STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125024	A. Building B. Wing	02/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nuuanu Hale	2900 Pali Highway Honolulu, HI 96817

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42871 Based on observations, record reviews, and interviews, the facility failed to maintain the dignity of three residents (R), R61, R31, and R17 of a total of 5 residents sampled. The urinary catheter and bag system for R31, R61, and R171 were exposed and visible, revealing their medical condition to other residents and their visitors. Findings include: 1) Cross reference F656 Develop/Implement Comprehensive Care Plan On 01/31/23 at 09:15 AM, observed R31's bed was next to the door. R31 laid in bed and his urinary catheter and bag system were placed on the left underside of his bed which faced the doorway. It was visible to anyone passing by R31's room. On 01/31/23, follow up observations of R31 were done at 11:16 AM, 01:14 PM, and 03:00 PM. The urinary catheter and bag system were still placed on the left underside of his bed, easily visible from the doorway. Reviewed P31's electronic health record (EHR). A General Order was noted for Privacy Bag for Down Drain Bag dated 12/28/21. Care Plan with last care conference date of 12/21/22, had a problem Indwelling Catheter started on 08/20/22. Ensure down drain bag has dignity cover intervention documented with a start date of 08/20/22. On 02/01/23 at 10:00 AM, interviewed Registered Nurse (RN)22. RN22 stated that P31's urinary catheter and bag system should not be easily visible and should always have a privacy bag to cover it to maintain P31's privacy and dignity. 2) On 01/31/23 at 09:10 AM and 12:58 PM, R61 was observed. R61's bed was next to the door. R61 laid in bed with her urinary catheter and bag system placed on the right underside of her bed which faced the doorway. It was easily visible to anyone passing by R61's room. Reviewed R61's EHR. The . PHYSICIAN DISCHARGE SUMMARY created on 11/18/22 stated that R61 was discharged from the hospital on 11/18/22 and was admitted to the facility on [DATE] to receive hospice care. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Care Plan with last care conference of 11/23/22 revealed a problem start date of 11/18/22 for Indwelling Catheter due to R61's condition of having a neurogenic bladder (the nervous system is unable to communicate with the bladder). The intervention, Ensure down drain bag has dignity cover, was created on 11/18/22. (Cross reference F656 Develop/Implement Comprehensive Care Plan) On 02/01/23 at 10:00 AM, interviewed Registered Nurse (RN)22. RN22 stated that P61's urinary catheter and bag system should not be easily visible and should always have a privacy bag to cover it to maintain P61's privacy and dignity. Reviewed policy, Catheter Care with revised date of 05/22. It stated under Policy, It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. 37229 3) During an initial observation, on 01/31/22 at 08:02 AM, R171's foley catheter was noted on the left side underside of the bed in room. The foley catheter was displayed not covered and hanging with half of the bag on the floor. (Cross reference to F690 Bowel/bladder incontinence, catheter, UTI). Reviewed policy, Catheter Care with revised date of 05/22. It stated under Policy, It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use.

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident has the right to receive notices in a format and a language he or she understands. 22063 Based on interview with resident council representatives, the facility failed to ensure residents are aware of the process to make a formal complaint to the State Agency (SA) and where to locate the Ombudsman's contact information. Findings include: On 02/02/23 at 09:00 AM an interview was conducted with resident council representatives. There were 10 residents in attendance, two of which were new admissions and does not attend meeting regularly. Residents were asked whether they know where the long-term care ombudsman's information is posted and are they aware that they can complain to the State Agency. The residents were not able to identify where the contact information for the ombudsman or State Agency is located. They were not aware they can complain to the State Agency.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 22063 Based on observation and interview with the resident council representatives, the facility failed to ensure residents are aware of the posting of the most recent survey and where to find it. Findings include: On 02/02/23 at 09:00 AM an interview was conducted with resident council representatives. There were 10 residents in attendance, two of which were new admissions and does not attend meeting regularly. The residents were asked whether the results of the State inspection were available to read. The representatives were not aware the State Agency prepares a survey report. The representatives were not aware of where the reports are posted. Observed the posting of survey results on the unit; however, the representatives were not aware of where to locate the report.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42871 Based on observations and interviews, the facility failed to maintain a clean, homelike environment for two residents (R), 40 and R30 of four residents sampled. R40's personal standing fan screens contained heavy dust. Another resident R30, was continuously exposed woken up to yelling and screaming as early as 03:30 AM making it difficult to get adequate sleep. Findings include: 1) Subsequent observations on 01/31/23 at 09:09 AM; 02/01/23 at 12:10 PM and 02/02/23 at 09:57 AM. R40 laid in bed next to the window and a black standing fan that was powered on was placed between the left of his bed and the window. The front and back grills of the fan had heavy black dust. R40 stated that it was his personal fan. He told the surveyor the facility never cleaned it. On 02/02/23 at 2:00 PM, a concurrent observation of R40's fan and interview were done with Unit Clerk (UC)10. UC10 confirmed that the fan was dirty, and that the housekeeping and maintenance departments are responsible for cleaning it. On 02/02/23 at 08:30 AM, queried the Administrator. Administrator stated that the maintenance department is responsible for cleaning the fans in residents' rooms on the nursing units. On 02/03/23 at 09:30 AM, interviewed the Maintenance Supervisor (MS). MS stated that the fans in the facility are checked and cleaned monthly by the maintenance department and that staff can complete a work order form to have a resident's fan serviced. 37229 2) On 01/31/23 at 07:30 AM, an initial observation was made of the hallway on the 2nd floor of the facility. Doors of the residents' rooms were opened . A loud pounding involving Resident (R)49 and shouting could be heard from room [ROOM NUMBER]. An interview was done on 01/31/23 at 07:38 AM in the hallway of the 2nd floor with Resident(R)30. R30 stated that early in the AM at 03:30, staff start bringing two residents out of their rooms who are yellers, Residents (R)36 and R27 and park them in the hall in front of my room, 217, and they start screaming. They wake me up and pretty much the whole floor. Continued observation on 01/31/23 at 08:38 AM of room [ROOM NUMBER], shows R49 hustling about and abrupt behavior in her room, pounding on the walls and making a lot of noise that could be heard across the hall while in room [ROOM NUMBER]. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/02/23 at 06:00 AM upon arrival to floor, observation shows two licensed nurses and four certified nurse aides (CNAs) on the unit. Residents on floor in wheelchairs on Ewa - 4; Diamond Head - 3, nursing station - 2 and [NAME] - 4. TVs are on. Interview with CNA1 at 06:25 AM done. CNA1 stated that the night shift gets the residents up to shower and places them in the halls. Queried about the yelling from certain residents and if staff close doors or the placement of resident's who are yelling in front of other's rooms. CNA1 stated that they would move them to the end of the hall. Observation continued 02/03/23 and at 07:21 AM R27 yelling in front of room [ROOM NUMBER] and moved to end of hall. R49 came to the entrance of room [ROOM NUMBER] and quickly went back in room when R27 started yelling. R36 is in hall in front of nursing station and yelling. Observation on 02/02/23 with licensed practical nurse (LPN)9 who is spending a lot of time with R36 who has outbursts of yelling and slides down on wheelchair. LPN9 states that R49 is usually good and needs a lot of redirection and attention.

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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. 22063 Based on interview with resident council representatives, the facility failed to ensure residents know how to file a grievance and a resident reported feeling concerned that staff members may be vindictive. Findings include: On 02/02/23 at 09:00 AM an interview was conducted with resident council representatives. There were 10 residents in attendance, two of which were new admissions and does not attend meeting regularly. The residents were asked whether they know how to file a grievance. The representatives were unable to report how they would file a grievance. One resident reported, they go to the nurses or social worker. One resident reported not wanting to file a grievance as it is felt certain people will be vindictive. This resident further reported uncertainty whether a complaint is shared with a staff member if it would be taken to the next level.

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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** 42871 Based on observation, record review and interview, the facility failed to provide an accurate picture of one resident (R), R31, out of 19 residents in the sample. R31's annual assessment revealed that he did not have a urinary catheter system, but R31 diagnosis makes him dependent on the invasive medical device. This deficient practice of having an inaccurate assessment poses the risk of having inadequate care. Finding includes: On 01/31/23 at 09:15 AM, observed R31. R31 laid in bed that was located next to the door and his urinary catheter and bag system was visible on the left underside of his bed. Reviewed R31's electronic health record (EHR). Reviewed Resident Face Sheet. R31 is a [AGE] year old resident admitted to the facility on [DATE] with the diagnoses of retention of urine, central cord syndrome (incomplete spinal cord injury), quadriplegia (paralysis of all four limbs and the torso, usually caused by a spinal cord injury in the neck), and obstructive and reflux uropathy (excess urine accumulation in the kidneys). Read Annual Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 12/23/22. Under Section H Bladder and Bowel H0100 Appliances R31 was coded as to not having a urinary catheter system. Reviewed the General Administration History report for 12/01/22 to 12/31/22. The treatment for Catheter Care with a diagnosis of obstructive and reflux uropathy had a start date of 12/28/21. It also revealed that catheter care was done on each shift for all days in December. On 02/01/23 at 10:00 AM, interviewed Registered Nurse (RN)22. RN22 stated that P31 has always had his urinary catheter system due to his diagnoses. On 02/03/23 at 3:50 PM, communication via email was done with the MDS coordinator (MDSC). MDSC stated that R31 did have his urinary catheter system during the period of her assessment and that she coded him as not having the medical device in error. Reviewed the policy, NURSING SERVICES, with revised date 01/05/18. Under Resident Assessment, it stated, 1. The Facility conducts a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity initially, quarterly, yearly and whenever there is a significant change in a resident's condition.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42871 Based on observations, interviews, and record reviews, the facility failed to provide an individualized person centered care plan for four of 19 residents sampled. The facility also failed to implement the care plan for two residents R61 and R31. This deficient practice has the potential of resulting in improper care of residents in the facility. Findings include: 1) Cross reference F690 Bowel/Bladder Incontinence, Catheter, UTI On 01/31/23 at 09:20 AM, R44 was observed. R44's urinary catheter tubing and bag system was placed on the underside of the left side of his bed. The urinary catheter tubing was touching the ground and tangled under the wheel of his bedside table. On 01/31/23 at 12:58 PM, observed R44's dressing change of his calf wounds by Physician Assistant (PA)1 assisted by the Infection Preventionist (IP). Noted R44's urinary catheter tubing and bag system was still located to the bottom left side of his bed. The urinary catheter tubing was touching the ground. On 02/01/23 at 09:57 AM, observed Registered Nurse (RN)22 change R44's dressing to both of his calf wounds. Noted R44's urinary catheter tubing was touching the ground. On 02/02/23 at 08:27 AM, observed R44's urinary catheter tubing touching the ground and tangled under the wheel of his bedside table. Reviewed R44's electronic health record (EHR). Resident Face Sheet revealed that R44 is a [AGE] year old resident admitted to the facility on [DATE]. Diagnoses includes paraplegia (paralysis of all or part of the trunk, legs, and pelvic organs), nerves unable to control bladder function, bone infection, and nosocomial infections (infections acquired in healthcare facilities that are caused by bacteria, fungi, viruses, or other pathogens that enter the body through medical devices, wounds, or contact with staff or other patients). Read R44's Care Plan with last care conference date of 01/25/23. Under the problem for Infection, with a start date of 11/02/22, R44's susceptibility to infections was not addressed. The problem for Indwelling catheter, with a start date of 08/20/22, did not have an intervention to maintain the cleanliness of his urinary catheter tubing and bag system to prevent further infections. On 02/03/23 at 10:00 AM, interviewed Unit Manager (UM)1. UM1 stated that R44's care plan should include R44's susceptibility to infections with individualized interventions and the proper handling of R44's urinary catheter tubing and bag system to prevent infection. 2) Cross reference to F550 Resident Rights/Exercise of Rights. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/31/23 at 09:10 AM, observed R61's urinary catheter and bag system was placed on the underside of the right side of her bed which faced the doorway. It was easily visible to anyone passing by R61's room. (F690 Bowel/Bladder Incontinence, Catheter, UTI). Reviewed P61's EHR. Read Care Plan with last conference date of 11/23/22. Problem Indwelling Catheter started on 11/18/22, documented an Ensure down drain bag has dignity cover intervention with a start date of 11/18/22. There was no intervention to maintain the cleanliness of R61's urinary catheter tubing and bag system to prevent infection. On 02/03/23 at 10:00 AM, interviewed Unit Manager (UM)1. UM1 stated that R61's care plan was not followed because there was no dignity cover on R61's urinary catheter bag and an intervention for Indwelling catheter should include the proper handling of the system to ensure R61 is kept free of infection. 3) Cross reference F550 Resident Rights/Exercise of Rights. On 01/31/23 at 09:15 AM, R31 was observed. R31's urinary catheter and bag system was placed on the underside of the left side of his bed which faced the doorway. It was visible to anyone passing by R31's room (F690 Bowel/Bladder Incontinence, Catheter, UTI). Reviewed P31's EHR. A General Order was noted for Privacy Bag for Down Drain Bag dated 12/28/21. Care Plan with last conference date of 12/21/22 had the problem of Indwelling Catheter started on 08/20/22. An intervention of Ensure down drain bag has dignity cover had a start date of 08/20/22. There was no intervention to maintain the cleanliness of R31's urinary catheter tubing and bag system to prevent infection. On 02/03/23 at 10:00 AM, interviewed Unit Manager (UM)1. UM1 stated that R31's care plan was not followed because there was no dignity over on R31's urinary catheter bag and an intervention for Indwelling catheter should include the proper handling of the system to ensure R31 is kept free of infection 4) On 01/31/23 at 09:15 AM, observed R46. R46 was grunting to verbal stimulation, he had his shirt up to cover his face, and a mattress was on the floor to the right side of his bed. On 02/01/23 at 09:37 AM, observed R46 lying in bed with his eyes closed, his arms stiffly straight to his sides. R46 did not respond to verbal stimulation. On 02/02/23 at 08:04 AM, R46 was observed to be awake in bed, responding appropriately to salutation and waving hello. On 02/03/23 at 06:17 AM, made a concurrent observation of R46 and inquiry with certified nurse aide (CNA)20. R46 was observed to be sleeping on the mattress on the floor located to the right side of his bed and CNA 20 stated that R46 was assisted to his bed 4 times during the night, but preferred to sleep on the mattress on the floor next to his bed. On 02/02/23 at 11:26 AM, interviewed R46's family member (FM)7. FM7 stated that R46 has a rare disease that needs long-term management with various types of medications. Their daughter, who is a pharmacist, is aware of the consequences of long-term therapy with these medications. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reviewed R46's EHR. Resident Face Sheet revealed diagnoses of dementia with behavioral disturbance and corticobasal degeneration (a rare condition where the brain shrinks, and the nerve cells degenerate and die over time). Care Plan with last care conference date of 01/11/23 was reviewed. There was no problem identified to address R46's rare diagnosis of corticobasal degeneration with associated behaviors and interventions to define R46's individualized management of his rare disease. On 02/03/23 at 10:00 AM, interviewed Unit Manager (UM)1. UM1 stated that R46's rare diagnosis of corticobasal degeneration and associated behaviors should have been addressed and should include individualized interventions of management with long-term therapy of medications and management of R46's behaviors. Reviewed the COMPREHENSIVE PERSON-CENTERED PLAN OF CARE policy and procedure, with revised date of 02/26/18. It stated, Policy . shall ensure each resident has a comprehensive person-centered individualized plan of care to provide a central source of information on the total needs and program of care for each resident which incorporates the resident's goals, preferences and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being, and communicate information regarding individual resident care needs and problems to all personnel involved in caring for the resident .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47783 Based on observations, record reviews, and staff interviews, the facility failed to ensure the comprehensive person-centered care plan (CP) was reviewed and/or revised by the interdisciplinary team for two of 19 residents in the sample. There was lack of evidence that the CP was evaluated for effectiveness and revised to meet the resident's needs. As a result of this deficient practice resident (R)23 continued to wander unsupervised, and R11 had a recurring open area/pressure injury. Findings include: 1) R23 is a [AGE] year-old resident with Alzheimer's disease, dementia, history of falls and fractures, muscle weakness, orthostatic hypotension (sudden drop in blood pressure when standing from a seated or lying position), difficulty in walking and age-related osteoporosis (weakened bones). Resident also has a history of wandering (Cross Reference to F689- Free of Accident Hazards/Supervision/Devices). Review of (CP) revealed the resident exhibits wandering with a start date of 9/18/21. Interventions include: Approach resident from the front, walk in step with resident first before redirecting; assess whether the behavior endangers the resident and/or others, intervene if necessary; assure that resident has proper fitting and appropriate foot attire; avoid over-stimulation (e.g., noise, crowding, other physically aggressive residents); if resident looks for family/significant other, re-assure the resident that family/significant other knows where to find the resident; maintain a calm environment and approach to the resident; when resident begins to wander, provide comfort measures for basic needs (e.g., pain, hunger, toileting, too hot/cold, etc.). CP notes from 07/13/22 revealed the interdisciplinary team discussed the following: .5/3/22 - Multiple attempts to get out of bed and forgetting how to use walker. 6/7/22 - Episode of wandering into other resident's rooms with walker; able to redirect by nursing. 7/4 - 7/6, Multiple episodes of wandering into other resident's rooms and back and forth to elevator, 7/6 also had incident of resident entering another room and eating another resident's food. Further record review revealed that R23 had an unwitnessed fall in her room on 10/08/22 at 09:39 PM, unwitnessed fall in the hallway on 11/21/22 at 01:23 PM, witnessed (by a resident) fall in the hallway on 12/19/22 at 02:21 PM, and was trapped in the elevator by herself on 11/26/22 for approximately 15 mins, and on 1/26/23 for approximately 50 minutes. On 02/03/23 at 10:27 AM, conducted an interview with UM1. Asked how closely is R23 being supervised then wandering in the hallway, she responded: we try to keep an eye on her as much as we can resident goes to activities and does not need constant assistance able to walk around and has a fascination with the elevator. We tried to have her sit by the nurse's station, but she would still try to get up and walk away. We have tried everything, maybe we can ask the family to help. We are not able to provide her with 1:1 supervision. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) Resident (R)11 is a [AGE] year-old resident admitted on [DATE]. Diagnoses include quadriplegia (paralysis that affects all four limbs and torso), contractures to all four extremities, cerebral infarction (damage to tissues in the brain due to a loss of oxygen), muscle spasms, hypertension (high blood pressure), and bed confinement status. Resident also has history of multiple pressure ulcers (Cross Reference to F686- Treatment/Svcs to Prevent/Heal Pressure Ulcer). During initial observation on 01/31/23 at 09:52 AM, noted R11 in bed using a specialty mattress, head of bed elevated, arms and legs severely contracted with rolled paper towel in both hands, pillows between legs and foam boot in place. No pillow noted between arms and torso. On 01/31/23 at 01:04 PM, observed Infection Preventionist (IP) and physician assistant (PA) change the dressing on left wrist open area and right foot pressure ulcer. After dressing was changed, IP and PA struggled to place a cushion between arm and torso because R11 would get spastic when stimulated. On 02/03/23 at 02:23 PM, interview with IP regarding resident's recurring left wrist open area was done. IP said they are using a cushion to offload pressure from the wrist and needs to be always in place unless the staff are providing care for the resident. IP did say that the resident gets spastic when stimulated and when that happens, the cushion could be pushed out of place. That is why the staff on the floor need to check on R11 more often. She also mentioned that the staff on the floor might have a difficult time placing the pillow back in place when the resident gets spastic. IP instructed them to notify her so she can assist them when this happens, but they don't. CP not updated with this information. Review of facility's policy and procedure Comprehensive Person-Centered Plan of Care states: . 10. Any revisions or additions in regards to the resident's problems and/or needs, goals and plan of action/interventions will be documented in the Plan of Care.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22063 Based on observations, interview with residents and staff members, and record review, the facility failed to ensure two Residents (R) 53 and R7 who are unable to carry out activities of daily living received the necessary services to maintain good grooming. Findings include: 1) On 01/31/23 at 08:50 AM, Resident (R)7 was observed in bed. R7 had facial stubble (beard and moustache). On 02/01/23 at 07:53 AM a resident interview was conducted with R7. R7 observed with continued facial stubble. At 09:10 AM, R7 was asked if he can shave himself. R7 answered he can shave himself with set up. Further asked if he likes a beard and moustache as he had facial stubble, R7 did not respond. R7 was asked if he usually has a beard and moustache, he responded, no. On the morning of 02/02/23 observed R7 was clean shaven. On 02/02/23 at 10:06 AM interviewed Certified Nurse Aide (CNA)82. CNA82 reported sometimes R7 will refuse shaving, he is offered shaves three times a week when he showers. Inquired whether staff document refusals, CNA82 reported this is not documented, it is only documented when shaving has been done. Record review was done on 02/03/23 at 10:37 AM. R7 was admitted to the facility on [DATE] from an acute hospital where he was hospitalized for septic shock. Diagnoses include but not limited to, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side; muscle spasm of calf; and acute respiratory failure with hypoxia. A review of the quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 10/26/22 documents, R7 yielded a score of 15 (no cognitive impairment) on administration of the Brief Interview for Mental Status. Further review found the assessment was not completed to indicate the level of assistance R7 required for personal hygiene (including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, and hands). R7 was coded for functional limitation in range of motion for the upper and lower extremities on one side. Review of the annual MDS with an ARD of 02/01/22 documents R7 coded for requiring extensive assistance with one personal physical assist for personal hygiene. A review of R7's care plan notes the resident is at risk for altered activities of daily living function secondary to cerebrovascula accident with hemiplegia, benign prostate hypertrophy, history T11 fracture, incontinence and decreased mobility. Intervention include but not limited to assist in completing activities of daily living tasks each day, provide dignity and respect, ad encourage independence. 2) On 01/31/23 at 08:50 AM, R53 was observed lying in bed. He had facial hair stubble (beard and moustache). Subsequent observations on 02/01/23 and the morning of 02/02/23, R53 observed with beard and moustache stubble. On 02/02/23 at 10:07 AM observed R53 had been shaved. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/02/23 at 10:07 AM interviewed CNA82. CNA82 reported R53 is shaved every other day, however, if the hair gets long, they will shave him. CNA82 reported sometimes R53 will refuse care and they are unable to shave him. CNA82 reported R53 is unable to shave himself and they will use a razor blade to shave residents. Inquired whether staff will document resident's refusal. CNA82 responded it is not documented, however, staff will try again the next day. Record review was done on 02/03/23 at 3:05 PM. R53 was admitted to the facility on [DATE] with diagnoses which includes but not limited to, non-traumatic brain dysfunction. A review of the quarterly MDS with an assessment reference date of 11/22/22 documents no rejection of care. R52 is coded to require extensive assistance with one-person physical assist for personal hygiene. A review of the care plan identified activities of daily functional/rehabilitation potential, R53 is at risk for altered activities of daily living function secondary to history of encephalopathy, anemia, benign prostate hypertroply, chronic kidney disease, afib, suprapubic catheter, and decreased mobility. The approaches include but not limited to assist in completing activities of daily living tasks each day, provide dignity and respect, and encourage independence.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22063 Based on observations, interviews with staff members, and record review, the facility failed to assure three of five residents (Residents 15, 16, and 61) sampled were provided with an ongoing activity program to support their choice of activities and designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident. The facility failed to develop and implement an onging activity program for residents with cognitive impairment. This deficient practice has ptoential to affect residents' psychosocial well-being. Findings include: 1) On 02/03/23 at 09:07 AM the Activities Director (AD) was interviewed. The AD was hired in January 2023 and worked in activities in a long-term care facility for over two years. Subsequent interview on 02/03/23 at 11:21 AM, AD reported that she has one full-time activity staff and one part-time staff (four hours a week). AD further reported activities are not provided on the weekends as there isn't enough activity staff to cover the weekends. 2) Cross Reference to F684 Quality of care. Resident (R)16 has multiple self-inflicted skin abrasions, activities were identified as a diversional intervention. Resident (R)16 was admitted to the facility on [DATE]. Diagnoses include but not limited to multiple diagnosis including pressure ulcer of sacral region, stage 2 (01/11/23). On 01/31/23 at 08:50 AM, R16 was observed in the hallway seated in a wheelchair. There was a cut above her lip with a dry stream of blood running down to her lip. At 09:15 AM, R16 was still seated in the hallway. Interview with Licensed Practical Nurse (LPN)8 was done. Inquired what happened to R16 as she is bleeding. LPN8 reported R16 keeps on picking at her skin. Further queried what is being done to address this behavior. LPN8 responded they will divert her attention. Also noted a black line running vertically over R16's left eye. LPN8 rubbed the eye, and the black substance was removed. LPN8 was unable to identify the black substance. Subsequent observation at 10:07 AM found R16 in the hallway, asleep in the wheelchair. At 10:12 AM, observed LPN8 ask R16, where is the one that was given. LPN8 wiped some of the blood from above the resident's lip. LPN8 then provided a fidget toy (colorful plastic pad with bumps on it to pop). LPN8 explained, this is to keep R16's hands busy, popping the bumps/bubbles. At 11:05 AM, R16 was in the room with a visitor. On 02/01/23 at 08:36 AM, R16 was observed in the hallway with no activities. R16 was later observed in the room with the television on and plastic pad sitting on the overbed tray. LPN8 stated they are supposed to keep R16 engaged in activities, so she stops scratching. LPN8 placed the fidget toy in R16's hands. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review done on 02/01/23 at 12:47 PM found a comprehensive/annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 09/23/22 which documents upon administration of the Brief Interview for Mental Status (BIMS), R16 yielded a score of zero indicating severe cognitive impairment. A resident interview was not conducted to assess the residents' preferences for customary routine and activities. The staff assessment identified the following activity and customary preferences, receiving shower, family, or significant other involvement in care discussions, reading books, newspapers, or magazine, listening to music, and participating in religious activities or practices. Review of R7's care plan with a start date of 08/31/21 indicates the resident prefers to self-direct herself in activities and participates in activities as desired. Also, R7 often out of bed watching television in the hallway. Interventions include but not limited to: accompany resident outside for fresh air, if interested; activity staff will visit resident at least once a week for social interaction; offer magazines to keep her occupaied during individual activities; and post calender in resident's room. On 02/03/23 at 09:07 AM an interview was conducted with the Activities Director (AD). The AD reported the residents' preferences are assessed in the MDS and is not aware how to update the preferences. AD further reported R16 prefers to self-direct her daily activities and participates in activity programs as desired. On 02/03/23 at 11:21 AM, the AD provided record of resident's participation in activities. Review of attendance record from 01/11/23 to 02/03/23 found R16 was asleep for four of seventeen attempts. And missed two attempts for activities due to shower. Inquired what are the 1:1 activity that is provided to R16. AD responded staff will ask resident what will be asked what she will be doing today and will ask her what she wants to do. AD shared that it is a struggle to provide 1:1 activity. A review of the quarterly care conference summary dated 12/21/22 notes there are no changes to the activity care plan. R16 prefers to self-direct her daily activities and participates in activity programs as desired. She is alert and able to verbalize her needs and preferences. 3) R15 was admitted to the facility on [DATE]. Diagnoses include non-traumatic brain dysfunction and dementia. On 01/31/23 at 10:14 AM observed R15 seated in the hallway in her wheelchair. R15's head was hanging down and swaying side to side. She was seated in front of the television and had an overbed tray in front of her. Subsequent observations at 10:26 AM and 10:33 AM, R15 was still seated in the hallway with her head hanging down. At 11:03 AM, R15 was observed to be eating her lunch, she feeds herself with her hands. At 11:24 AM she was still eating and at 11:39 AM was in the hallway with her head hanging down. Last observation of the day at 01:57 PM, R15 was in bed asleep. On 02/01/23 at 08:01 AM, R15 was seated in the hallway and asleep (head hanging down and eyes closed). On 02/02/23 at 07:20 AM, R15 was seated in the hallway, had eaten her breakfast, and her head was hanging down with eyes closed. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review was done on 02/03/23 at 10:12 AM. A review of the quarterly MDS with an ARD of 01/09/23 documents, the BIMS was administered, R15 yielded a score of zero which indicates severe cognitive impairment. R15 was not interviewed to identify her customary routine and activities preferences. R15 was noted to prefer, receiving a shower, family, or significant other involvement in care discussions, and reading books, newspapers, or magazines. The care plan for activities identified R15 needs activities to promote social and sensory engagement. Also noted, resident is often lethargic during activities. The following interventions included: include in morning activity programs at least 1-2X per week for social and sensory engagement; offer magazines or newspaper to browse to keep her occupied; encourage resident to watch TV in the hallway or movies in activity room daily; engage her via 1:1 conversation, watching food or Okinawan dance videos on YouTube or taking her outdoor when she becomes restless; greet and encourage R15's attendance in daily morning programs by making eye contact; and offer the telephone or FaceTime video call to contact family upon resident's request or when scheduled by family. On 02/03/23 at 11:21 AM, the AD provided a copy of R15's participation in activities. There are 19 activity entries from 01/11/23 through 02/03/23. R15 was documented as asleep for 9 of 19 attempts to provide activities. 42871 4) On 01/31/23 from 09:15 AM to 12:58 PM, frequent observations found R61 to be in bed with no television or music player in her room. At 12:58 PM, R61 was non-verbal to salutation, laid in bed with a neck pillow and hand motioned for state agency (SA) to open her privacy curtain. On 02/02/23 from 08:00 AM to 12:30 PM, frequent observations found R61 to be in bed with no television or music player in her room. Reviewed R61's EHR. The . PHYSICIAN DISCHARGE SUMMARY created on 11/18/22 stated that R61 was discharged from the hospital on 11/18/22 and admitted to the facility on [DATE] to receive hospice care. Admission MDS with ARD of 11/24/22 was read. Section F Preferences for Customary Routine and Activities revealed that R61 finds listening to music and going outside to get fresh air when the weather is good very important to her. Doing activities with groups of people is not very important to R61. Reviewed Care Plan with last care conference on 11/23/22. There was no problem, goal, and interventions to address activities for R61. On 02/03/23 at 09:07 AM, requested from the Activities Director (AD) an Activities care plan for R61. At 11:20 AM, received from the AD the document POC History Report (95 Records) with date range 01/09/23 to 02/03/23 identified as the activities log for R61, but no care plan. Reviewed R61's activities log for date range 01/09/23 to 02/03/23. Out of the 15 entries for activities, two were group activities and there were no activities on the log that involved music. Reviewed the policy and procedure for Activities, revised on 10/04/17. It stated under Procedures, .3. A comprehensive assessment based on the resident's past and present interests, functioning levels, and needs is completed and used to develop appropriate activities to meet resident interest, which is incorporated into the comprehensive, individualized person-centered plan of care. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/03/23 at 11:00 AM, a concurrent observation of R61 in her room and interview were done with Certified Nurse Aide (CNA)3. CNA3 stated that R61 doesn't like group activities because she will go to the activity and want to come right back. CNA3 confirmed that R61 did not currently have a music player in her room for her listening enjoyment.

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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** 22063 Based on observation, the facility failed to assure preventative interventions and treatment for one resident with multiple self-inflicted wounds was provided to maintain her highest practicable physical, mental, and psychosocial well-being. The facility did not assure behavior monitoring was done and ensure resident does not experience pain during wound assessment and treatment. Findings include: Cross Reference to F679 (Activities) and F686 (Pressure Ulcers). Resident (R)16 was admitted to the facility on [DATE]. Diagnoses include but not limited to, sepsis, unspecified organism; other osteoporosis without current pathological fracture; urinary tract infection, site not specified; chronic kidney disease, stage 3 unspecified; vascular dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; subsequent non-ST elevation myocardial infarction; unilateral primary osteoarthritis right knee; effusion, right knee; syndrome of inappropriate secretion of antidiuretic hormone; and pressure ulcer of sacral region, stage 2 (01/11/23). On 01/31/23 at 08:50 AM, R16 was observed in the hallway seated in a wheelchair. There was a cut above her lip with a stream of blood. At 09:15 AM, R16 was still seated in the hallway. Interview with Licensed Practical Nurse (LPN)8 was done. Inquired what happened to R16 as she is bleeding. LPN8 reported R16 keeps on picking at her skin. Further queried what is being done to address this behavior. LPN8 responded they will divert her attention. Also noted a black line running vertically over R16's left eye. LPN8 rubbed the eye, and the black substance was removed. LPN8 was unable to identify the black substance. On 01/31/23 at 11:15 AM observed R16 also had multiple cuts on the left side of her neck and left side of her chest. The cuts were red and fleshy. Also observed resident had a bandage around her left shin. Record review done on 02/01/23 at 12:47 PM and 02/02/23 at 12:34 PM found a care conference entry for 12/21/22 noting R16 with multiple episodes of excessive scratching (10/8, 11/15, 11/15, 12/9, and 12/17) and removal of dressing despite explanation from direct care nurses. The progress note of 02/01/23 by the wound consultant notes wounds from last week are variable. There are multiple new wounds notes this week on the face, flank, and neck from scratching/skin picking. R16 was seen by the dermatologist on 12/08/22. The diagnoses include erosions and pruritus (an uncomfortable, irritating sensation that creates an urge to scratch that can involve any part of the body). The recommendation was to encourage applying Vaseline to wounds and cover, suggest [NAME] sensitive lotion or CeraVe, and discontinue topical antibiotics. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the psychiatry consult dated 01/31/23 notes increased episodes of scratching her own wounds/itching all over her body and limbs. Consultant noted R16 was seen by a dermatologist with diagnosis of neurodermatitis and resident very difficult to redirect (scratching through her bandages). The consultant also noted R16 complains of itchy and painful left leg, attributed to spider bites. The consultant further documents resident seems to have some new onset dermatillomania/psychogenic itching, with diagnosis of neurodermatitis, very hard to redirect given cognitive decline and alleged intense itchiness. Consultant recommended continuation of antidepressant (Remeron) to target depression/insomnia/poor appetite and discontinue low dose of nortriptyline (medication used to treat depression and also sometimes used for neuropathic pain), and trial hydroxyzine (antihistamine) for pruritis. Also recommended consideration for trial of abilify for obsessive compulsive disorder to augment treatment or if increased psychosis. On 01/31/23 at 11:15 AM the State Agency surveyor interviewed R7 in her language of origin. R7 denied that she was itchy; however, her visitor reported that R7 is [NAME] itchy, all over her body. The visitor also reported R7 has dementia. On 01/31/23 at 01:28 PM observed wound consultant examine R16. R16 was laid on her right side with her left leg stacked above her right leg. The consultant unwrapped the bandage and pulled off a piece of gauze in the middle. The resident made a sound and flinched. The Infection Preventionist/Unit Manager (IP/UM) was observed entering the room stating she has the saline. IP proceeded to saturate the gauze with the saline. The consultant removed another piece of gauze, and R16 yelped and began to loudly ramble (not in English) On 02/02/23 at 02:29 PM interview was conducted with the Director of Nursing (DON), Nursing Management, Nurse Manager, and IP/UM. The team was asked what is happening with R16. IP/NM replied a referral was made for a psychiatric consult and based on the recommendation; the physician made changes to the resident's medication. The team reported the scratching and self-inflicting wound began in December and has been more excessive and noticeable. On 02/03/23 at 07:41 AM, shared the observation of the wound consultant removing R16's wound dressing with the IP. Informed IP when the consultant removed the middle piece of gauze, R16 flinched. IP reported she had left the room to get the saline to moisten the gauze before removing. IP stated that she had asked consultant to wait for her but she proceeded removed the gauze before IP could saturate the gauze stuck to the skin/wound. Inquired whether R16 is bored, no activities. The team reported she is being provided with a fidget toy to keep her hands busy but R16 is not interested in it for a very long time. It was also reported R16 doesn't care for group activities. Further queried whether the interdisciplinary team has done root cause analysis (including behavioral monitoring) involving R16's physician. The response was the physician will review and approve orders as appropriate. The team shared R16's son is very involved in his mother's care so they are trialing and trying to figure it out, meanwhile, medication and treatment are being provided.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22063 Based on observation, record review, and interview with staff members, the facility failed to ensure 2 (Residents 11 and 16) of 5 residents sampled with pressure injuries received preventative care to avoid the development of pressure ulcers. The facility failed to ensure accurate weekly skin assessments were done for Resident (R)16, resulting in delayed treatment to prevent the development of a Stage 3 pressure injury. The facility also failed to develop interventions for R11 to prevent the recurrent development or pressure injuries related to contractures. Findings include: 1) Resident (R)16 was admitted to the facility on [DATE]. Multiple medical diagnoses include but not limited to pressure ulcer of sacral region, stage 2 (01/11/23). R16 noted with multiple self-inflicted wounds and a Stage 2 pressure ulcer to the left buttock. A review of the Long Term Weekly Charting from 12/05/22 through 01/30/23 was done. The charting for 12/05/22 documents open lesions, however, no documentation of location. Subsequent assessment of 12/12/22 documents new onset of skin impairment with pressure reducing device for bed. The entry for 12/19/22 notes open lesions (cut fissure, boil, cyst, cancer lesion, small wound under nose with scant on and off bleeding due to scratching. The weekly documentation for 12/26/22, 01/03/23, 01/09/23, 01/10/23, 01/16/23, and 01/30/23 notes no wound present. There was a missing assessment for 01/23/23. A review of the Minimum Data Set (MDS) with assessment reference date of 12/21/22. R16 assessed as being at risk for developing pressure ulcers. There was no documentation of pressure ulcers. A review of the care plan dated 08/31/21 for skin integrity has a goal for R16 to have no unaddressed alteration to skin integrity. Interventions include alternating pressure air mattress as prescribed (01/19/23); assist with turning/frequent repositioning, as needed (08/15/22); barrier cream to peri-area after toileting and as needed (08/15/22); provide skin and incontinence care assistance, as needed (08/15/22); and weekly skin check per facility schedule, notify MD of alterations for prompt/proper intervention (08/15/22). A review of the progress note dated 01/11/23 at 10:30 AM documented R16 with a Stage 2 pressure injury located on the bottom of her left buttock, measuring 2 cm x 1.5 cm with bloody drainage. The physician ordered application of topical Medi-Honey daily until healed as well as repositioning every two hours. Review of wound consultant reports were done. The consultation report of 01/17/23 noted skin ulcer of flank with fat layer exposed, skin ulcer of right side of neck with fat layer exposed, ulcer of abdomen wall with fat layer exposed, skin bulla, and decubitus ulcer of left buttock, stage 3. The consultant notes that wounds occurred by excoriation/skin picking mechanism for unknown duration, with noted worsening over the past week. The stage 3 pressure ulcer to the left buttock measured 4.3 cm in length x 4.5 cm in width with a depth of 0.2 cm. Also noted serosanguineous drainage (thin and watery fluid that is pink in color due to the presence of small amounts of red blood cells). The most current consultant report dated 01/31/23 notes wounds from last week are variable. The measurement was 3 cm x 1 cm. x 0.2 cm. Also noted small amount of serosanguineous drainage. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 02/03/23 at 07:41 AM an interview was conducted with Unit Manager (UM)2. UM2 reported the identification of the pressure injury was 01/11/23 when it was brought to her attention. UM2 reported staging of pressure injuries are done by the facility's consultants. The consultants staged the pressure injury to the resident's right buttock as a Stage 3 on 01/17/23. UM2 reported if impairment to the resident's skin was brought to her attention earlier interventions would have been aggressively implemented and wound probably would not have progressed to a Stage 3 (at this stage, the sore has gone through all layers of skin into the fat tissue, exposing the patient to infection). UM2 confirmed there was a missing weekly assessment for 01/23/23. UM2 also confirmed the weekly assessments prior to the actual skin break down did not document R16's skin was compromised. UM2 reported the Stage 3 pressure injury was initially measured at 3 cm x 1 cm and most recently 3.8 cm x 1.5 cm. 47783 2) During initial observation on 01/31/23 at 09:52 AM, noted R11 in bed using a specialty mattress, head of bed elevated, arms and legs severely contracted with rolled paper towel in both hands, pillows between legs and foam boot in place. No pillow noted between arms and torso. On 01/31/23 at 01:04 PM, observed Infection Preventionist (IP) and physician assistant (PA) change the dressing on left wrist open area and right foot pressure ulcer. IP and PA had a difficult time placing the cushion between the resident's arms and torso. IP had to use both hands to separate resident's arms from his body as another staff positioned the cushion. Observed that R11 gets spasms when he is stimulated by sound and touch and cushion had to be adjusted a second time before IP and contracted staff exited the room. Record review of Wound Notes for R11 revealed that left wrist open area recurred 5 times in 2022 on the following dates: 03/29/22, 07/05/22, 08/02/22, 08/16/22, and 11/22/22 for the most recent one which started as a 0.2 X 0.5-centimeter (cm) open area. Measurement as of 01/31/23 is 2.0 X 6.0 cm. Wound culture and sensitivity test was done on 01/03/23 and was found to be infected, Levofloxacin for 14 days was started on 01/06/23 for 14 days. (Cross Reference to F657- Care Plan Timing and Revision). Treatments for the left wrist from Orders are as follows: 03/09/22: Wound care: Cleanse with NS (normal saline), apply silver alginate and bordered foam dressing to re-opened left wrist wound. 08/16/22: Wound care: Cleanse with NS, apply silver alginate and bordered foam dressing to re-opened wound to left wrist dorsal (back portion) area. 08/22/22: MediHoney (honey)gel; 80 %; amt: 1 application; topical. Special Instructions: Cleanse with NS, pat dry, apply honey gel to L (left) dorsal wrist and cover with foam dressing once daily until healed. 09/07/22: Wound care for left wrist wound: Cleanse with NS, pat dry, apply wet to dry dressing once daily until healed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	10/05/22: Wound prophylaxis for left wrist: Cleanse with NS, pat dry, apply border foam dressing for pressure injury prevention. 10/29/22: Use air filled cushion between chest and hands/forearms at all times, to decrease risk of skin breakdown. Skin check q shift to assess skin integrity. Remove for showers. Assess firmness each shift, if it is not firm, notify therapy. 11/23/22: MediHoney (hydrocolloid-honey) (honey-hydrocolloid dressing) bandage; 2X2 (inches) ; amt: 1 application; topical. Special Instructions: Cleanse L (left) wrist wound w/ (with) NS and pat dry. Apply MediHoney and cover w/ foam dressing daily. IP was interviewed on 02/03/23 at 02:23 PM. She stated that the cushion between the R11's wrist and chest area can come off if the resident gets spastic when stimulated and the staff have a hard time putting it back. She also said that she has asked staff to call her when they need help replacing it, but they don't. Review of facility's policy and procedure Pressure Injury Prevention and Staging states: . 4. Resident's Care Plan will reflect appropriate preventative interventions to be followed and the RN will document these in the resident's clinical record.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22063 Based on observation, record review and interview with staff members, the facility failed to ensure a resident with limited range of motion receives appropriate treatment and services to prevent further decrease in range of motion for one Resident (R)7 of one resident in the sample. Findings include: Resident R7 was admitted to the facility on [DATE]. Diagnosis include but not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. On 01/31/23 at 10:09 AM R7 was observed asleep in bed, his right arm was covered by the blanket and his left arm was held up close to his chest. Subsequent observation at 11:04 AM, R7 was eating lunch, using his left hand. On 02/01/23 at 07:47 AM, R7 was interviewed. R7 was asked whether he has any limitations in the movement of his hands or legs. R7 responded he is unable to use his right side so must use his left. Further queried if he is provided with exercises and/or a splint. R7 reported that he will throw the baseball for exercise as he played baseball and football in college. Clarified whether staff does exercises with him to stretch his hand, arm, and/or legs? He did not answer. R7 confirmed that he is not receiving any therapy. R7 was observed with no splints. R7 also reported he can no longer use his right hand and has learned to use his left hand. R7 ate his breakfast holding the utensil in his left hand. Record review was done on 02/03/23 at 10:37 AM. The quarterly Minimum Data Set (MDS) with assessment reference date (ARD) of 10/26/22 documents R7 is cognitively intact, yielded a score of 15 of 15 upon administration of the Brief Interview for Mental Status. R7 was coded with limited range of motion to upper and lower extremities on one side. In Section O. Special Treatments, Procedures, and Programs, R7 was not coded to have received restorative nursing services in the last seven calendar days. R7 was coded with splint or brace assistance. Further review found care plan with a start date of 05/12/21 and last reviewed 01/10/23 noting R7 with impaired range of motion to right hand related to cerebrovascular accident. The goal was for R7 to maintain range of motion (ROM) in the right hand. The interventions included, refer to physical/occupational therapy as indicted; range of motion to right hand as indicated, and monitor for presence of pain, intolerance, or muscle spasm during range of motion. On 02/03/23 at 1:20 PM, the physical therapist (PT) provided a copy of the R7's therapy discharge summaries. The Therapy Communication to Nursing with a handwritten date of 05/24/21 comments, please perform bilateral lower extremity stretches as indicated in the handout. The occupational therapy discharge summary for dates of service from 08/04/20 to 08/28/20 notes the goal to tolerate wearing of right-hand roll splint for 4 hours on, 4 hours off daily was achieved. Also, the goal to increase passive range of motion (PROM) on right MCP (Metacarpophalangeal) to 45 degrees for adequate hygiene and grooming. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/03/23 at 1:45 PM interviewed Unit Manager (UM)1. UM1 reported restorative usually performs range of motion, however, currently the facility does not have restorative nursing services. UM1 confirmed there is no physician order for application of splint or to perform range of motion. UM1 reported she has never observed R7 with a splint and there is no flow sheet to perform restorative nursing services. On 02/03/23 at 1:50 PM, R7 was observed in bed. R7's right hand was fisted and there was a white roll in his hand. Inquired when the hand roll was applied, he replied, today. He further reported the hand roll is applied at breakfast and removed after lunch. Further queried if staff massage or stretch his hand before placing the hand roll. R7 replied no and reported he never had a splint. On 02/03/23 at 1:55 PM, interviewed Certified Nurse Aide (CNA)9. Inquired whether R7 has a hand splint. CNA9 proceeded to look through the resident's drawers and closet then reported she is not aware of a splint. CNA9 reported they do not perform passive range of motion or range of motion. CNA9 further reported in the past restorative nurse aides would do PROM/ROM. CNA9 stated either the CNAs or nurses apply the resident's handroll. On 02/03/23 at 1:57 PM, interviewed Licensed Practical Nurse (LPN)82. LPN82 reported they are looking for the splint, recalled R7 had one before.

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F 0689 Level of Harm - 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** 37229 Based on observations, record review, and interviews with staff members, the facility failed to implement interventions, including adequate supervision, to reduce the risk of accidents for two of six sampled residents, Residents 23 and 36. As a result of this deficient practice, Resident (R)36 had multiple falls, with a fall resulting in the resident being taken to the emergency department for evaluation. Finding include: Resident (R)36 has an extensive history but not limited to hereditary musculoskeletal disease, blindness to the left eye secondary to a ruptured globe (repaired). Recurring depression/anxiety, cognitive decline with behavioral disturbances. Also hereditary spinocerebellar ataxia (type 3, [NAME]-[NAME] with recurrent falls and dysarthria.) Facility reported incident summary dated 01/10/23 at 12:30 AM in Ewa Hallway revealed R36 was found lying belly down with hands out in front of him and forehead touching the floor. Wheelchair was on top of resident and his chest belt was still strapped on. R36 was taken to a hospital emergency room by emergency medical services (EMS). Record documented that the resident lost consciousness and had a weak and thready pulse. Record review (RR) reveals fall events on: 09/30/22 - slid out of chair - no injury. 01/07/23 - Fall with abrasion to left forehead. 01/10/23 - Fall with loss of consciousness. 02/02/23 - Fall with a minor scratch to his forehead Observation on 02/01/23 at 09:05 AM, R36 was waiting in que for a shower. This surveyor noted that his toe was bleeding. Noted that R36's toes were dangling on the floor and leaving a trail of blood. Unit manager (UM)1 was notified. Observation on 02/02/23 at 08:46 AM in the hall, R36 is in the hall in his wheelchair with his iPad. R36 is slouched down and tends to slide in his wheelchair. No wedge pillow was noted. No dedicated staff to supervise resident on a one-to-one basis. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 02/02/23 at 11:45 AM, interview with Registered Nurse (RN)6 stated that R36 had an unwitnessed fall this am before morning shift and sustained a minor scratch to his forehead. Interview with director of nursing (DON) about what the facility is doing about falls for R36. DON stated that the Physician (MD) is discontinuing his blood thinner. DON stated R36's mother is very involved and has ordered a special wheelchair that is custom fit to the resident, ordered in August but not available yet. Resident has refused a Geri-chair, vest restraint, changing rooms. Resident is brought to nursing station but will loosen lap belt and slide out of chair. Facility has had 1:1 sitting in the past. Mother comes in every afternoon and sits with him. Resident has been seen to propel himself onto the floor by staff. RR on 02/03/23 at 07:32 details R36 was seen on the floor on 02/02/03, surrounded by morning staff. CNA witnessed resident slide himself from the wheelchair onto the floor and falling forward face down, small laceration superior to left eyebrow, no bleeding, no change in LOC, called American Medical Response (AMR) for pick up. Interview on 02/03/23 at 07:56 AM with LPN 9, who is R36's nurse today. Queried LPN9 if she was aware of the fall. LPN9 stated that she was aware of the fall but had not had a chance to review it. LPN9 stated honestly, it's a matter of keeping him comfortable and entertained. Observation on 02/03/23 at 08:27 AM of nurse talking with R36. Immediately after nurse goes down the hall, R36, is calling out in hall to be pulled up. All staff in rooms, busy and unit clerk is the only person nearby. Observation on 02/03/23 at 09:22 AM of R36 who is loudly crying out I'm going to fall down. LPN9 responded to R36. 47783 2) R23 is a [AGE] year-old resident with Alzheimer's disease, dementia, history of falls and fractures, muscle weakness, orthostatic hypotension (sudden drop in blood pressure when standing from a seated or lying position), difficulty in walking and age-related osteoporosis (weakened bones). R23 also has a history of wandering. On 1/31/23 at 09:10 AM, observed R23 lying in bed with only her head and back directly on the bed, and both feet touching the floor. Registered Nurse (RN) 6 was in the room passing medications to another resident, asked if the resident needs to be positioned properly in the bed. RN6 replied that that's how R23 is and can get combative if they try and place her on the bed properly. On 02/02/23 at 10:45 AM, observed resident get out of bed unsupervised and unassisted, used front wheel walker (FWW) and walked to the toilet. After using the toilet, R23 proceeded to the elevator by herself using her FWW as the recreational therapy staff was bringing other residents down to the first-floor activities area. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review revealed that R23 had an unwitnessed fall in her room on 10/08/22 at 09:39 PM, unwitnessed fall in the hallway on 11/21/22 at 01:23 PM, witnessed (by a resident) fall in the hallway on 12/19/22 at 02:21 PM, and was trapped in the elevator by herself on 11/26/22 for approximately 15 mins and on 01/26/230 for approximately 50 minutes. Most recent Rocky Mountain Fall Risk assessment dated [DATE] described the resident as a moderate fall risk with no mobility concerns and impulsive actions. However, assessments for the following dates: 10/08/22 described R23 as high fall risk, requires assistance or supervision for mobility, transfers, or ambulation and lack of understanding of physical and/or cognitive limitations; 11/21/22 as high fall risk with unsteady gait, altered awareness on immediate physical environment, impulsive actions and lack of understanding of physical and/or cognitive limitations; and on 12/19/22 as high fall risk, requires assistance or supervision for mobility, transfers, or ambulation, altered awareness on immediate physical environment, and lack of understanding of physical and/or cognitive limitations. Review of care plan (CP) documented the resident was at risk for falls (11/06/21), and wandering (09/18/21). (Cross reference to F657 Care Plan Timing and Revision). On 02/02/23 at 11:04 AM, conducted an interview with RN6 and unit clerk (UC)10. Asked RN6 if they have a device to prevent R23 from accessing the doors, she confirmed that R23 does not have a wander bracelet. According to the UC10, they used to have wander bracelets but not anymore since they upgraded their doors. A key card is needed to open the door. The residents are still able to access the elevator, but all the doors downstairs also require a key card to open. On 02/03/23 at 10:27 AM, conducted an interview with Unit Manager (UM)1. Asked how closely is R23 being supervised when wandering in the hallway, UM1 responded: we try to keep an eye on her as much as we can resident goes to activities and does not need constant assistance able to walk around and has a fascination with the elevator. We tried to have her sit by the nurse's station, but she would still try to get up and walk away. We are not able to provide her with one to one supervision.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42871 Based on observations, record reviews, and interview, the facility did not provide appropriate treatment to prevent urinary tract infections for three residents (R), R44, R61, and R31 out of a sample of four residents. This deficient practice exposes these residents to bacteria which may cause urinary tract infections and subject them to injury. This has the potential to affect all residents requiring the use of an invasive medical device such as the urinary catheter tubing and bag system. Findings include: 1) On 01/31/23 at 09:20 AM, made an initial observation of R44. R44's urinary catheter tubing and bag system was placed on the underside of the left side of his bed. The urinary catheter tubing was touching the ground and tangled under the wheel of his bedside table. On 01/31/23 at 12:58 PM, observed R44's dressing change of his calf wounds by Physician Assistant (PA)1 assisted by the Infection Preventionist (IP). Noted R44's urinary catheter tubing and bag system was still located to the bottom left side of his bed. The urinary catheter tubing was touching the ground. On 02/01/23 at 09:57 AM, observed R44's urinary catheter tubing was touching the ground. On 02/02/23 at 08:27 AM, observed R44's urinary catheter tubing touching the ground tangled under the wheel of his bedside table. Reviewed R44's electronic health record (EHR). Resident Face Sheet revealed that R44 is a [AGE] year old resident admitted to the facility on [DATE]. Diagnoses include cervical (neck) spinal cord injury, paraplegia (paralysis of all or part of the trunk, legs, and pelvic organs), nerves unable to control bladder function, bone infection, and nosocomial infections (infections acquired in healthcare facilities that are caused by bacteria, fungi, viruses, or other pathogens that enter the body through medical devices, wounds, or contact with staff or other patients). Reviewed Care Plan with last care conference date of 01/25/23. R44's susceptibility to infection was not addressed and there was no intervention to maintain the cleanliness of his urinary catheter tubing and bag system (Cross reference F656 Develop/Implement Comprehensive Care Plan). Reviewed the policies and procedures for CATHETER CARE, revised on 05/22, INFECTION PREVENTION AND CONTROL, reviewed/revised on 04/09/21, and NURSING SERVICES, revised on 10/10/17. These policies and procedures did not include infection prevention and control measures for managing the urinary catheter tubing and bag system to prevent infections in their resident who require these invasive medical devices. On 02/01/23 at 10:00 AM, interviewed Registered Nurse (RN)22 who stated that P44's urinary catheter should not be touching the ground due to the possibility of R44 acquiring an infection from contamination of the system, which should be kept clean. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) On 01/31/23 at 12:58 PM, observed R61 being assisted with lunch by the Certified Nurse Aide (CNA)3. R61's urinary catheter tubing and bag system were located to the right underside of her bed. The urinary catheter tubing was touching the floor. On 02/01/23 at 09:34 AM, observed R61's lying in bed with her neck pillow and noted that her urinary catheter tubing and bag system touched the ground. On 02/02/23 at 08:26 AM, observed R61 sleeping in bed and noted that her urinary catheter tubing and bag system touched the ground. Reviewed R61's EHR. Resident Face Sheet revealed diagnoses of dementia, Alzheimer's disease, pulmonary embolism (clot in the lung), and neuromuscular dysfunction of bladder (central nervous system cannot control bladder functions). The . PHYSICIAN DISCHARGE SUMMARY created on 11/18/22 stated that R61 was discharged from the hospital on 11/18/22 with a diagnosis of having a clot in R61's lung. R61 was admitted to the facility on [DATE] to receive hospice care. Reviewed Care Plan with last care conference date of 11/23/22. Under the problem for Indwelling catheter (urinary catheter tubing and bag system) there was no intervention to maintain the cleanliness of R61's urinary catheter tubing and bag system to prevent infection. (Cross reference F656 Develop/Implement Comprehensive Care Plan). On 02/01/23 at 10:00 AM, interviewed RN22. RN22 stated that P61's urinary catheter should not be touching the ground due to the possibility of R61 acquiring an infection from contamination of the system, which should be kept clean. 3) On 01/31/23 at 02:11 PM, observed R31's urinary catheter tubing and bag system on the underside of the left side of his bed. The urinary catheter system tubing was touching the ground. Reviewed R31's electronic health record (EHR). Reviewed Resident Face Sheet. R31 is a [AGE] year old resident admitted to the facility on [DATE] with the diagnoses of retention of urine, central cord syndrome (incomplete spinal cord injury), quadriplegia, and obstructive and reflux uropathy (excess urine accumulation in the kidneys). Reviewed Care Plan with last care conference date of 12/21/22. Under the problem for Indwelling catheter (urinary catheter tubing and bag system) there was no intervention to maintain the cleanliness of R31's urinary catheter tubing and bag system to prevent infection (Cross reference F656 Develop/Implement Comprehensive Care Plan). On 02/01/23 at 10:00 AM, interviewed RN22 who stated that P31's urinary catheter system tubing should not be touching the ground due to the possibility of R22 acquiring an infection from contamination of the system, which should be kept clean.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22063 Based on observation and interview with staff members, the facility failed to provide treatment and services to prevent complications of enteral feeding for two Residents (R) 50 and R11 in the sample. The facility did not assure the date and time of the resident's formula bag and feeding set was documented. This deficient practice has the potential to put the resident at risk for complications. Findings include: 1) Resident (R)50 was readmitted to the facility on [DATE]. Diagnoses include but not limited to, cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery, aphasia (comprehension and communication (reading, speaking, or writing) disorder resulting from damage or injury to the specific area in the brain), and dysphagia (condition with difficulty in swallowing food or liquid. This may interfere in a person's ability to eat and drink) following cerebral infarction. On 01/31/23 at 09:00 AM observed R50 asleep in bed. The feeding bag was labeled as Diabeta Source with a start date of 01/31/23 and no documentation of time (it was left blank). The formula was not infusing. Second observation on 02/02/23 at 07:20 AM, the formula bag was dated 02/02/23 with no documentation of time. On 01/31/23 at 01:52 PM concurrent observation and interview was done with the Licensed Practical Nurse (LPN)8. LPN8 confirmed the formula bag was labeled with a date of 01/31/23 and there was no documentation of the time. Inquired how often the formula bag/feeding set is changed. LPN8 responded it is changed every morning by the night shift staff. On 02/01/23 at 09:05 AM an interview was conducted with the Director of Nursing (DON). DON confirmed the feeding set is changed every 24 hours, typically by the night shift. The pharmacy provides labels for the formula. Further queried why does the label include a space to document the time when the feeding set was first used, and without documentation of the time how do they know when 24 hours has transpired and feeding set requires changing. The DON replied if there is a space to document the date and time, staff need to document the time. Requested a copy of the policy and procedure for enteral feeding. On 02/02/23 at 12:30 PM, the DON provided a copy of a policy and procedure titled Administration of IV Fluids and Medications, Setting Up a Primary Infusion (Hydration or Medication). Clarified that this policy and procedure relates to IV fluids not nutrition. Inquired whether there is a different policy and procedure, possibly in pharmacy policy and procedures that is specific to enteral feedings. DON was agreeable to follow up. At 1:08 PM, the DON stated the policy and procedure provided is utilized for enteral feeding. DON confirmed that the date and time should be documented if it is included on the label. 47783 (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) R11 is a [AGE] year-old resident admitted on [DATE]. Diagnoses include quadriplegia (paralysis that affects all four limbs and torso), contractures to all four extremities, cerebral infarction (damage to tissues in the brain due to a loss of oxygen), muscle spasms, hypertension (high blood pressure), and bed confinement status. On 01/31/23 at 10:51 AM, observed R11 in bed with eyes closed. Noted an empty tube feeding (TF) set hanging on a pole by the bedside. TF set had a label with R11's name, formula to be given including amount and frequency. On the bottom of the label, there was a space for the date and time. Date identified was 01/31/23, but there was no time noted. On 02/01/23 at 09:58 AM, noted an empty tube feeding set hanging on a pole at R11's bedside. Tube feeding set had a label with R11's name, formula to be given including amount and frequency. On the bottom of the label, there was a space for the date and time. Date identified was 01/31/23, but there was no time noted. Interview with the Director of Nursing (DON) on 02/01/23 at 09:05 AM. Asked DON how often do the staff change the TF set. She said it is changed every 24 hours and done by the night shift registered nurse (RN). When asked how the night shift RN would know if 24 hours has passed since they do not fill out the time on the label, DON replied that the RN needs to document the time and will look for the policy and procedure for changing the TF set. Interview with registered nurse (RN)6 on 02/01/23 at 11:30 AM, asked who changes the TF bag and how often is it done. RN said it is done by the night shift RN daily. When asked if she knows what time the night shift RN changes them, she said she does not know.

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	125024	A. Building B. Wing	02/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nuuanu Hale	2900 Pali Highway Honolulu, HI 96817

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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. 42871 Based on observation and interviews, in one of two medication carts observed, the facility failed to ensure that the bulk liquid medications for three residents (R), R31, R38, and R29, were appropriately labeled with the date it was opened. This deficient practice exposes these residents to the risk of being given expired medications which might adversely affect them. Finding includes: On 02/02/23 at 10:28 AM, a concurrent observation of a nursing unit's medication cart and interview were done with Registered Nurse (RN)22. Three separate bulk liquid medication bottles for R31, R38, and R29, were noted to be opened with no open date written on the bottle. RN22 confirmed that there was no date written on the three bottles of bulk liquid medication and stated that the date of when it was opened should have been written on the bottle by the staff member who opened it. On 02/02/23 at 02:25 PM, interviewed the Director of Nursing (DON). DON stated that the bulk liquid medications should have been labeled with the date the bottle was opened.

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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. 42871 Based on observations and interviews, the facility failed to store and serve food under sanitary conditions to prevent the spread of foodborne illnesses. This deficient practice has the potential to affect all who receive meals prepared in the kitchen. Findings include: 1) On 01/31/23 at 08:10 AM, made an initial observation of the kitchen. The Ice Cream Freezer Temperature Daily Log, Walk-In Refrigerator Temperature Daily Log, and the Walk-In Freezer Temperature Daily Log for January 2023 were incomplete for temperature, time, and initials documentation for the PM shift on 1/30/23. The logs were completed for the AM shift of 01/31/23 and on the AM and PM shifts for the dates of 01/01/23 through 1/29/23. The SANITIZER CONCENTRATION LOG from 1/20/23 to 1/26/23 were missing the time, concentration, and initials documentation for 1/20/23, 1/23/23, 1/24/23, 1/24/23, 1/25/23, and 1/26/23. On 02/02/23 at 09:21 AM, did a concurrent observation of the kitchen and interview with the Food Services Manager (FSM). FSM stated that all the logs should be completed for both the AM and PM shifts up to the current date. FSM also stated that the SANITIZER CONCENTRATION LOG for the dishes should be completed every two hours to verify that the chlorine concentration is 100 parts per million (ppm) and the log is completed to confirm it was done. FSM demonstrated the low temperature dishwasher chemical check and was queried as to where the result was documented. FSM stated that they have not been keeping a log and therefore is unable to verify if staff did the low temperature dishwasher chemical concentration test or if the chemical concentration was within the acceptable range. Reviewed Sanitation policy, revised on 02/26/18. Under Food items . 2 .Refrigerator and freezer temperatures shall be maintained at appropriate temperatures . Under Cleaning and disinfection of utensils, dishware, pots and pans . 3 .When a chemical dish machine is utilized .using a chemical sanitizer that .is in a concentration equivalent to 50 parts per million (ppm) available chloride . 2) On 02/03/23 at 06:30 AM, observed the ceiling fans in the kitchen to be covered in dust. On 02/03/23 at 08:30 AM, queried the Administrator about who cleans the fans in the kitchen and Administrator stated the Maintenance department is responsible for that task. On 02/03/23 at 09:30 AM, interviewed the Maintenance Supervisor (MS). MS stated that the fans in the kitchen are checked and cleaned monthly by the maintenance department. On 02/03/23 at 09:45 AM, a concurrent observation of the ceiling fans in the kitchen and interview were done with the Food Services Manager (FSM). FSM confirmed that the ceiling fans were dusty, and that the Maintenance department had a system of inspecting and cleaning them every month, but has not been done. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Reviewed SANITATION policy, revised 02/16/18. It stated, . shall assure the storage, preparation, distribution and serving of food under sanitary conditions to prevent the spread of foodborne illnesses and reduce those practices which results in food contamination and compromise food safety . 3) On 02/02/23 at 09:54 AM, observed a nourishment refrigerator for resident's snacks on a nursing unit. Several cups of orange liquid with lids were not labeled as to what the contents were and dated. Registered Nurse (RN)5 confirmed that the cups of liquid had no label and date. On 02/02/23 at 2:25 PM, queried the DON. DON stated that food items kept in the nourishment refrigerator for residents should be labeled with the contents and dated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 22063 Based on observations and interview with staff, the facility failed to ensure resident shared equipment (blood pressure cuff) was properly sanitized. The facility also failed to perform hand hygiene during wound care when donning and doffing gloves. Findings include: 1) On 02/03/23 at 07:50 PM observed Registered Nurse (RN)5 exit resident's room. RN5 was holding blood pressure machine. RN5 wrote down the resident's blood pressure reading, picked up a pack of microkill from side pocket of cart, remove cloth and wipe down the blood pressure machine. RN5 used the same cloth and wiped the inside and outside of the rolled-up blood pressure cuff. On 02/03/23 at 07:54 AM an interview was conducted with the Infection Preventionist (IP). Inquired what is the procedure for sanitizing the blood pressure machine and cuff. The IP explained a paper towel should be placed atop the medication cart, hand sanitizing is performed, staff member then puts on gloves and wipes down the machine and cuff. IP was asked if the cuff is properly sanitized if the cuff is wiped while it is rolled up. The IP responded, the cuff should be unrolled and the inside and outside of the cuff wiped with the sanitizing cloth. 42871 2) On 01/31/23 at 12:58 PM, observed Physician Assistant (PA)1 do a dressing change of R44's wounds on each calf, assisted by the Infection Preventionist (IP). IP stated that R44 was on contact isolation due to an infection to both wounds on his calves. PA1 did not hand sanitize in between glove changes during the dressing change and walked outside into the hallway with her yellow gown. Reviewed R44's electronic health record (EHR). A General Order dated 01/25/23 revealed that R44 was on contact precautions with no diagnosis documented. Read Internal Medicine and Infectious Diseases Telehealth Follow-up Note with date of encounter 11/16/22. It stated that R44 has had multiple infections and currently has a left leg infection and the wounds on his calves had bacteria. On 02/03/23 at 2:30 PM, interviewed the IP. IP stated to prevent the spread of infections in the facility , PA1 was supposed to disinfect her hands in between glove changes during the dressing change and was not supposed to go out of the room and into the hallway wearing the gown during R44's dressing change.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42871 Based on observations, interviews, and record reviews, the facility failed to ensure the specialty mattress was functioning properly for one Resident (R) 31, in a sample of one. This deficient practice has the potential to affect all residents needing a specialty mattress and could result in an injury. Finding includes: On 01/31/23 at 09:15 AM to 1:14 PM, periodically observed R31's specialty mattress control box to be alarming. At 09:15 AM, a certified nurse aide (CNA) was in R31's room, but did not address the audio alarm on the machine. On 01/31/23 at 3:00 PM, queried R31 about the beeping from his specialty mattress control box. R31 stated that the audio alarm did not bother him. On 02/02/23 frequent observations between 08:00 AM to 11:00 AM found that the specialty mattress control box was still alarming. On 02/02/23 at 11:00 AM, a concurrent observation of R31's specialty mattress control box and interview were done with Registered Nurse (RN)22. RN22 stated that R31's specialty mattress is supposed to be checked by staff regularly and is unsure if the malfunctioning specialty mattress was reported to their unit manager. On 02/02/23 at 2:00 PM, interviewed Unit Clerk (UC)10. UC10 stated that R31's malfunctioning specialty mattress was reported to the unit manager earlier in the week. On 02/02/23 at 2:26 PM, a concurrent observation of R31's specialty mattress control box and interview were done with the Maintenance Supervisor (MS). MS examined the alarming control box and stated that the specialty mattress should have been changed because the mattress could experience air loss. Reviewed R31's electronic health record (EHR). Read Resident Face Sheet. R31 is a [AGE] year old resident admitted to the facility on [DATE] for central cord syndrome (incomplete spinal cord injury) and quadriplegia (paralysis of all four limbs). Reviewed Care Plan with last care conference date of 12/21/22. Problem for skin integrity edited on 01/19/23 had the approach, Alternating Pressure Air mattress, as prescribed. The Treatments Administration History for 01/31/23 to 02/03/23 was reviewed. The entry, Low air loss mattress. Check for placement and functioning, on every shift, revealed that on 01/31/23 day and night shifts and on 02/02/23 evening shift, no, was documented.