STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hale Malamalama	6163 Summer Street Honolulu, HI 96821

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record and document review, the facility failed to protect one resident (R)1 of two investigated for staff abuse/neglect. Specifically, Certified Nurse Assistant (CNA)2 was witnessed to make inappropriate, unsympathetic comments to R1, and willfully neglected to provide her the necessary services of toileting on more than one occasion. As a result of these willful acts, R1 suffered mental anguish and emotional harm. Findings include: 1) On 01/10/2025, the Office of Healthcare Assurance (OHCA) received an anonymous report of potential abuse of R1 (alleged victim/AV) by facility staff. The narrative account included but not limited to: - R1 was admitted to the facility on [DATE] for skilled nursing level of care after being hospitalized . - Presenting Problem: Allegations of physical abuse and psychological abuse of a [AGE] year old female short-term rehab (rehabilitation) resident by a male Certified Nursing Assistant (CNA) .and a female Certified Nursing Assistant. - On 01/07/2025, AV reported to .Social Worker (SW)1 that a male (alleged perpetrator/AP) and female AP threw her on the bed after she was done using the bedside commode and sustained a lump to the back of her head 5 days ago during the night.AV did not report this earlier because she was afraid of retaliation, so felt it better to remain quiet. - AV did not have any known pain/injury, but was afraid. - AV needs care, but does not want to remain at facility because she is afraid due to the incident. - AV stated she knows staff get frustrated because she frequently asks to go to the bathroom. Reviewed the APS Incident Report completed by the SW1 submitted on 01/07/2025. The report included the following: - Abuse types: Caregiver Neglect, Physical Abuse, Psychological Abuse - Abuse indicators: Change in behavior or appearance, Failure to provide necessary care/health care (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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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 0600 Level of Harm - Actual harm Residents Affected - Few	in a timely manner, Injury-suspicious, Nervous, anxious, Threatened or intimidated. - Narrative-This afternoon, SW (SW1) had a conversation with the resident regarding her discharge planning and resident stated that she would prefer to go home as she has been mistreated by staff during the evening and night shifts. This is the first time the resident brought this up, so SW requested to elaborate more. Resident stated that 5 days ago, when she requested to be toileted, a man and a woman (CNAs) came into her room and were rough with her. She stated that she understands that it is hard because she keeps wanting to go to the bathroom and she knows that staff gets frustrated with her because of that, but that gives staff no right to treat her the way they do. Resident stated that on that night 5 days ago, .a male and female came into her room and were rough with her while pulling her off the bedside commode. The 2 CNA's threw her on the bed with no care and she sustained a lump on the back of her head. SW checked resident's head and found a lump on the back of her head and immediately reported to the DON (Director of Nursing) and [sic] who came to take a look and also saw the lump on the back of resident's head. SW asked the resident why she waited so long before saying anything, and the resident stated that staying quiet is better as she does not want any staff to retaliate against her and she appeared anxious when she said that. SW told the resident she needs to make a report immediately when something happens like that, and if she does, she is not putting anyone in trouble as these CNAs are here to care for the residents and not to hurt them. 2) Review of Medical records revealed R1 is a [AGE] year old Korean female admitted to the facility on [DATE]. She had medical diagnosis that included cancer of the stomach, Type 2 Diabetes, hypertension, heart disease, atrial fibrillation, repeated falls, weakness, ascitis (accumulation of fluid in the cavity of the abdomen), Stage 2 coccyx pressure ulcer and is vision impaired. She has occasional bladder incontinence and is on diuretic therapy for her edema, hypertension and congestive heart failure. R1 is a fall risk due to her impaired mobility and weakness. She was able to bear weight, but required assistance for transfers, and to use the toilet. R1's baseline was that she was alert, oriented, and although primary language was Korean, she spoke and understood English well and a translator was not needed Her records included a Physician Certificate of Capacity dated 12/17/2024 that certified R1 had the ability to understand significant benefits, burdens, risks, and alternatives to proposed health care and does have the ability to make and communicate health care and financial decisions. Her BIMS (Brief Interview for Mental Status/snapshot of cognitive functioning) score was 14, which indicates intact cognitive response on the MDS (Medical Data Sheet) dated 12/24/2024. Reviewed R1's progress notes that included: 01/07/2025 at 02:45 PM, Social Services note by Social Worker (SW)1: . This afternoon, SW had a conversation with the resident regarding her discharge planning and resident stated that she would prefer to go home as she has been mistreated by staff during the evening and night shifts. This is the first time the resident brought this up, so SW requested to elaborate more. Resident stated that 5 days ago, when she requested to be toileted, a man and a woman (CNA) came into her room and were rough with her. She stated that she understands that it is hard because she keeps wanting to go to the bathroom and she knows that staff gets frustrated with her because of that, but that gives staff no right to treat her the way they do. Resident stated that on that night 5 days ago, .a male and female came into her room and were rough with her while pulling her off the bedside commode. The 2 CNA's threw her on the bed with no care and she sustained a lump on the back of her head. SW checked resident's head and found a lump on the back of her head and immediately reported to the DON and who came to take a look and also saw the lump on the back of resident's head. SW asked the resident why she waited so long before saying anything, and the resident stated that staying quiet is getter as she does not want any staff to retaliate against her and she appeared anxious. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	01/07/2025 at 03:52 AM, Nursing Behavior note entered by RN3: . Res (Resident/R1) continues to be awake most of the time throughout the night, requesting to be on recliner, bed, commode, sitting in bed, falling asleep, calling out help me, expressed being afraid but don't know what, requesting staff to stay with her all the time, explained why we cant [sic] stay beside her for a long time. 3) Reviewed staff statements the facility collected during their investigation, which included: RN2's email statement provided on 01/15/2025 regarding events week of 12/30/2024: On my noc shift, R1 was under the care of CNA2. Throughout the shift, R1 would request for assistance to transfer to the toilet . This is a common request of R1 given her health status.I observed CNA2 telling R1 that she was not going to transfer her to commode because she had just moved her back into bed. Despite her pleas, CNA2 ignored R1. CNA2 would be seen not wearing a mask in R1's room. When R1 would cough, CNA2 would say, Cover your mouth, and if I get sick I'm blaming you. RN1's typed statement dated 01/15/2025 regarding the shift on 01/06/2025: CNA reporting resident (R)1 requiring more assistance with toileting, unable to bear weight and a major fall risk with only one CNA. Around 1930, noted yelling coming from the dining room. Resident requesting to go to the toilet; however CNAs not taking resident as they claimed, she just went and didn't do anything. Resident getting upset at staff and raising voice, to which one CNA (CNA2) responded by also raising voice to resident. Shouting between resident and CNA2 increased to a point where writer asked what was happening.Writer told resident that CNA will take her to the toilet in a few minutes. 4) On 01/29/2025 at 09:00 AM interviewed SW1 in the conference room. She said when she met with R1 about discharge planning, she said she wanted to go home because of how she was mistreated. She told SW1 that a certain night CNAs were rough with her and she sustained a hematoma on her head. She said R1 initially could not identify the CNAs and did not want to file a complaint for fear of retaliation, but later identified the male (CNA1). SW1 said after interviewing other staff, about three days later, she found out about an argument CNA2 had with R1 that was witnessed and overheard. SW1 said she reported this incident to the DON. She said she checked in with R1 to see how she was doing several times and that the incident really upset R1 and that she became teary eyed and they cried together. On 01/30/2025 at 01:30 PM, conducted an interview with CNA2 on the telephone. She said she often cared for R1, and that she had been deteriorating. She went on to say R1 is hard to get up to stand, get back to bed and that she asks to go to the bathroom every five minutes. When inquired if she knew why R1 feels she had to go to the bathroom so often, she said No, they said she has cancer, that's all I know. She has medicine for her to pee a lot. CNA2 described the routine care she provided to R1, which was to assist her with getting to the commode at bedside at noc. She said she would give her the walker and guide her to the commode a few steps away, and that one person could provide this assistance safely. CNA2 went on to say during the day R1 usually was in the recliner in the dining area and would often need assist to the bathroom. She said she worked the 02:00 PM to 10:00 PM shift and the night shift 01/06/2025, and recalled R1 being in the dining area and that she took her to the bathroom. CNA1 said she told her to stay awhile and she would return. After she returned and put her in the dining area, about five minutes later, she wants to go [NAME] (urinate) again. I told her I would take her at 09:00 PM before putting her to bed. I told her Mama if you feel like going, then you can use the diaper because that day she had a hard time to stand up. I told her I'd just finish (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	my work. I told her that she needs to sleep and she can use diaper so she can sleep. This is the only time I told her to use her diaper. On 01/31/2025 at 11:32 AM, during another interview with SW1, she confirmed that R1 was cognizant until the last couple of days and that her mental status had declined and she was no longer responding to questions and only speaking Korean. Inquired if the facility had completed their investigation of the allegation of mistreatment related to the bump on R1's head, and she referred to the Investigion Report Form. She went on to say the investigation was completed and it was not substantiated as they could not identify any witnesses or specific event that might have caused the injury. SW1 said there were eye witness accounts of the argument, so they did substantiate verbal abuse. Review of the Investigation Report Form revealed it contained no details related to the verbal comments CNA2, made to R1, or that she neglected to provide the needed services of toileting. On 01/30/2025 at 10:20 AM, interviewed RN3 by telephone. Inquired about the behavior note she wrote on R1 01/07/2025. She confirmed she wrote the note, and that R1 was afraid to be alone that night, and wanted someone there with her all the time. RN3 said they left the lights, and she thought maybe it was a new environment for R1. She said she did not pursue the issue further or ask why she was afraid. 5) Observed R1 in bed. She was awake, appeared comfortable, but unable to answer questions.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to report two of a sample size of two allegations of Resident (R)1 and R2 abuse/neglect as mandated to the Office of Healthcare Assurance (OHCA). The Administrator (ADM)was not notified immediately of R1's allegation of mistreatment, and the facility failed to notify OHCA of results and actions taken. Findings include: 1) On 01/10/2025, the Office of Healthcare Assurance (OHCA) received an anonymous report of potential abuse of R1 (alleged victim/AV) by a staff member of the facility. The narrative account included: - R1 was admitted to the facility on [DATE] for skilled nursing level of care after being hospitalized . - Presenting Problem: Allegations of physical abuse and psychological abuse of a [AGE] year old female short-term rehab (rehabilitation) resident by a male Certified Nursing Assistant (CNA) .and a female Certified Nursing Assistant. - On 01/07/2025, AV reported to .Social Worker (SW)1. that a male (alleged perpetrator/AP) and female AP threw her on the bed after she was done using the bedside commode and sustained a lump to the back of her head 5 days ago during the night.AV did not report this earlier because she was afraid of retaliation, so felt it better to remain quiet. - AV did not have any known pain/injury, but was afraid. - AV needs care, but does not want to remain at facility because she is afraid due to the incident. -AV stated she knows staff get frustrated because she frequently asks to go to the bathroom. - Facility is in the process of doing an investigation. Record review revealed the following: 01/07/2025 at 02:45 PM Social Service (SS) note by SW1: . This afternoon, SW had a conversation with the resident regarding her discharge planning and resident stated that she would prefer to go home as she has been mistreated by staff during the evening and night shifts.Resident stated on that [sic] night 5 days ago, .a male and female came into her room and were rough with her while pulling her off the bedside commode. The 2 CNA's threw her on the bed with no care and she sustained a lump on the back of her head. SW checked resident's head and found a lump on the back of her head and immediately reported to the DON (Director of Nursing) and who came to take a look and also saw the lump on the back of resident's head.told the resident that a report would be put into APS, . On 01/29/2025 at 02:00 PM. interviewed the DON in the conference room. She said she was informed of the incident by SW1 on 01/07/2025. The DON said the Administrator (ADM) was notified two days later. When asked what the delay was notifying the ADM, she replied I thought SW1 had already informed (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her. On 01/30/2025 at 12:30 PM interviewed the ADM in the conference room with the DON. She said she was aware a CNA was accused of verbal abuse and was going to determine actions based on the APS and OHCA investigations. The ADM said she had learned of the second case around the time OHCA came in, and thought that one had been resolved. On 01/31/2025 at 11:30 AM, interviewed SW1 in the conference room. At that time, SW1 confirmed this case was actively being investigated by APS, and confirmed the allegation and findings (within 5 days) had not been reported to OHCA. She said when she was made aware of the event, she notified the DON, but did not notify the Administrator (ADM). 2) On 01/14/2025, OHCA received an anonymous report of caregiver neglect of R3. The report alleged on 12/18/2024, caregivers did not provide the necessary services and care to R3 when she was soiled with feces and needed a diaper change. Despite the fact that APS notified the facility they opened a case related to R3 for investigation, and the facility knew of concerns related to R3 being soiled and CNA assignments, the facility failed to investigate for neglect and notify OHCA. 3) Reviewed the facility policy titled Reporting Abuse to Facility Management, with date at bottom of policy 04/00. The policy included: 4. When an alleged or suspected case of mistreatment, neglect, injury of an unknown source, or abuse is reported, the facility administrator, or his/her designee, will notify the following persons or agencies of such incident: a. The State Licensing/Certification agency (OHCA) responsible for surveying/licensing the facility; . Reviewed the facility policy titled Protection of Residents During Abuse Investigations with date at bottom of policy 09/07. The policy included: 2. Upon completion of the investigation, the resident, the resident's representative, the ombudsman, state survey and certification agencies (OHCA) .will be provided a written report of the findings of the investigation and summary of corrective action taken to prevent such incident from recurring. Reviewed the facility policy titled Reporting Abuse to State Agencies and Other Entities/Individuals with date at bottom of policy 04/00. The policy statement was All alleged/suspected violations and all substantiated incidents of abuse will be promptly reported to appropriate state agencies and other entities or individuals as may be required by law. The policy included 1. Should an alleged/suspected violation or substantiated incident of mistreatment, neglect, injuries of unknown source, or abuse . be reported, the facility administrator, or his/her designee, will promptly notify the following persons to agencies (verbally and written) of such incident: a. Department of Health Office of Healthcare Assurance; .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and document review, the facility failed to provide evidence they conducted thorough investigations of two Resident (R)1 and R3 abuse/neglect allegations of a sample of two. In addition, the facility failed to remove the alleged perpetrators immediately when identified for R1's case. The facility also failed to internally investigate an Adult Protective Services (APS) case on R3 for neglect to provide needed services because they felt it was a resolved issue with staff assignments. Due to this deficiency, the underlying issue of providing timely services was not investigated to identify any quality issues or neglect. Findings included: 1) R1 is a [AGE] year old female admitted to the facility from the hospital on [DATE] for skilled nursing services. She had a history that included, but not limited to hypertension, cardiomyopathy, heart failure, atrial fibrillation, malignant neoplasm of stomach, malignant ascites, Type 2 Diabetes, difficulty in walking and muscle weakness. On [DATE], R1 informed the Social Worker (SW)1 she had been mistreated. Request made for all facility investigation documents related to R1's allegation. Documents provided included the Investigation Report Form dated [DATE] and copies of staff statements. The Investigation Details included: - Investigator Names: Director of Nursing and Social Worker - Date of investigation: [DATE] to present - Resident interviews conducted [DATE] and [DATE]. - Investigation Findings included choices to be marked Yes or No. The choices were: Substantiated, Unsubstantiated or Unable to Determine. The form was marked Yes for unsubstantiated, with the comment for lump on back of resident's head. - DON and SW1 conducted extensive interviews with all staff members, including over the phone interview with alleged perpetrators. Investigators could not substantiate or find reasonable reasons for how resident got bump on back of her head. - All CNA and nursing staff members in-serviced regarding resident abuse and neglect and a safety plan was developed for the resident by updating residents care plan and making sure that resident receives adequate supervision to prevent issues of abuse/neglect in the future. - Some risk factors identified during the investigation are as follows: 1. Urge Incontinence/Fluid accumulation which are all due to her health status. 2. Lack of staff training about individualized care in order to support residents needs, capabilities, and rights. DON implemented consistent staffing assignments and took steps to ensure adequate staffing at all times. Statements of staff scheduled the PM and Night shift of [DATE] were collected by SW1. The (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	statements revealed information that CNA2 displayed inappropriate behaviors and neglected to assist R1 to the bathroom in timely manner on more than one occasion. Other performance issues were identified, but not related to R1. On [DATE] at 09:00 AM interviewed SW1 in the conference room. She confirmed R1 informed her of mistreatment on [DATE]. SW1 said she immediately reported it to the DON, APS and initiated the investigation as directed by the DON. She said she did not notify the Administrator or OHCA. SW1 said when CNA1 was identified, she recommended the DON or Administration interview CNA1 due to a previous encounter she had with him. SW1 went on to say, about three days into the investigation she found out about an argument CNA2 had with R1 and that she refused to take her to the bathroom and provide services. On [DATE] at 10:20 AM, a second interview was conducted with SW1 after review of the investigation packet provided. At that time inquired if she interviewed CNA2 and CNA3. She said she talked to them on the phone, but they could not remember anything. SW1 said there was no documentation of time or date of the calls, or specifics of the interview. SW1 said interviews were not conducted with other residents these staff cared for. On [DATE] at 11:00M, a third interview was conducted with SW1. Inquired if the facility had completed their investigation, and she said yes, and referred to the investigation summary referenced above, dated [DATE]. She went on to say they did not substantiate physical abuse as there were no witnesses to any event that might have caused the bump on R1's head, but that they did substantiate the verbal abuse because there were eye witness accounts of the incident. When inquired what action had been taken to prevent any further occurrence, she said it would be up to administration, and to her knowledge, there was discussion about progressive disciplinary action. She confirmed all three CNAs were still suspended. On [DATE] at 01:30 PM, conducted an interview with CNA2 on the telephone. She confirmed she was on suspension related to the care of R1. CNA2 said the Administrator called her and told her there was a problem and she would be off the schedule, and to wait for a call from APS. She said she tried to contact the DON, but unable to reach her. CNA2 said she did not know specifics of the concern and was not asked to provide a written statement. She said she had not yet talked to APS. On [DATE] at 02:45 PM, conducted an interview with CNA1 on the telephone. He said he had been contacted by the DON first, and then SW1 about one week after the suspension. They told me that my name came up related to R1, and to wait for the APS investigation. CNA1 confirmed he worked scheduled shifts after the date the allegation was made, and prior to the suspension. On [DATE] at 01:00 PM, interviewed the DON in the conference room. She said she was informed of the incident by SW1 on [DATE]. When inquired what happened after she was informed, she said I told her to do an inservice for abuse, an incident report and chart if R1 had any decline in condition. Inquired who was in charge of the investigation, she said SW1 should initiate the investigation and I will collaborate with her. The DON said the ADM was notified two days later because she thought the SW1 had already informed her. On [DATE] at 12:30 PM interviewed the Administrator (ADM) in the conference room with the DON. The ADM said she had heard that a CNA was accused of verbal abuse, and that they were going to wait until the OHCA and APS investigation was complete to determine what actions to take. She said SW1 is doing the investigation. When asked if any abuse had been substantiated, she replied, I relied on SW1. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Discussed the requirement of the facility to timely conduct their own internal investigation with findings and take action on those findings to prevent any future occurrence. Timeline events and investigation: [DATE] at 02:45 PM: R1 informed SW1 she has been mistreated by staff during the evening and night shifts. Said the CNA's threw her on the bed with no care and she sustained a lump on the back of her head. Reported to the DON and who came to take a look and also saw the lump on the back of resident's head.told the resident that a report would be put into APS (adult protective services), . SW will conduct an investigation as mandated. [DATE] at 05:10 PM, SS progress note by SW1: MD notified of resident's injury. [DATE] at 07:36 PM, Health Status Note by Nursing: Exam by physician. [DATE] and [DATE], CNA1 and CNA worked and provided care to residents. [DATE] at 03:37 PM, SS progress note by SW1: : Investigations was [sic] carried out by the DON (Director of Nursing) and SW and staff were interviewed. [DATE] at 05:19 PM, SS progress note: .All staff members (CNA1, CNA2 and CNA3) that were named/described by resident will have no contact with any resident until the investigation is done by APS.Ongoing investigation continues . Staff suspended (CNA1, CNA2 and CNA3) pending investigation after facility had discussion with APS. [DATE]: The DON signed the Investigation Report Form, documented Investigators could not substantiate or find reasonable reasons for how resident got the bump on back of her head. [DATE]: Staff statements collected and included accounts of inappropriate comments CNA2 made to R1, as well as refusal to provide services needed to take her to the bathroom. There were no statements from CNA1, CNA2 or CNA3. [DATE]-[DATE]: OHCA investigation. At the time of survey, all three CNA's were still suspended and waiting to hear from the facility regarding findings. Cross Reference F600 Free from Abuse/neglect The facility failed to protect R1 from verbal abuse and neglect to provide needed services of toileting. CNA2 refused to assist R1 to the toilet, witnessed shouting at R1 and reported to have made other inappropriate comments. CNA2 stated during interview that she told R1 to urinate in her diaper. As a result of these willful acts, R1 suffered mental anguish and emotional harm. 2) R3 was a [AGE] year old female admitted to the facility on [DATE]. Her medical diagnosis included but not limited to chronic kidney disease, Type 2 Diabetes, hypertension, dysphasia, Hemiplegia and hemiparesis affecting right dominant side following stroke, full incontinence of bowel and bladder. R3 is dependent on staff for meeting emotional, physical and social needs due to her physical limitations. She was on hospice and expired on [DATE]. The facility was notified by APS that they opened a case for R3 and requested documents. (continued on next page)

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	125050	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hale Malamalama	6163 Summer Street Honolulu, HI 96821

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reviewed a typed unsigned statement that included On [DATE]. I was the evening Charge Nurse .when 1 CNA came to me and told me that the agency CNA and a regular staff of the facility are arguing loudly inside room [ROOM NUMBER]. I went to intervene and saw them close to eachother still arguing. Prior to the incident, I learned that they were arguing about resident assignment .When asked if she (agency CNA) can change the said resident (R3), the agency CNA agreed to change her.After separating them, I was not really sure what happened why they came to a point where they are shouting to each other. I just wanted to separate them. On [DATE] at 10:00 AM, interviewed the DON in the conference room. At that time, she said she was aware of a situation with R3 on [DATE], and that she was in charge at that time. The DON confirmed the unsigned statement referenced above was hers. She went on to say there was an issue with CNA assignments at change of shift but that the issue had been resolved and assignments had been worked out. The DON said apparently R3 was found to be soiled by the assigned CNA, and there was a question of why she had been assigned to that particular resident. The DON said she had recently been made aware that there was a APS case opened on R3. When inquired if she reviewed R3's medical records to identify any potential care issues and specifically if she had reviewed the CNA task documentation for timely brief changes on [DATE], since this had been brought to her attention, she replied no. The DON reviewed the documentation and agreed there was lack of evidence R3 had been checked every two hours for incontinence that day. There was no investigation to identify any care issues or neglect to provide services conducted by the facility after the CNA expressed concern of staff not changing residents in a timely manner and the incident that occurred on [DATE]. It was viewed as an interpersonal conflict between staff related to assignments which was considered resolved. Cross Reference F684 Quality of care The facility failed to provide the needed incontinence care and standards of practice for R3, which was to check her every two hour checks to ensure she was clean and dry. RR revealed staff did not provide these checks on multiple occasions, which put her at increased risk of skin breakdown. On review of CNA task documentation revealed on [DATE], R3 was checked at 12:00 PM, and not again until 07:25 PM. 3) Reviewed the facility policy titled Protection of Residents During Abuse Investigations with date at bottom of page 08/07. The policy included: -The policy statement Our facility will protect residents from harm during investigations of abuse allegations. - 1. During abuse investigations, residents will be protected from harm by the following measures: a. Employees accused of the alleged abuse will be immediately reassigned to duties that do not involve contact with any resident or will be suspended with or without pay until the findings of the investigation have been reviewed by the administrator or representative clearing the employee of any wrong doing. b. Duties that do not involve contact with any resident include work in the dietary department or the administrative office. Reviewed the facility policy titled Abuse Investigations with date 08/07 at bottom of page. The policy included: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Policy statement: All reports of resident abuse, neglect, and injuries of an unknown source shall be promptly and thoroughly investigated by .management. - 3. The individual conducting the investigation will , at [sic] a minimum: . i. Interview other residents to whom the accused employee provides care or services; .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to timely update one Resident's(R)1 care plan. R1 initially required one assist for toileting/transfers. When her condition declined, she required two person assist and then the Hoyer lift to safely transfer her, but the facility did not revise her CP in a timely manner. As a result of this deficiency, there was the potential not all staff were aware of what assistance R1 required to provide safe transfers, increasing the potential for falls with injury or harm. Findings include: R1 is a [AGE] year old female admitted to the facility from the hospital on [DATE] for skilled nursing services. She had a history that included, but not limited to hypertension, cardiomyopathy, heart failure, atrial fibrillation, malignant neoplasm of stomach, malignant ascites, Type 2 Diabetes, difficulty in walking and muscle weakness. Reviewed the electronic medical record which included the following entries: 01/03/2025 at 02:44 PM, Nursing note: .Toileted by staff with extensive assist as per request. 01/05/2025 at 03:37 AM, Nursing note: While trying to put her in recliner, knee buckled and staff slide [sic] and guided down the Res (resident) to the floor. No c/o of pain. Able to get up with 2 assist with good weight bearing.: 01/06/2025 09:35 PM, Nursing note: .CNA reports resident requiring more assistance with toileting. 01/07/2025 12:52 PM, Nursing note: Resident had her last PT (physical therapy) session this shift and able to participate with some activities given by the therapist, but weakness noted per PT. 01/22/2025 02:10 PM, Social Services note: Late entry significant change for 01/16/2025: Resident was readmitted to .Hospice on 01/08/2025 as she was previously on hospice before she had a fall and sent to the hospital. She has hospice diagnosis of Gastric Cancer .she requires extensive to total assistance with her ADL's (activities of daily living) and care due to increased weakness. She is unable to ambulate but can bear weight partially and requires 2-3 staff assistance during transfers. Reviewed R1's active care plan (CP), which included the focus The resident has an ADL self-care performance deficit r/t (related to) impaired mobility, muscle weakness. The interventions included the following: - Toilet Use: The resident requires substantial/maximal assistance by (1) staff for toileted. Date initiated 12/26/2024. Revision on 01/15/2025. - Transfer: The resident requires substantial/maximal assistance by (1) staff to move between surfaces as necessary. Revision on 01/15/2025. R1 was documented to require more assistance with toileting on 01/06/2025 and on 01/22/2025, indicated she required 2-3 staff assistance for transfers. On 01/28/2025, it was documented she required the Hoyer lift for transfers. The CP was not revised to include these changes in a timely manner.

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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** Based on observation, record review (RR) and interviews, the facility failed to provide the needed incontinence care and standards of practice for two residents, (R)2 and R3, of a sample size of three that needed incontinence care. This deficient practice has the potential to affect any resident requiring incontinence care. Findings include: 1) R2 is a [AGE] year old female admitted to the facility on [DATE]. She has a medical history that includes but not limited to dementia, retention of urine, muscle weakness, difficulty walking and syncope. She is chairfast and has very limited ability to change position without moderate to maximum assistance, and is considered high risk for developing pressure sores. Reviewed R2's Care plan (CP) which included the following: - Date initiated: [DATE]: The resident has bladder incontinence r/t (related to) Dementia, Impaired Mobility. - Interventions initiated [DATE] included Brief use: The resident uses disposable briefs. Check every 2 hours and prn (as needed) and change prn., and Incontinent: Check every 2 hours and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes. Reviewed the documentation of Certified Nurse Assistant (CNA) tasks for the period of [DATE] through [DATE], which revealed bladder elimination was not checked and documented every two hours per R2's CP, facility policy, or current standard of care. The entries below are not all inclusive of missed checks for incontinence care by the nursing staff: - [DATE] checked at 11:27 PM. (incontinent). Next check [DATE] at 09:48 AM (did not void). - [DATE] checked at 11:21 PM. Next check [DATE] at 06:00 AM (incontinent both times). - [DATE] checked at 11:10 PM. Next check [DATE] at 06:00 AM (incontinent both times). - [DATE] checked at 12:00 PM. Next check [DATE] at 05:11 PM (incontinent both times). - [DATE] checked at 11:36 PM. (incontinent). Next check [DATE] at 09:42 AM (did not void). - [DATE] checked at 01:10 PM. Next check [DATE] at 07:33 PM (incontinent both times). - [DATE] checked at 11:03 PM. Next check [DATE] at 09:22 AM (incontinent both times). - [DATE] checked at 11:18 PM. Next check [DATE] at 09:45 AM (incontinent both times). - [DATE] checked at 01:30 PM. Next check [DATE] at 07:44 PM (incontinent both times). - [DATE] checked at 11:07 AM. Next check [DATE] at 07:23 PM (incontinent both times). - [DATE] checked at 12:57 PM. Next check [DATE] at 08:43 PM (incontinent both times). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- [DATE] checked at 03:44 PM. Next check [DATE] at 08:45 PM (incontinent both times). - [DATE] checked at 11:07 PM. Next check [DATE] at 10:01 AM (incontinent both times). - [DATE] checked at 12:00 PM. Next check [DATE] at 08:16 PM (incontinent both times). - [DATE] checked at 10:56 PM. Next check [DATE] at 11:10 AM (incontinent both times). - [DATE] checked at 12:54 PM. Next check [DATE] at 08:22 PM (incontinent both times). 2) R3 was a [AGE] year old female admitted to the facility on [DATE]. Her medical diagnosis included but not limited to chronic kidney disease, Type 2 Diabetes, hypertension, dysphasia, Hemiplegia and hemiparesis affecting right dominant side following stroke, full incontinence of bowel and bladder. R3 is dependent on staff for meeting emotional, physical and social needs due to her physical limitations. She was on hospice and expired on [DATE]. Reviewed R3's Care plan (CP) which included the following: - Date initiated: [DATE]: The resident has bladder incontinence r/t Impaired Mobility. - Interventions initiated [DATE] included Brief use: The resident uses disposable briefs. Check every 2 hours and prn and change prn. Clean peri-area with each incontinence episode, and Incontinent: Check every 2 hours and as required for incontinence episodes. Reviewed the documentation of Certified Nurse Assistant tasks for the period of [DATE] through [DATE], which revealed bladder elimination was not checked and documented every two hours per R3's CP, facility policy, or current standard of care. The entries below are not all inclusive of missed checks for incontinence by the nursing staff: - [DATE] checked at 12:58 PM. Next check [DATE] at 07:06 PM (incontinent both times). - [DATE] checked at 11:00 PM. Next check [DATE] at 05:51 AM (incontinent both times). - [DATE] checked at 01:13 PM. Next check [DATE] at 07:45 PM (incontinent both times). - [DATE] checked at 10:56 PM. (incontinent) Next check [DATE] at 06:00 AM (Did not void). - [DATE] checked at 12:00 PM. Next check [DATE] at 07:25 PM (incontinent both times). - [DATE] checked at 11:23 PM. Next check [DATE] at 11:45 AM (incontinent both times). On [DATE], the DON was made aware that R2 had been found by oncoming CNA incontinent of bowel and bladder. 3) Reviewed the facility policy (not dated) titled Perineal Care For The Incontinent Patient. The policy purpose included 2. Perineal care is completed every morning and/or after each incontinence episode. At the bottom of the policy was REMINDERS: *Check the patient every two hour for incontinence. (continued on next page)

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