/24 despite no documented behaviors and did not attempt a gradual dose reduction (GDR) even though no behaviors had been documented since the increase through present. This failure had the potential to result in oversedation, worsening cognitive decline, increased confusion, and loss of independence. Findings: On 08/18/25 at 10:43 AM, R6 was observed seated in her wheelchair in the activities area, doing coloring activity with another resident led by recreation staff. R6 responded when greeted Review of Face sheet (admission record) revealed R5 was admitted to the facility 07/18/24, with diagnoses including dementia.Review of a physician's order dated 10/23/24, revealed an order for quetiapine (antipsychotic medication) 25 mg tablet, give one tablet by mouth at bed time for Alzheimer's with behavioral adjustment.Review of the Neurologist's consultation note dated 10/23/24, revealed R6 was seen for the first time by the Neurologist as a referral from the Skilled Nursing Unit (SNU). Documentation showed staff reported no behavior changes and R6 behavior remained stable. Despite this, the dose of quetiapine was increased from 12.5 to 25 mg with no documented rationale for the increase. Review of the Behavior monitoring form from October 2024 to August 2025 revealed R6 was being monitored by staff every shift for behaviors of confusion/agitation related to the use of quetiapine. Further review showed there were no documented behaviors of confusion or agitation from October 2024 to present. On 08/21/2025 9:57 AM, an interview and concurrent medical record review was conducted with Registered Nurse (RN) 2, who acknowledged the above findings. RN 2 stated R6 has not shown any behaviors and was considered stable. When asked about the facility's process for psychotropic medication use, RN 2 stated, we have a green form. RN 2 explained the green form is used to document monitoring of behaviors and side effects, and staff use it to determine if the medication is effective, if the dosage is sufficient, or if an increase is needed before informing the physician. When asked what steps would be taken if a resident, such as R6, did not have any documented behaviors, RN 2 stated, we don't discuss that. On 08/22/245 at 10:59 AM, an interview and concurrent review of the Medication Regimen Review (MRR) was conducted with the Consultant Pharmacist (CP), who stated she was responsible for the monthly medication regimen review (MRR) in the Skilled Nursing Unit (SNU). Review of the CP's MRRs from February 2025 to July 2025 showed she documented the same assessment/plan each month for the use of quetiapine: successfully tapered up to quetiapine 25 mg [milligrams] PO [by mouth] QHS [at bedtime] and will remain at this dose for now.Record review revealed no behaviors had been documented for R6 since October 2024, when the dose of quetiapine was increased, despite the absence of behaviors at that time. The CP stated the SNU had been cited the previous year for use of quetiapine for R6 for sleep, and it was recommended that the resident see a neurologist. The CP reported the neurologist subsequently increased the dose. When asked why a GDR was not attempted given the absence of documented behaviors, the CP stated she was not familiar with the requirement for GDR for psychotropic medications. The CP further stated she believed that because the neurologist ordered the medication, she could not question it.On 08/22/25 at 02:26 PM, an interview was conducted with the Director of Nursing (DON) and stated the interdisciplinary (IDT) discussed psychotropic medications every Wednesday. The DON stated the team had discussed that R6 was very calm and good. When asked why a GDR was not attempted, the DON did not provide an answer.The facility did not have a policy specific to GDR for psychotropic medications.

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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 interview and record review, the facility failed to ensure the Minimum Data Set (MDS) assessments were accurate and complete for 2 of 19 sampled residents (Resident(R)19 and 23). R19's MDS indicated she was receiving insulin and diuretic, when she was not.R23's discharge MDS was not completed.These failures had the potential to result in inaccurate care planning and failure to meet the residents' care needs.Findings:For R19:Review of Face sheet (admission record) revealed R19 was admitted to the facility 07/20/25 with diagnoses including left hip fracture.Review of the MDS with assessment reference date of 07/25/25 revealed Section N for medications, which showed that the number of injections received by R19 during the last 7 days was coded as 7. The number of days insulin injections were received during the last 7 days was also coded as 7. The MDS further indicated that R19 was taking a diuretic.However, review of the physician's orders and the Medication Administration Record (MAR) for July 2025 revealed that R19 had no orders for insulin or a diuretic and did not receive either medication during the assessment reference period. R23:Review of Face sheet (admission record) revealed R23 was admitted to the facility on [DATE] and was discharged on 04/01/25.However, review of the medical record revealed a discharge MDS was not completed for R23.On 08/20/2025 3:20 PM, an interview and concurrent record review of the MDS's for R19 and R23 was conducted with the MDS Coordinator. The MDS Coordinator reviewed R19's medical record and verified R19 was not administered insulin nor diuretic during the assessment reference period of the MDS and should have been coded zero. The MDS Coordinator also reviewed R23's MDS and verified the discharge MDS was not completed, and should have been.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure staff adhered to professional standards related to addressing weight variance for one of three residents (Resident [R] 7) reviewed for nutrition. The deficient practice could potentially delay the implementation of appropriate measures to prevent unintended weight loss or weight gain before complications arise. Findings:Review of R7's medical record indicated, R7 was re-admitted in the facility after hospitalization on 08/01/25 with diagnoses including recurrent urinary tract infection (UTI) and stage IV decubitus ulcer (severe form of skin damage). In an interview on 08/19/2025 at 10:06 AM, Licensed Practical Nurse (LPN) 1 explained that staff weigh residents on the first and 15th day of the month.Review of R7's weight records indicated the following:08/01/25 = 89.5 kilograms (kgs)08/15/25 = 85.9 kgs (4% weight loss in two weeks)08/17/25 = 92.8 kgs (8% weight gain in two days)On 08/20/25, at 09:38 AM, the Registered Dietician (RD) reviewed R7's weight record and stated that R7 was receiving tube feeding formula with protein supplement and had been consistent on his weight. RD stated that the weight variance was probably due to calibration of the weighing scale and added that she was not notified of the weight variance. In an interview on 08/20/25 at 01:10 PM, Registered Nurse (RN) 1 reviewed the weight record of R7 and stated, If there's a huge weight difference the CNA [Certified Nursing Assistant] should re-weigh [R7], we also notify the Dietician, and it will be mentioned in the IDT [Interdisciplinary Team] meeting every Wednesday. RN1 added that R7 was re-weigh today [08/20/25] by [LPN1], it's 84.7 kgs. They removed the pads and other things in the bed before weighing.In a follow up interview on 08/20/25 at 01:24 PM, RN1 stated, there's no IDT notes from August 1 to present or any notes regarding weight variance. Also, no documentation that nursing address the weight variance to RD.In an interview on 08/21/25, at 11:44 AM, RD stated, Patients have to be re-weigh if there's a drastic weight difference and they have to inform me if after re-weighing it's still the same. Most likely the residents might have weight loss or weight gain, and I need to review the current diet or formula if they are getting tube feeding [TF]. For [R7], I reduced the TF before then he went to the hospital because he had CHF [congestive heart failure], and we have to cut on the volume of the formula.In an interview on 08/21/25 at 12:06 PM, LPN1 explained that CNA reports weight variance to the assigned medication nurses. If there's a discrepancy, we let the Charge Nurse know. If there is a big discrepancy, then we will re-weigh [the residents]. We remove everything just the regular sheets, no heavy blanket and pillows to make sure it's accurate.On 08/21/25 at 05:30 PM, the Director of Nursing (DON) confirmed via electronic mail (email) that the facility did not have weight policy, instead the facility follow Lippincott procedure for guidance.Review of Lippincott procedure provided by the DON titled, Weight monitoring, long term dated 08/19/24, indicated Weight [NAME] in older adults can result from various conditions. Unplanned weight loss in residents is associated with increased mortality; a decrease in weight of 5% or more in a month or of more than 10% in 6 months should be reported to the practitioner for further evaluation. Under Implementation indicated, Compare the resident's current weight with previous measurements to assess for trends in weight gain or loss. If you note a weight change, assess the resident to help determine a possible cause of the weight change. Notify the practitioner if weight changes are beyond the expected range. Document the procedure.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of two residents with a colostomy (a surgical opening in the abdomen that allows waste to pass into a bag) had an adequate supply of colostomy bags (special pouches used to collect waste from the opening) required for proper care. Due to lack of supply, staff washed the colostomy bags. This resulted in residents being required to use rewashed bags, which are not designed for reuse. This deficient practice resulted in R28's reports of humiliation and embarrassment related to odor and the awareness that others might notice it.Findings:On 08/19/25 at 09:35 AM, an interview was conducted with R28, inside her room. R28 stated she has a colostomy, pointing to a bulge on her left abdominal area, and reported that the facility often runs out of colostomy bags. R28 stated, this is not reusable. R28 reported that Certified Nursing Assistants (CNAs) wash out the colostomy bags when no new ones are available.When asked when this last occurred, R28 stated that it happened this Saturday when a CNA washed the colostomy bag because they could not find a new one. R28 stated, I feel very uncomfortable because the smell is still there. R28 also stated that she frequently leaves the facility for dialysis, doctor's appointments, and enjoys going out of her room. R28 explained, When I go out, say, for a doctor's appointment, I get embarrassed because I can smell it, that means other people can smell it too. R28 stated that both the smell from the reused colostomy bag and not getting showers due to lack of linens, makes her angry and caused her to refuse care.Review of the electronic health record (EHR) revealed R28 is a [AGE] year-old resident readmitted to the facility on [DATE], with diagnoses including end stage renal disease on hemodialysis, sacral pressure ulcer, and seizure disorder.Review of the Minimum Data Set (MDS, a standardized assessment tool) with assessment reference date of 08/04/25, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating R28 had no cognitive impairment. The MDS showed R28 had an ostomy appliance (including colostomy).Review of the Physician Progress Note dated 08/06/25, revealed documentation of R28's refusal of care and medication. The note showed, In reviewing nursing notes patient has had multiple refusals of medications and care plan for her wound care. This is not specific to Depakote or to midodrine. Referred to Guam behavioral [sic] Health. Patient seen by Guam behavioral [sic] Health. Seen by psychiatry. Diagnosis of MDD [Major Depressive Disorder] Increase risperidone to .5 mg b.i.d The note showed that R28 is easily upset.Review of the ostomy bag product specifications revealed that it is a drainable pouch with an attached flange (the flange is the sticky part that attaches the pouch to the skin around the stoma to hold it in place). The manufacturer's warning indicated that reuse by reprocessing, cleaning, disinfection, and sterilization may compromise the product. This may result in odor or leakage.On 08/19/25 at 01:17 PM, an interview was conducted with CNA 1, who stated R28 goes to dialysis three times a week and also had a colostomy on her left lower quadrant. CNA 1 explained that as a CNA, she is responsible for emptying and cleaning the colostomy site, while the licensed nurses are responsible for applying the flange as needed.CNA 1 stated that the facility does not have a steady supply of colostomy bags. CNA 1 stated, If it is full, we have to clean it and reuse it.it is unsanitary. The licensed nurses know.they are aware of it.CNA 1 further stated that there are currently two residents with colostomies in the facility, R28 and R7. CNA 1 explained, we do the same for both residents. [R7] is nonverbal and cannot tell us how he feels. [R28] is not happy with it.CNA 1 stated they have been out of colostomy bags in the last 2-3 weeks. When asked when this last occurred, CNA 1 stated that it happened last Sunday morning, when she was endorsed by the night shift that the colostomy bag had to be washed because there were no new ones available.On 08/19/25 at 01:31 PM, an interview was conducted with CNA 3, who stated that R28 likes to go out and participate in group activities. CNA 3 stated, however, that there are days when R28 suddenly becomes quiet, does not want to do anything, and refuses to eat.On 08/21/25 at 10:38 AM, an interview was conducted with Registered Nurse (RN) 2 regarding colostomy care for R28 and R7. RN 2 verified that both residents have colostomies and require colostomy care, which includes emptying the bag and placing a new one. RN 2 stated that the colostomy bags are not reusable and should be replaced when full; however, at times there is no supply available. RN 2 stated she is aware the CNAs are washing and reusing the bags. RN 2 explained, we have to find a way, you have to wash.what can we do rather than nothing. RN 2 acknowledged that this practice is unsanitary and further stated that the residents, especially R28, did not like it. When informed that R28 had expressed feeling humiliated because of the odor coming from the reused bag, RN 2 responded, oh yeah, she is young, and she likes to go out [of her room]

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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. Based on observation, interview and record review, the facility failed to provide pharmaceutical services that assure accurate administration of medications to meet the needs of 1 of 5 residents (Resident(R)16) observed during medication administration. Specifically, the facility failed to follow the physician's order when administering medication to R16. This failure had the potential to result in ineffective treatment.Findings:On 08/20/2025 at 8:43 AM, during a medication administration observation for R16, Registered Nurse (RN) 1 was observed preparing and administering medications, including one tablet of multivitamin with minerals. R16 swallowed all oral medications without difficulty.However, review of the physician's order dated 08/17/25 revealed an order for multivitamin, one tablet by mouth daily. The order did not include minerals.On 08/20/25 at 11:55 AM, an interview and concurrent review of the R16's physician's order was conducted with RN 1. RN 1 verified the order was for multivitamin only, but she administered a multivitamin with minerals. RN 1 stated she was not familiar with R16's morning medications because she typically works the night shift. According to the facility's policy titled Medication Administration and Documentation revised 09/2018, Medications will be administered only upon the order of a privileged and credentialed provider who are members of the medical staff.Before administration, the individual administering the medication does the following: A. Verifies that the medication selected matches the medication order and the product label.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe storage of medications for one of two medication cart observation when the first side medication cart was not locked and left unattended.The deficient practice had potential for unauthorized people to have access to medications.Findings:On 08/20/2025, at 8:22 AM, the first side medication cart was observed in front of room [ROOM NUMBER] not locked and unattended.In an interview with Registered Nurse (RN) 1 on 08/20/2025, at 8:23 AM, RN1 opened the medication cart and stated, It's not locked. It should be closed and secured or locked for safety reasons. Someone can steal medications. RN 1 explained that the nurse in charge of the medication cart was attending to a resident inside the room.Review of the facility policy, titled Storage of Medications in Patient Care Areas, dated 07/01/2009 indicated, Medication will be stored in secured carts or drawers at all times when not in use.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observations and interviews, the facility failed to ensure food safety standards when:1. The box of dishwasher heater booster and the storage cart were rusty.2. The hinge and handle of the food steam table had a thick whitish, black and brownish build-up.3. Staff food items were stored inside the kitchen walk-in refrigerator where the residents' food items were stored.4. Tray line or plating was not performed in a sanitary manner and food items were not measured accordingly.Failure to provide a food production environment that is safe and sanitary may result in foodborne illness, cross contamination of food and equipment and use of expired ingredients that may affect flavor and/or texture of food. Foodborne illness and cross contamination may result in gastrointestinal distress and in severe instances may result in death. This had the potential to affect 17 residents who received meals from the facility. Findings:1.During the initial tour of the kitchen with the Food Service Supervisor (FSS) on 08/18/25 at 9:00 AM, the box of dishwater heater booster and the two-tier stainless-steel storage cart were rusty. In addition, the hinge and handle of the food steam table had a thick whitish, blackish, brownish build up. 2.During observation on 08/19/25 at 09:25 AM, inside the walk-in refrigerator, several food items were placed on the top of one of the shelves labeled as EMPLOYEE BIN. FSS stated that the food items are staff personal food brought from home and added that local public health told them that they can keep staff food item as long as it's separated from the resident's food item.Review of facility policy titled, Outside Food Policy at Skilled Nursing Unit dated 03/2016 indicated, Food brought in from the outside are to be stored in separate refrigerators or storage areas from residents' food storage areas.The U.S. Food and Drugs Administration 2022 Food Code 6-403.11 Designated Areas indicated, Because employees could introduce pathogens to food by hand-to-mouth-to-food contact and because street clothing and personal belongings carry contaminants, areas designated to accommodate employees' personal needs must be carefully located. Food, food equipment and utensils, clean linens, and single-service and single-use articles must not be in jeopardy of contamination from these areas.3.On 08/20/25 at 09:56 AM, Food Service Worker (FSW) 1 was observed entering the kitchen from the common dining area without washing their hands. In an interview at 09:57 AM, FSW1 acknowledged that he did not wash his hands before entering the kitchen and stated that he will wash his hand in the sink located at the back of the kitchen.Review of undated in-service information provided by the facility titled, Food Safety In-Service Personal Hygiene & Handwashing indicated, Although handwashing seems like an easy task, it is often one in which many people take shortcuts. We need to be vigilant when it comes to handwashing. Handwashing with soap and water is the single most effective way to prevent the spread of bacteria and viruses, the major causes of foodborne illness. Further, Bacteria and viruses can travel easily from one person to another or from people to food and food contact surfaces. Therefore, it is important to wash hands frequently and after any task that may potentially contaminate your hands. 4.During the food tray line and food distribution on 08/20/25 at 11:16 AM the following was observed:i. FSW1 was wearing a glove on his left hand and no glove on his right hand while dishing out the food. In between the scooping of regular diet, FSW1 was cutting and chopping the food items for trays with mechanically chopped diet. FSW1 was observed touching the food with his gloved hands. FSW1 moved one scooped of rice to another plate using his gloved hands, directly touching the rice. In addition, FSW1 was observed going in and out at the washing area to wash the chopping board without changing the glove or performing hand hygiene.ii. Observed food scoopers and serving utensils handle were touching and resting inside the food tray.iii. After FSW1 hand over the food tray, FSW2 was observed adding extra scoop of salmon in the tray.iv. FSW1 was using kitchen tongs to dish out spaghetti and stated, we don't have enough [measuring] scoops.At 11:54 AM, the Hospital Food and Beverages Manager (HFBM) observed the above findings and went to the back of the kitchen to get a measuring cup to measure the spaghetti. HFMB advised FSW1 measure the food items according to the meal ticket and not to add additional food items on top of what FSW1 had already scooped in the tray. HFBM also told FSW1 to perform hand hygiene and not to let the scooper rest in the food. HFBM stated prepping the chopped dishes should not be done on the spot. All food items should be prepared beforehand (before the tray line). HFBM added, [FSW1] should not be touching the food, and they should be using the proper scooper or measuring cup at least.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. Based on interview and record review, the facility failed to ensure its governing body appointed an administrator who is licensed pursuant to Guam Code Annotated (GCA), and responsible for the management of the facility, reporting to and being accountable to the governing body. The facility had no Administrator since April 2024. This failure had the potential to result in ineffective oversight and lack of accountability, leading to supplies not being consistently available to residents, including essential items such as linens and colostomy bags placing residents at risk for unmet care needs and diminished quality of life.Findings:On 08/18/25 at 08:50 AM, during the entrance conference attended by the Director of Nursing (DON) and the Medical Director (MD), both stated that the facility did not have an administrator. Without being prompted, the MD introduced himself as overseeing clinical work, with no administrative oversight of the facility. When asked, when the facility had been without an administrator, the DON stated that this had been the case since April 2024.On 08/18/25 at 11:35 AM, the hospital Chief Executive Officer (CEO), introduced herself to the survey team and stated she oversaw the Skilled Nursing Unit (SNU) because it was still under the hospital. When asked, the hospital CEO acknowledged she did not have a Nursing Home Administrator license as required by the Guam Code Annotated, Chapter 15, governing nursing home administrators. The hospital CEO further stated that the SNU had been without a licensed administrator for some time and that efforts were ongoing to recruit one.On 08/22/25 at 03:01 PM, an interview was conducted with the DON, MD, and Compliance Officer (CO). The CO stated she sat on the governing board and verified the SNU did not have an administrator. The CO stated Human Resources had announced the position and there had been several rounds of interviews, but the challenge was that the facility was too small for the salary expectations of those applying.Review of the Guam Code Annotated (GCA) Chapter 15 Nursing Home Administrators included under S 15102. Administrator's License Required, No nursing home shall operate except under the supervision of a nursing home administrator, and no person shall be a nursing home administrator unless he is the holder of a sufficient nursing home administrator's license issued pursuant to this Chapter.Cross reference to F584, F561, F691, F837, F838

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility failed to maintain an effective Quality Assurance and Performance Improvement (QAPI) program by not conducting quarterly meetings for three consecutive quarters, and when a meeting was held in July 2025, the team failed to address an ongoing supply concern. In addition, there was no system in place for obtaining feedback and input for direct care staff and residents, including how such input would be used to identify and address problems. These failures limited the facility's ability to identify systemic problems, implement corrective actions, and monitor effectiveness, placing residents at risk for unmet needs.Findings:Review of the QAPI plan submitted during the entrance conference titled QAPI Plan 2024, revealed indicators and measures derived from survey results spanning 2019 through 2023. The QAPI plan did not contain indicators, measures, or performance improvement projects for 2025.On 08/22/25 at 03:01 PM, an interview and concurrent review of the facility's QAPI program was conducted with the Director of Nursing (DON), Medical Director (MD), and Compliance Officer (CO). The DON stated the Skilled Nursing Unit (SNU) had not held QAA committee meetings because there was no administrator in place to oversee the process. The CO stated she played a supportive role to the SNU and had discussed QAPI at the hospital level, and that she had offered to chair the committee moving forward. The DON further stated that when the MD was on leave in July 2025 and the former Medical Director was covering, the covering physician learned the facility had not been holding QAPI meetings, so he called for a QAPI meeting on07/22/25. When asked when the last QAPI meeting had been held before that, the DON stated there had been none for the past three quarters prior to the July meeting.When asked how linen inventory is tracked and what process ensures adequate supply is maintained for all resident care needs, including showers, MD stated he was not aware of a linen shortage. The DON stated Environmental Services staff had been reporting linen shortages during meetings with hospital leadership and were told, that's all we have. The DON further stated this issue was brought up in their QAPI last July 22,2025, where the reason provided was that linens were damaged and stained. The CO stated Environmental Services is part of the QAPI committee at the hospital and confirmed that linen shortages have been discussed during meetings with hospital leadership. The CO stated the Assistant Administrator at the hospital has been seeking a contract to replace the damaged linens. When asked how staff and resident feedback, such as R28's reports of not receiving showers due to linen and colostomy bag shortages, are incorporated into QAPI monitoring for quality of life, the CO stated I don't have an answer. I don't know when QAAs happen or what is discussed. What usually happens is it goes from the QA committee then back out to staff but not from resident and staff in.Review of the QAPI Agenda dated 07/22/25, did not include documentation of review of discussion of ongoing facility concerns, including linen and colostomy bag shortages.Cross reference to F561, F584, F691, F837, and F868.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to ensure the Quality Assessment and Assurance (QAA) committee met at least quarterly and evaluated activities under the Quality Assurance Performance Improvement (QAPI) program, including identifying issues related to QAA activities and implementing performance improvement projects (PIP) as required. In addition, the facility's QAA committee failed to include the administrator, owner, board member or designee.This failure had the potential to result in failure to identify and correct systemic problems, such as supply shortages, leading to unresolved issues that negatively impact the quality of care and services provided to residents.Findings:On 08/22/25 at 03:01 PM, an interview and concurrent review of the facility's QAA and QAPI program was conducted with the Director of Nursing (DON), Medical Director (MD), and Compliance Officer (CO). The DON stated the Skilled Nursing Unit (SNU) had not held QAA committee meetings because there was no administrator in place to oversee the process. The CO stated she played a supportive role to the SNU and had discussed QAPI at the hospital level, and that she had offered to chair the committee moving forward.The DON further stated that when the MD was on leave in July 2025 and the former Medical Director was covering, the covering physician learned the facility had not been holding QAPI meetings, so he called for a QAPI meeting on07/22/25. When asked when the last QAPI meeting had been held before that, the DON stated there had been none for the past three quarters prior to the July meeting.Review of the QAPI agenda dated 07/22/25 revealed the section for QAA committee members was left blank.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to implement an effective infection control program in accordance with internal policies and procedures, nationally recognized infection control guidelines and regulations when:1. Hand hygiene was not performed before entering the kitchen and tray line and in between changing of gloves during medication preparation. 2. The facility water management plan (WMP) did not include testing protocols, acceptable ranges for control measures, and corrective actions when control limits are not maintained to prevent growth of opportunistic waterborne pathogens such as Legionella bacteria. According to the Centers for Disease Control and Prevention (CDC), Legionella is a type of bacteria that causes Legionnaires' disease a serious lung infection. 3. Staff were not provided with updated infection control training and education. (Refer to F945) 4. The Facility Infection Control Policy was not updated to reflect current federal requirements. (Refer to F887) 5. Hand hygiene was not performed during medication administration to Resident(R)10 and 16.Failure to implement infection prevention practices may contribute to cross contamination of infection that can jeopardize the health and safety of residents and staff. Findings: 1. During medication administration on 08/19/25 at 01:36 PM, Licensed Practical Nurse (LPN) 1 was don on gloves and started mixing the intravenous antibiotics. LPN1 removed the glove, did not perform hand hygiene and took the medication inside the room. On 08/20/25 at 09:56 AM, Food Service Worker (FSW) 1 was observed entering the kitchen from the common dining area without washing their hands. In an interview at 09:57 AM, FSW1 acknowledged that he did not wash his hands before entering the kitchen and stated that he will wash his hand in the sink located at the back of the kitchen. During the food tray line and food distribution on 08/20/25 at 11:16 AM, FSW1 was observed wearing a glove on his left hand and no glove on his right hand while dishing out the food. In between the scooping of regular diet, FSW1 was cutting and chopping the food items for trays with mechanically chopped diet. FSW1 was observed touching the food with his gloved hands, moving one scoop of rice to another plate using his gloved hands directly touching the rice. In addition, FSW1 was observed going in and out at the washing area to wash the chopping board without changing the glove or performing hand hygiene. Review of facility policy titled, Hand Hygiene Policy dated 04/2023, for indication of hand hygiene indicated, “J. Perform Hand Hygiene after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. K. Perform Hand Hygiene after removing gloves.” 2. In an interview on 08/22/25, at 03:35 PM, the Acting Maintenance Supervisor (ASM) stated that water testing and monitoring was done “daily and weekly” for water temperature, softness and hardness of water and for pH level conductivity. In addition, ASM stated that “water sample is sent out to lab [laboratory] for testing every month.” However, the ASM could not explain what test is being done in the laboratory. On 08/22/25 at 04:11 PM, ASM showed a “CFU” (Colony Forming Units) result dated 06/16/25 with stamped that reads no growth in 2 days. ASM stated that he does not know what it means. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy titled Water Management Program to Reduce Legionella was reviewed with ASM. The policy indicated that WMP “will be reviewed annually” by Water Management Team. However, there was no documentation of evidence that WMP was reviewed annually. Additionally, the policy indicated, the following “situations that would warrant a team meeting to address and/or anticipated plan for action” includes, i. Changes in the municipal water quality (e.g. increase sediment, lower disinfections level, increase turbidity, pH outside of parameters). ii. Equipment change iii. Increase in cases of Legionella iv. Updates in requirements. ASM acknowledged that the policy did not address testing protocols, acceptable ranges for control measures, and corrective actions that should be taken when control limits are not maintained to prevent the growth of opportunistic bacteria in water system. According to the CDC Water Management Standards titled, Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings A PRACTICAL GUIDE TO IMPLEMENTING INDUSTRY STANDARDS dated 06/24/21, Control [means] to manage the conditions within your building according to your water management program. Control measures: Things you do in your building water systems to limit growth and spread of Legionella, such as heating, adding disinfectants, or cleaning. Control limits: The maximum value, minimum value, or range of values that are acceptable for the control measures that you are monitoring to reduce the risk for Legionella growth and spread. Control points: Locations in the water systems where a control measure can be applied. Under the Control Measures & Corrective Actions: The Basics indicated, “If you find that a control limit (i.e., temperature levels, disinfectant levels) is not being met, you need to take corrective actions to get conditions back to within an acceptable range… Remember, any time there is a suspected case of Legionnaires’ disease associated with your building you should: Contact your local and/or state health department or work with them if they contact you. Notify anyone who could be affected by the growth and spread of Legionella in your building if the health department asks you to. Decontaminate the building water systems if necessary (you may need to get additional help from outside experts). Review the water management program and revise it, if necessary. ” Further, You will need to monitor to ensure your control measures are performing as designed. Control includes a minimum and a maximum value. Examples of chemical and physical control measures and limits to reduce the risk of Legionella growth: Water quality should be measured throughout the system to ensure that changes that may lead to Legionella growth (such as a drop in chlorine levels) are not occurring. Water heaters should be maintained at appropriate temperatures. Decorative fountains should be kept free of debris and visible biofilm. Disinfectants and other chemical levels in cooling towers and hot tubs should be continuously maintained and regularly monitored. Surfaces with any visible biofilm (i.e., slime) should be cleaned… Building water systems are dynamic. You should plan for your monitoring results to vary over time and be prepared to apply corrective actions. Corrective actions are taken in response to systems performing outside of control limits… Environmental testing for Legionella is useful to validate the effectiveness of control measures. The program team should determine if environmental testing for Legionella should be performed and, if so, how test results will be used to validate the program. Factors that might make testing for Legionella more important include: Having difficulty maintaining the building water systems within control limits. Having a prior history of Legionnaires’ disease associated with the building water systems. Being a healthcare facility that provides inpatient services to people who are at increased risk for Legionnaires’ disease. If the program team decides to test for Legionella, then the testing protocol should be specified and documented in advance. You should also be familiar with and adhere to local and state regulations and accreditation standards for this testing.” (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the United States Environmental Protection Agency (EPA) article titled, LEGIONELLA: DRINKING WATER FACT SHEET, dated September 2000, Legionella are relatively resistant to standard water disinfection procedures and can occur in potable water. Early symptoms include muscle pain, loss of appetite, headache, high fever, dry cough, chills, confusion, disorientation, nausea, diarrhea, and vomiting. Later symptoms include chest pain and difficulty breathing. It is difficult to distinguish this disease from other pneumonias. Early diagnosis and treatment are extremely important. Treatment consists of intravenous administration of antibiotics . Legionella are most commonly found in water, including groundwater, fresh and [NAME] surface waters, and potable (treated) water. Legionella are protected against standard water disinfection techniques, by their symbiotic relations with later microorganisms. These bacteria have been found in water distribution systems of hospitals, hotels, clubs, public buildings, homes, and factories. Other waters in which Legionella have been found include cooling towers, evaporative condensers and whirlpools. These bacteria may be transported from potable water to air by faucets, showerheads, cooling towers, and nebulizers. Furthermore, ANALYTICAL METHODS Environmental samples should be collected by swabbing areas where water flows (such as faucets and shower heads). The specimen should be concentrated by filtration, treated with an acid buffer to enhance Legionella recovery, and cultured on a selective buffered charcoal yeast extract (BCYE) [NAME] medium. Culture assays are the most common tests used to detect Legionella in environmental and biological samples. WATER TREATMENT Control methods designed to disinfect an entire water distribution system include thermal (super heat and flush) hyperchlorination copper-silver ionization Control methods designed to disinfect only a specific portion of a water distribution system include ultraviolet light sterilization ozonation instantaneous steam heating Selecting one or a combination of these two types of control methods would be best for eradicating Legionella colonies and preventing recolonization of the water distribution system . 3. In an interview on 08/21/25 at 02:41 PM, Registered Nurse (RN) 1 stated, “I cannot remember the last time we received in-service or training for infection control.” In an interview on 08/21/25 at 02:51 PM, the Infection Control Officer (ICO) stated that she oversees infection control (IC) training and education for the staff since 2022. ICO admitted that since 2023 to present (August 2025) there was no documented evidence that she provided an IC education or in-service training. The last in-service training was conducted on 07/07/2023. In an interview on 08/22/25 at 02:22 PM, Certified Nursing Assistant (CNA) 1 stated, “The last [IC] in-service was way back 2023 when our IC was still Mr. [name redacted].” 4. In an interview on 08/22/25 at 01:56 PM, the ICO stated that only three out of 75 total employees were updated on COVID-19 vaccination. ICO explained that COVID-19 vaccination education was provided to the staff by giving them “handouts.” In a follow-up interview on 08/22/25 at 02:16 PM, ICO stated that all the staff are not provided with education about benefits and risks and potential side effects associated with COVID-19 vaccination. ICO explained, “COVID [19] vaccination is not a requirement of the hospital for the staff and patients. So, we only educate if they agreed to get the vaccine.” (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled, MANDATORY COVID-19 VACCINATION PROTOCOL, dated 08/2022 indicated, “SNF [Skilled Nursing Facility] shall make a good faith effort to assure that by January 27, 2022 all applicable individuals have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the organization and/or its patients.” The policy did not include information regarding the requirements in providing staff education of benefits and risks and potential side effects associated with COVID-19 vaccine. 5. R10: On 08/20/25 at 08:29 AM, during a medication administration observation for R10, RN 1 was observed preparing and administering medications, including oral medications and a subcutaneous injection. After preparing the medications, RN 1 sanitized her hands using alcohol based hand rub (ABHR), donned gloves, and entered R10’s room. RN 1 mixed the crushed calcium into pudding, which the resident consumed. R10 then took the remaining oral medications individually. RN 1moved the overbed table and exposed R10’s abdominal area. RN 1 cleansed the right side with an alcohol pad, pinched the skin with her left hand, and administered the subcutaneous injection with her right hand. Hand hygiene was not observed at this time. While still wearing the same gloves, RN 1 stated “Oh I forgot something, I’m going to place this on your back.” RN 1 lowered the head of the bed using the bed rail controls. R10 turned to the right side, and RN 1 applied hydrocortisone cream by squeezing the cream from the tube into her gloved hand. RN 1 then moved to the left side, dispensed a pea-sized amount into her gloved hand, and applied it to the resident’s back. This process was repeated twice. RN 1 then covered the treated area, repositioned R10, placed the blanket and moved the overbed table to the side. The same gloves were used throughout the entire process, and hand hygiene was not performed between tasks. During the interview on 08/20/25 at 11:55 AM, RN 1 verified the observation and acknowledged that she should have performed hand hygiene and changed gloves before and after the subcutaneous injection. RN 1 also stated that the ointment should have been dispensed into a medication cup rather than directly into gloved hands, as this practice increases risk of contamination. R16: On 08/20/2025 at 8:43 AM, during a medication administration observation for R16, RN 1 was observed preparing and administering medications, including oral medications, a subcutaneous injection, and a topical application. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	After preparing the medications, RN1 sanitized her hands using ABHR, donned gloves, and entered R16”s room. RN 1 explained the procedure to the resident, pulled the overbed table toward R16, opened the individual foils, and placed the pills in a medication cup while explaining each medication. After R16 took the oral medications, RN 1 exposed the abdominal area, cleansed the left side with an alcohol pad, removed the injection from its packet, pinched the skin with her left hand, and administered the injection with her right hand. RN 1 was not observed performing hand hygiene before and after administering the subcutaneous injection. RN 1 was then observed checking R16’s heels, which were noted to be offloaded on one pillow. RN 1 repositioned the resident and provided the call light. All of these tasks were performed using the same gloves without hand hygiene between tasks. On 08/20/25 at 11:55 AM, RN1 was interviewed and verified the observation. RN 1 “I should have washed my hands and changed gloves before and after administering the subcutaneous injection.” According to the facility’s policy titled Hand Hygiene Policy revised 04/2023, “Hand Hygiene must take place before and after patient contact, including direct contact with a patient’s skin (taking a pulse or blood pressure, etc.).”

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Infection Control Officer (ICO) was performing the duties of an infection preventionist (IP) who is responsible for implementing programs and activities to prevent and control infection.This failure resulted in improper implementation of the facility's Infection Prevention and Control Program (IPCP) that may contribute to cross contamination of infection and jeopardize the health and safety of residents and staff.Findings: In an observation on 08/19/25 at 01:36 PM, Licensed Practical Nurse (LPN) 1 don on gloves and started mixing the intravenous antibiotics. LPN1 removed the gloves, did not perform hand hygiene and took the medication inside the room.On 08/20/25 at 08:29 AM, Registered Nurse (RN) 1 did not perform hand hygiene in between tasks during administration of Resident 10's medication. RN1 was observed using the same gloves throughout the entire medication administration process and hand hygiene was not performed.On 08/20/25 at 09:56 AM, Food Service Worker (FSW) 1 was observed entering the kitchen from the common dining area without washing their hands. At 08/20/25 at 11:16 AM, during the tray line, FSW1 was observed wearing a glove on his left hand and no glove on his right hand while dishing out the food. In between the scooping of regular diet, FSW1 was cutting and chopping the food items for trays with mechanically chopped diet. FSW1 was observed touching the food with his gloved hands, moving one scoop of rice to another plate using his gloved hands directly touching the rice. In addition, FSW1 was observed going in and out at the washing area to wash the chopping board without changing the glove and performing hand hygiene.2. In an interview on 08/21/25 at 02:41 PM, Registered Nurse (RN) 1 stated, I cannot remember the last time we received in-service or training for infection control. RN1 stated that the EBP was implemented because the previous [CMS] surveyor taught us what to do. Who is the patient needs EBP. We (staff) implement it ourselves. We did not receive in-service training about it. In an interview on 08/22/25 at 01:49 PM, Licensed Practical Nurse (LPN) 1 stated that she did not received education regarding current COVID-19 vaccination requirements. In an interview on 08/22/25 at 01:51 PM, the Housekeeping Staff (HSK) 2 stated that she did not receive any in-service training provided by ICO. In an interview on 08/22/25 at 02:16 PM, ICO stated that all the staff are not provided with education about benefits and risks and potential side effects associated with COVID-19 vaccination. ICO explained, COVID [19] vaccination is not a requirement of the hospital for the staff and patients. So, we only educate if they agreed to get the vaccine. ICO did not offer an answer when asked if she is familiar with the federal requirement regarding employee COVID-19 vaccination. In an interview on 08/22/25 at 02:22 PM, Certified Nursing Assistant (CNA) 3 stated, The last [IC] in-service was way back 2023 when our IC was still Mr. [name redacted]. CNA3 stated that she did not receive an in-service regarding EBP and current Covid-19 vaccination requirement.In an interview on 08/22/25, at 04:35 PM, RN2 stated that she did not received any in-service provided by ICO. RN2 also stated that I completed my annual skills check in the hospital the other day. There's no infection control topic that was discussed. RN2 added that the skills check lasted for four hours.3a. In an interview on 08/21/25 at 03:39 PM, ICO stated that Pharmacy Consultant oversees the facility's Antibiotics Stewardship Program (PC). According to ICO, she did not have the data on the use of antibiotics and stated, we only monitor if the infection occurs here. On 08/22/25 at 11:31 AM, the facility's ASP was discussed with the Pharmacy Consultant (PC). PC stated that she oversees the facility ASP including monitoring of the use of antibiotics and reviewing the criteria for the use of antibiotics. According to the PC, there is no active Collaboration with ICO regarding ASP. PC added, Nurses write down symptoms, but I need to look back at the documentation.3b. In an interview with the ICO, DON, and Acting Maintenance Supervisor (ASM) on 08/22/25 at 04:55 PM, ICO stated that ASM oversees the Water System Management (WSM) facility to prevent legionella.Review of undated facility policy titled Water Management Program to Reduce Legionella was reviewed with ASM. The policy indicated that WMP will be reviewed annually by Water Program Management Team (WPTM). WPTM includes Infection Control Preventionist.The CDC Water Management Standards titled, Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings A PRACTICAL GUIDE TO IMPLEMENTING INDUSTRY STANDARDS dated 06/24/21 indicated, certain skills are needed to develop and implement water management program. In healthcare facilities the team should include Someone who understands accreditation standards and licensing requirements. Someone with expertise in infection prevention. A clinician with expertise in infectious diseases. Risk and quality management staff. In an interview on 08/21/25

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to ensure 73 out of 75 employees are provided with education regarding benefits and risks and potential side effects associated with COVID-19 vaccine. This failed practice prevented employees to make an informed decision about COVID-19 vaccination.Findings:In an interview on 08/21/25 at 02:51 PM, the Infection Control Officer (ICO) stated that she oversees infection control training and education for the staff.In an interview on 08/22/25 at 01:49 PM, Licensed Vocational Nurse (LVN) 1 stated that she did not received education regarding COVID-19 vaccination. In an interview on 08/22/25 at 01:56 PM, the ICO stated that only three out of 75 total employees were updated on COVID-19 vaccination. ICO explained that COVID-19 vaccination education was provided to the staff by giving them handouts.In a follow-up interview on 08/22/25 at 02:16 PM, ICO stated that all of the staff are not provided with education about benefits and risks and potential side effects associated with COVID-19 vaccination. ICO explained, COVID [19] vaccination is not a requirement of the hospital for the staff and patients. So, we only educate if they agreed to get the vaccine. Review of ICO's documented record of staff education regarding COVID-19 vaccination indicated that only Housekeeping Staff (HS) 1 and HS2 (two staff) received COVID-19 benefits and risks and potential side effects education. ICO corrected her previous statement and confirmed that only two staff were updated on COVID-19 vaccine and was provided COVID-19 vaccine handouts. ICO was not able to provide evidence that the remaining 73 staff was given education of benefits and risks and potential side effects associated with COVID-19 vaccine.In an interview on 08/22/25 at 02:22 PM, Certified Nursing Assistant (CNA) 3 stated that she does not have recollection that ICO provided education regarding COVID-19 vaccination.Review of the facility policy titled, MANDATORY COVID-19 VACCINATION PROTOCOL, dated 08/2022 indicated, SNF [Skilled Nursing Facility] shall make a good faith effort to assure that by January 27, 2022 all applicable individuals have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the organization and/or its patients. The policy did not include information regarding the requirements in providing staff education of benefits and risks and potential side effects associated with COVID-19 vaccine.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guam Memorial Hospital Authority	449 N Sabana Dr Barrigada, GU 96913

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. (continued on next page)

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff received an infection prevention and control program in-service training to support current scope and standard of practice specifically for current COVID-19 vaccination requirement and Enhanced Barrier Precaution (EBP) practices for six of six staff (RN1, RN2, LPN1, CNA1, CNA3 and CNA4) reviewed over 75 total facility staff.This failure could affect the proper implementation of current infection prevention practices and placed residents at risk of not receiving appropriate care and services that could jeopardize their health and safety. Findings:In an interview on 08/21/25 at 02:41 PM, Registered Nurse (RN) 1 stated, I cannot remember the last time we received in-service or training for infection control. RN1 stated that the EBP was implemented because the previous [CMS] surveyor taught us what to do. Who is the patient needs EBP. We (staff) implement it ourselves. We did not receive in-service training about it. In an interview on 08/21/25 at 02:51 PM, the Infection Control Officer (ICO) stated that she oversees infection control (IC) training and education for the staff since 2022. ICO admitted that since 2023 to present (August 2025) there was no documented evidence that she provided an IC education or in-service training. The last in-service training was conducted on 07/07/2023. The ICO also explained that the hospital educators are providing the overall facility wide training in the form of (web based) [NAME] training where there is a test after the training.In an interview on 08/22/25 at 01:01 PM, the Director of Nursing (DON) stated the facility assigned ICO in the current position since 2022. The ICO responsibility includes providing infection control training to all staff. In an interview on 08/22/25 at 01:49 PM, Licensed Practical Nurse (LPN) 1 stated that she did not received education regarding current COVID-19 vaccination requirements. In an interview on 08/22/25 at 02:16 PM, ICO stated that all the staff are not provided with education about benefits and risks and potential side effects associated with COVID-19 vaccination. ICO explained, COVID [19] vaccination is not a requirement of the hospital for the staff and patients. So, we only educate if they agreed to get the vaccine. In an interview on 08/22/25 at 02:22 PM, Certified Nursing Assistant (CNA) 3 stated, The last [IC] in-service was way back 2023 when our IC was still Mr. [name redacted]. CNA3 stated that she did not receive an in-service regarding EBP and current Covid-19 vaccination requirement. In an interview on 08/22/25, at 04:35 PM, RN2 stated that she did not received any in-service provided by ICO. RN2 also stated that I completed my annual skills check in the hospital the other day. There's no infection control topic that was discussed. RN2 added that the skills check lasted for four hours. Review of training records transcript of RN1, RN2, LPN1, CNA1, CNA3 and CNA4 revealed no record of completed training for EBP and COVID-19 vaccination requirement for employees. Review of facility policy titled, SNU Infection Control Program dated 04/18/24, under program description indicated, 1. Infection control at Skilled Nursing Facility is managed using supervised, coordinated and continuous approach encompassing A. CDC guidelines. OSHA regulations and pertinent federal, state, and local regulations pertaining to infection control are implemented and followed.D. In-service education will be provided for all employees' facility-wide with particular emphasis on hand hygiene, proper use of personal protective equipment (PPE) for staff at risk of accidental exposure to blood and body fluids.G. Employee health-related issues will be reviewed and in-service education related to infection control practices will be provided. Review of CDC Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, dated 6/28/24, at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html documented Enhanced Barrier Precautions is primarily intended to apply to care that occurs within a resident's room where high-contact resident care activities, including transfers, are bundled together with other high-contact activity, such as part of morning or evening care. This extended contact with the resident, and their environment increases the risk of MDRO [multidrug resistant organism, bacteria that are resistant to three or more classes of antimicrobial drugs] spreading to staff hands and clothes.