

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2016
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NAME OF PROVIDER OR SUPPLIER ANN PEARL NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 45-181 WAIKALUA ROAD KANEHOE, HI 96744
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 088	<p>Continued From page 1</p>  <p>The facility failed to maintain the activities stated in their previous Plan of Correction for their last survey. Additionally, they failed to have systems in place to address quality issues such as environment, infection control, and sufficient nurse staffing.</p>	4 088	<p>Continued from page 1</p> <p>Residents admitted within the last month were identified have had their care plans and interventions reviewed to ensure fall risk factors are identified and appropriate prevention interventions are in effect.</p> <p>Residents who have sustained a fall in the past 30 days have had their records to review with a new falls assessment completed as necessary with care plans revised accordingly.</p> <p>Residents who have demonstrated a change of condition for improvement have had their falls assessment and care plan interventions reviewed with appropriate action and revisions made accordingly.</p> <p>Regarding F431: A review of all medication rooms, medication and treatment carts for any other opened and expired items was conducted with no other items discovered.</p> <p style="text-align: center;">Continued on page 2-2</p>	
4 123	<p>11-94.1-27(12) Resident rights and facility practices</p> <p>Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including:</p> <p>(12)The right to be fully informed in advance about care and treatment and of any changes in that care and treatment and the right to participate in planning care and treatment,</p>	4 123	<p>See page 3 of 43</p>	

Continued from page 1 (4 088)

Regarding F463: All call bells were audited to assure proper functioning of call lights and proper functioning/programming of pagers on 2/19/16. Any call bells/pagers found to be mal functioning were immediately fixed. No other residents were found to be affected by this deficient practice.

III. Regarding F279: Restraint care plans will be reviewed quarterly at care plan meeting to ensure intended use is unchanged, necessity exists, change of condition warrants continued use. A therapy screen will be conducted at any time the resident's condition changes to ensure appropriateness of device used.

03/30/16

Falls care plans will be reviewed quarterly at care plan meeting to ensure interventions remain current and aligned with resident's current condition.

Any fall reviews will occur at morning clinical meetings with the interdisciplinary team (IDT) to ensure that a new falls assessment is conducted. Identified risk factors will be reviewed with appropriate prevention interventions implemented and care plan revisions completed.

MDS nurses and resident care managers (RCMs) will be further educated on comparison of RAI findings and falls assessment to ensure all risk factors have been reviewed prior to decision to proceed or not for falls care plan.

Regarding F431: Licensed staff has been in-serviced on requirements for medication expiration and destruction protocols. Newly hired licensed staff will have policy reviewed as part of their unit orientation. Night shift staff will be responsible for checking medication rooms, medication and treatment carts nightly and discard any undated or outdated medications.

Regarding F463: A preventative maintenance program was created based on manufacturers recommendations to address call light batteries, call light bulbs, call cords, call bell computer maintenance, pager batteries, and pager programming. An extra pager was programmed and placed at each nursing station to be available 24/7 to staff in the event that a pager malfunctions. A pager check will be conducted at the change of every shift where a call light will be pulled and pager functionality will be verified. Nursing staff were in-serviced on the availability of extra pagers on each unit and how/when to conduct a pager check. Maintenance staff will check the primary computer for the call bell system for any warnings 3x per week and address any concerns accordingly.

Quality assurance audits will continued to be conducted and reported at monthly performance improvement meeting until the following survey if 100% compliance has not been reached and maintained for 3 consecutive months.

IV. Random audits will be conducted monthly X 3 and quarterly X 3 of all identified areas from annual survey. Results of audit findings will be reviewed at facility Performance Improvement Committee meeting. An ongoing semiannual audit through an intra-company process further validating compliance in this area.

04/04/16

Responsible Party: Administrator and/or
Designee

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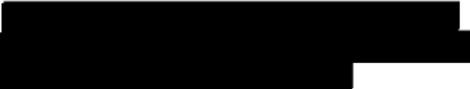
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4 123	<p>Continued From page 2</p> <p>unless adjudged incompetent or incapacitated;</p> <p>This Statute is not met as evidenced by: Based on Resident interview, staff interview, and record review the facility failed to create an environment that is respectful of the right for one resident in the Sample Survey to exercise autonomy in making choices regarding aspects of life at the facility.</p> <p>Findings Include:</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p>	4 123	<p>I. Resident 195 no longer resides at the facility.</p> <p>II. All shower preferences for current residents was conducted, documentation was updated as needed. No other residents were found to be negatively affected by this deficient practice.</p> <p>III. Resident room change procedure will be updated to include shower preferences procedure. Facility staff will then be in-serviced on the policy. All room changes within the first month will be audited to assure shower preferences are being met.</p> <p>IV. Audits will be conducted for shower preferences for any residents with room change monthly x3 then quarterly thereafter results of audit findings will be reviewed at facility Performance Improvement Committee meeting. An ongoing semiannual audit through an intra-company process further validating compliance in this area.</p> <p>Responsible Party: Director Nursing and/or Designee</p>	<p>03/18/16</p> <p>03/22/16</p> <p>03/30/16</p> <p>04/04/16</p>

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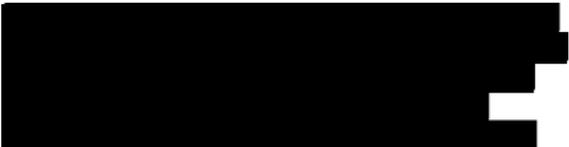
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4 123	Continued From page 3  	4 123		
4 127	<p>11-94.1-28(a) Resident accounts</p> <p>(a) In the event the resident or family member requests the facility to manage the resident's personal funds, an itemized account shall be made available in writing to the resident or the legal guardian or surrogate, and shall be maintained and kept current for the resident, including:</p> <p>(1) Written receipts for all personal possessions and funds received by or deposited with the facility; and</p> <p>(2) Written receipts for all disbursements made to, or on behalf of, the resident.</p> <p>This Statute is not met as evidenced by: Based on a review of residents' personal funds, staff interview and facility policy review, the facility failed to refund residents' personal funds within 30 days upon death of 4 of 10 residents who had trust fund accounts with the facility.</p> <p>Findings include:</p>	4 127	<p>I. Facility reimbursed 4 identified trustees .</p> <p>II. Facility audited all residents with trust funds who have expired within the last 3 months and appropriate action taken as necessary.</p> <p>III. Facility business office was in-serviced on the policy regarding Trust Fund: Refund Process. Business office will review any expired residents within the facility weekly and initiate process accordingly.</p> <p>IV. A monthly audit will be conducted of all expired residents with trust funds to assure that the facility is executing its policy and procedure. Audit will be conducted monthly x3 months then quarterly thereafter results of audit findings will be reviewed at facility Performance Improvement Committee meeting. An ongoing semiannual audit through an intra-company process further validating compliance in this area.</p> <p>Responsible Party: Business Office Manager/ Designee</p>	<p>03/11/16</p> <p>03/04/16</p> <p>03/17/16</p> <p>04/04/16</p>

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4 127	Continued From page 4   	4 127		
4 128	11-94.1-28(b) Resident accounts (b) Upon request of each resident or legal guardian or surrogate, articles kept for safekeeping shall be released. This Statute is not met as evidenced by: Based on resident and staff interviews and facility policy review, the facility failed to ensure residents received their trust fund monies upon request. Findings include: 	4 128	I. Upon notification facility assured resident #8 trust fund request was processed. Responsible Party: Business Office Manager/ Designee II. No other residents were found to affected by this deficient practice. Review of the facility concern log did not indicate any further concerns regarding trust funds. Emergency funds were found to be available to residents. Responsible Party: Business Office Manager/ Designee III. Facility staff were in-serviced on current policy and procedure to include but not limited to the business office. All current residents with trust fund accounts will be notified of our current policy. All future residents who sign up for trust funds with the facility will have policy reviewed with them by the business office. Responsible Party: Business Office Manager/ Designee Continued on page 6	02/17/16 02/17/16 04/01/16

Hawaii Dept. of Health, Office of Health Care Assurance

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4 128	Continued From page 5   	4 128	Continued from page 5 IV. A random sample of trust fund residents will be audited to assure that the facility is executing its policy and procedure. Audit will be conducted monthly x 3 months then quarterly thereafter, results of audit findings will be reviewed at facility Performance Improvement Committee meeting. An ongoing semiannual audit through an intra-company process further validating compliance in this area. Responsible Party: Social Services/Designee	04/04/16
4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention;	4 136	I. Resident # 116 has a comprehensive care plan addressing the use of  consistent with physician orders, reasons for use and appropriateness of such. Resident # 121 no longer resides in the facility. Resident # 3 had splint schedule assessed immediately and applied accordingly. Resident has been further assessed  for any further contracture management with appropriate revisions taken. All resident with splints had schedule pushed to Kardex. Staff have been educated on proper splint use and passive range of motion for resident #3. Splinting application and Continued on page 7	03/17/16

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4 136	<p>Continued From page 6</p> <p>(6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interviews, and record review the facility failed to ensure that 3 Residents received the appropriate care and treatment to attain and maintain their highest practicable ability (R #116 for restraints; R #3 for range of motion services; and R #121 for fall prevention).</p> <p>Findings Include:</p> <div style="background-color: black; width: 100%; height: 100px; margin-bottom: 5px;"></div> <div style="background-color: black; width: 100%; height: 100px; margin-bottom: 5px;"></div> <div style="background-color: black; width: 100%; height: 100px;"></div>	4 136	<p>Continued from page 6 schedule have been updated on the Kardex and care plan accordingly. No other residents found to be negatively affected.</p> <p>Resident # 121 no longer resides in the facility.</p> <p>II. Any resident currently utilizing [REDACTED] for any reason have had their medical record care plan reviewed. Care plans have been updated to appropriately reflect the use of [REDACTED] including assessment, rationale, physicians orders, and release schedule to ensure [REDACTED] is used.</p> <p>Residents admitted within the last month were identified have had their care plans and interventions reviewed to ensure fall risk factors are identified and appropriate prevention interventions are in effect.</p> <p>Residents who have sustained a fall in the past 30 days have had their records to review with a new falls assessment completed as necessary with care plans revised accordingly.</p> <p>Residents who have demonstrated a change of condition for improvement have had their falls assessment and care plan interventions reviewed with appropriate action and revisions made accordingly.</p> <p>Resident's currently using splints or contracture management devices have had their care plans and treatment plans reviewed with appropriate action taken to ensure compliance with all recommended interventions.</p> <p>Staff have been educated on proper contracture management and schedule with Kardex and care plan updated accordingly.</p> <p>Residents admitted within the last month were identified have had their care plans and interventions reviewed to ensure fall risk factors are identified and appropriate prevention interventions are in effect.</p> <p style="text-align: right;">Continued on page 8</p>	03/25/16

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4 136	<p>Continued From page 7</p> <p>[REDACTED]</p>	4 136	<p>Continued from page 7</p> <p>III. Restraint care plans will be reviewed quarterly at care plan meeting to ensure intended use is unchanged, necessity exists, change of condition warrants continued use. A therapy screen will be conducted at any time the resident's condition changes to ensure appropriateness of device used.</p> <p>Falls care plans will be reviewed quarterly at care plan meeting to ensure interventions remain current and aligned with resident's current condition.</p> <p>Any fall reviews will occur at morning clinical meetings with the interdisciplinary team (IDT) to ensure that a new falls assessment is conducted, care plan and interventions updated appropriately. Identified risk factors will be reviewed with appropriate prevention interventions implemented and care plan revisions completed.</p> <p>MDS nurses and resident care managers (RCMs) will be further educated on comparison of RAI findings and falls assessment to ensure all risk factors have been reviewed prior to decision to proceed or not for falls care plan.</p> <p>Resident's currently using splints for contracture management have been screened by therapy. Splint use and schedules for identified residents have been updated on the care plan, Kardex and reviewed with staff. Residents with contractures have been screened/reviewed by therapy for splints and splints will be ordered per therapy recommendations.</p> <p>Upon discharge from therapy, therapist will bring recommendations to morning meeting for IDT discussion and appropriate resident specific interventions and care plan updates. Resident care managers (RCM's) will then in-service staff.</p> <p>Splint usage will be documented through nursing assessment and the treatment administration record.</p> <p>Continued on page 9</p>	04/04/16

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4 136	Continued From page 8 [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED]	4 136	Continued from page 8 IV. Random care plan, splint, and fall audits will be conducted monthly X 3 and quarterly X 3. Results of audit findings will be reviewed at facility Performance Improvement Committee meeting. An ongoing semiannual audit through an intra-company process further validating compliance in this area. Responsible Party: Director of Nursing and/or Designee	04/04/16

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4 136	Continued From page 9 [REDACTED]	4 136		

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4 136	Continued From page 10   	4 136		

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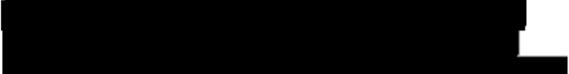
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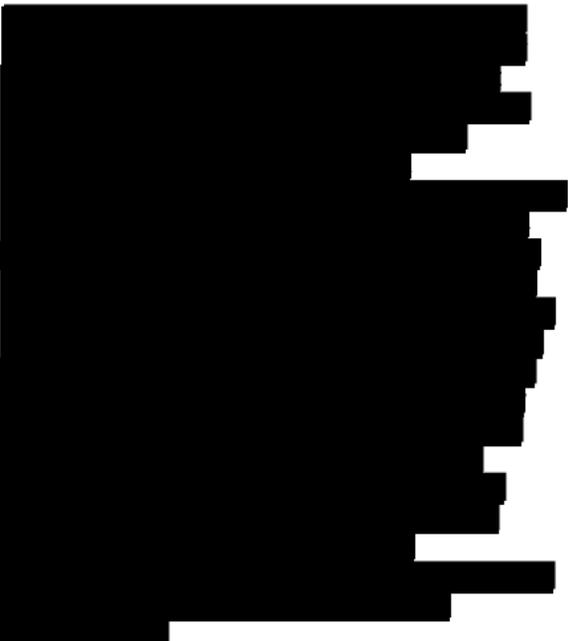
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4 136	Continued From page 12    	4 136		

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4 136	Continued From page 13 	4 136		
4 148	11-94.1-39(a) Nursing services (a) Each facility shall have nursing staff sufficient in number and qualifications to meet the nursing needs of the residents. There shall be at least one registered nurse at work full-time on the day shift, for eight consecutive hours, seven days a week, and at least one licensed nurse at work on the evening and night shifts, unless otherwise determined by the department. This Statute is not met as evidenced by: Based on resident, family, staff member interviews; observations, and record reviews the facility failed to assure that there are adequate	4 148	I. The facility does provide sufficient staffing on a 24 hour basis to provide nursing care to all residents in accordance with their care plan. Resident #135 has had  needs met with no negative outcomes. II. Call logs were reviewed by the facility for areas of concern including shift, unit, and room for patterns or trends. Identified patterns or trends have been individually addressed and will continue to be monitored ongoing. III. All departments will educated on call bell response expectations. Available agency staff have been utilized for any vacant shift. Company sponsored CNA class begins on 3/28/16 with a projected 18 students enrolled. Continued on page 15	02/20/16 03/22/16 03/30/16

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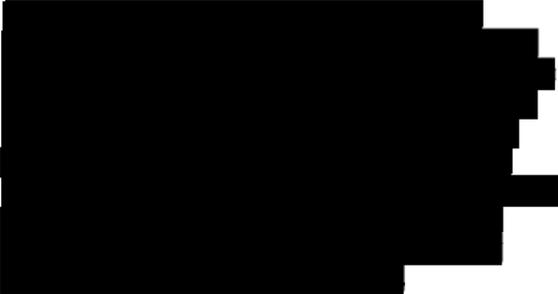
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4 148	<p>Continued From page 14</p> <p>staff to meet direct care needs, planning, evaluation, and supervision in a manner which promotes each resident's physical, mental, and psychosocial well-being thus enhancing their quality of life.</p> <p>Findings include:</p> <div style="background-color: black; width: 100%; height: 150px; margin-top: 10px;"></div> <div style="background-color: black; width: 100%; height: 150px; margin-top: 10px;"></div>	4 148	<p>Continued from page 14</p> <p>Staffing is reviewed based on census and daily the nursing administration reviews the acuity and determines the need for additional staffing and admission capabilities for that day</p> <p>Staffing will be reviewed monthly for any projected shortages and agency staff assignments or classes will be proactively scheduled accordingly.</p> <p>% of resident and/or responsible parties will be interviewed via QIS staffing questionnaire weekly. Based on the questionnaire if a negative response is solicited the residents call light response time will be reviewed to determine any issues or patterns.</p> <p>% of call log response times will be reviewed by administration weekly for areas of concern or patterns with appropriate action taken as needed.</p> <p>V. Random staffing audits will be conducted monthly X 3 and quarterly X 3. Results of audit findings will be reviewed at facility Performance Improvement Committee meeting. An ongoing semiannual audit through an intra-company process further validating compliance in this area.</p> <p style="text-align: center;">Responsible Party: Director of Nursing and/or Designee</p>	04/04/16

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2016
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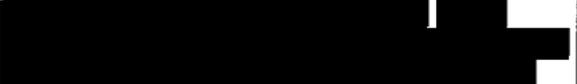
NAME OF PROVIDER OR SUPPLIER ANN PEARL NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 45-181 WAIKALUA ROAD KANEOHE, HI 96744
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4 148	Continued From page 15    	4 148		

Hawaii Dept. of Health, Office of Health Care Assurance

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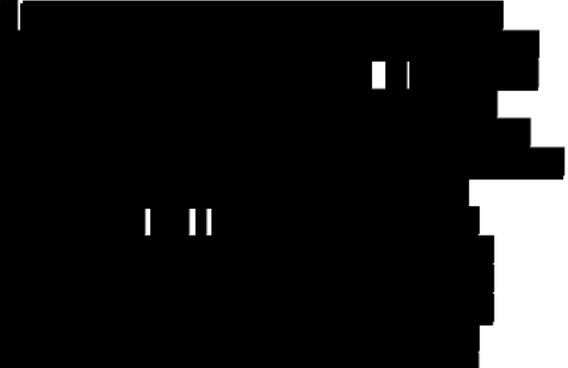
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4 148	Continued From page 16     	4 148		

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/19/2016
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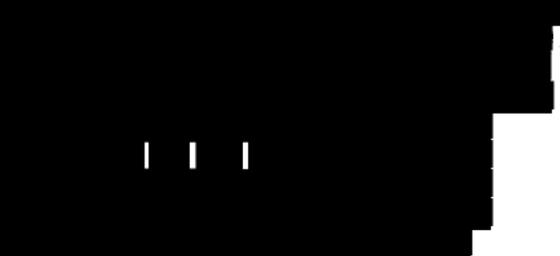
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4 148	Continued From page 17   	4 148		

Hawaii Dept. of Health, Office of Health Care Assurance

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4 148	Continued From page 18     	4 148		

Hawaii Dept. of Health, Office of Health Care Assurance

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4 148	Continued From page 19    	4 148		

Hawaii Dept. of Health, Office of Health Care Assurance

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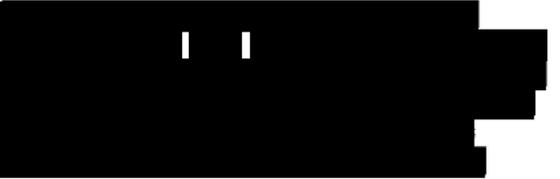
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4 148	Continued From page 20 [REDACTED]	4 148		
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty-first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and	4 149	I. Resident # 116 has a comprehensive care plan addressing the use of [REDACTED] consistent with physician orders, reasons for use and appropriateness of such. Resident # 121 no longer resides in the facility. II. Any resident currently utilizing [REDACTED] for any reason have had their medical record care plan reviewed. Care plans have been updated to appropriately reflect the use of [REDACTED] including assessment, rationale, physicians orders, and release schedule to ensure [REDACTED] is used. Residents admitted within the last month were identified have had their care plans and interventions reviewed to ensure fall risk factors are identified and appropriate prevention interventions are in effect. Residents who have sustained a fall in the past 30 days have had their records to review with a new falls assessment completed as necessary with care plans revised accordingly.	03/17/16 03/25/16

Hawaii Dept. of Health, Office of Health Care Assurance

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4 149	Continued From page 22      	4 149		

Hawaii Dept. of Health, Office of Health Care Assurance

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4 149	Continued From page 23 	4 149		
4 159	<p>11-94.1-41(a) Storage and handling of food</p> <p>(a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions.</p> <p>(1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and</p> <p>(2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage.</p> <p>This Statute is not met as evidenced by: Based on observations, staff interview, and record reviews the facility failed to store, prepare, distribute, and serve food under sanitary conditions, putting residents at risk for pathogen</p>	4 159	<p>I. The alleged out of date items were discarded. The dates located on the items were open dates vs. the alleged use by dates. Sanitizer machine was verified by outside vendor to be in proper working order before next scheduled meal service on 2/16/16. Ice machine lid, two air conditioners, radio, fans in kitchen and side of steam table was cleaned. There were no residents found to be affected by this deficient practice</p> <p>II. Review of infection log reveals no residents were negatively affected by this deficient practice. All open items were checked for any expired products and appropriate action taken as needed. A quick guide for staff regarding food labeling dates was posted in kitchen. Sanitizer was monitored for proper ppm following service by outside vendor and verified by food services director to be in proper working order. Staff were in-serviced on cleaning schedules and expectation.</p> <p>III. Open food items will be checked daily by food services staff for any expired food items. Dietary staff to be in-serviced on policy Food and Supply Storage. Dietary Continued on page 25</p>	<p>02/20/16</p> <p>02/20/16</p> <p>03/25/16</p>

Hawaii Dept. of Health, Office of Health Care Assurance

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4 159	<p>Continued From page 24</p> <p>exposure and physical contamination of food.</p> <p>Findings include:</p> <div style="background-color: black; width: 100%; height: 100px; margin-bottom: 5px;"></div> <div style="background-color: black; width: 100%; height: 80px; margin-bottom: 5px;"></div> <div style="background-color: black; width: 100%; height: 150px; margin-bottom: 5px;"></div> <div style="background-color: black; width: 100%; height: 50px; margin-bottom: 5px;"></div> <div style="background-color: black; width: 100%; height: 50px;"></div>	4 159	<p>Continued from page 24</p> <p>staff to be in-serviced on procedures in the event that sanitizer ppm reads out of range. Cleaning schedules were updated and revised to include daily, weekly, monthly and quarterly cleanings. Dietary staff to be in-serviced on updated cleaning schedules.</p> <p>IV. Audits of dating and labeling, sanitizer ppm, and cleaning schedules will be conducted monthly x3 then quarterly thereafter results of audit findings will be reviewed at facility Performance Improvement Committee meeting. An ongoing semiannual audit through an intra-company process further validating compliance in this area.</p> <p style="text-align: center;">Responsible Party: Food Services Director and/or Designee</p>	04/04/16

Hawaii Dept. of Health, Office of Health Care Assurance

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4 159	Continued From page 25 	4 159		

Hawaii Dept. of Health, Office of Health Care Assurance

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4 159	Continued From page 26 [REDACTED]	4 159		

Hawaii Dept. of Health, Office of Health Care Assurance

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4 197	Continued From page 27	4 197	I. No residents were found to be negatively affected by this finding.	02/20/16
4 197	<p>11-94.1-46(n) Pharmaceutical services</p> <p>(n) Discontinued and outdated prescriptions and containers with worn, illegible, or missing labels shall be disposed of according to facility policy.</p> <p>This Statute is not met as evidenced by: Based on observation, interview with staff members and review of the facility's policy and procedure, the facility failed to ensure drugs were labeled in accordance with currently accepted professional principles and the expiration date when applicable.</p> <p>Findings include:</p> <div data-bbox="194 1113 763 1585" style="background-color: black; width: 100%; height: 100%; min-height: 200px;"></div> <div data-bbox="194 1606 763 1732" style="background-color: black; width: 100%; height: 100%; min-height: 60px;"></div>	4 197	<p>II. A review of all medication rooms, medication and treatment carts for any other opened and expired items was conducted with no other items discovered</p> <p>III. Licensed staff has been in-serviced on requirements for medication expiration and destruction protocols. Newly hired licensed staff will have policy reviewed as part of their unit orientation. Night shift staff will be responsible for checking medication rooms, medication and treatment carts nightly and discard any undated or outdated medications.</p> <p>IV. Random medication expiration audits will be conducted of medication rooms, medication and treatment carts monthly X 3 the quarterly thereafter with results reviewed at performance Improvement Committee. An ongoing semiannual audit through an intra-company process further validating compliance in this area.</p> <p style="text-align: center;">Responsible Party: Director of Nursing and/or Designee</p>	02/20/16 03/30/16 04/04/16

Hawaii Dept. of Health, Office of Health Care Assurance

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4 197	Continued From page 28   	4 197		
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4 203	<p>11-94.1-53(a) Infection control</p> <p>(a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste.</p> <p>This Statute is not met as evidenced by: Based on observation and staff interviews, the facility did not implement practices to control or prevent infection in the long term care facility as well as the Adult Day Health shower room.</p> <p>Findings include: Based on observation and interview with staff</p>	4 203	<p>I. The facility does allege that there is an established and maintained an Infection Control Program.</p> <p>Resident # 200 is not on the sample resident list therefore unable to determine who was affected by this deficient practice.</p> <p>The pulse oximeter and storage area were thoroughly cleaned and sanitized.</p> <p>Resident # 123 suffered no negative outcome from this practice.</p> <p>LN#1 received education and counseling regarding infection control practices during skin care treatments.</p> <p>Shower gurney on Maile was pressure washed and bleached. A new mat was ordered for shower gurney. Nursing staff on unit were in-serviced on appropriate use of disinfectant.</p> <p style="text-align: right;">Continued on page 30</p>	02/20/16
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Hawaii Dept. of Health, Office of Health Care Assurance

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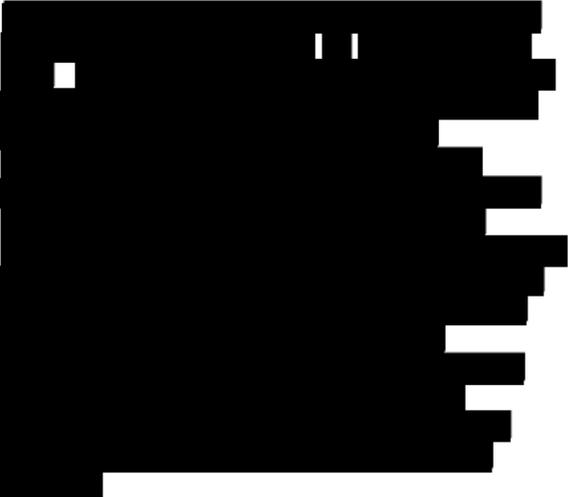
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4 203	<p>Continued From page 29</p> <p>members the facility failed to maintain an infection control program to provide a safe, sanitary and comfortable environment to prevent the transmission of disease and infection.</p> <p>Findings include:</p> <div style="background-color: black; width: 100%; height: 100px; margin-bottom: 10px;"></div> <div style="background-color: black; width: 100%; height: 100px; margin-bottom: 10px;"></div> <div style="background-color: black; width: 100%; height: 100px;"></div>	4 203	<p>Continued from page 29</p> <p>Wash cloths were immediately removed from the shower area.</p> <p>II. Pulse oximeters and storage areas for vital sign equipment were inspected and thoroughly sanitized as necessary.</p> <p>All shared shower equipment was checked and addressed as appropriate.</p> <p>All shower rooms were checked for any unlabeled wash cloths.</p> <p>No residents were found to be negatively affected by this practice.</p> <p>III. Review of the past 6 months of resident council minutes regarding infection control practices will occur with action plans developed to address.</p> <p>Routine cleaning schedule will be conducted for pulse ox machine.</p> <p>A shower equipment cleaning schedule to be created and maintained by environmental services staff. Schedule will also include checks by environmental services staff for equipment wear and tear to be addressed as deemed appropriate. Night shift staff will check each night to assure that disinfectant is stocked in designated area.</p> <p>Nursing staff will be educated on infection control practices with equipment, storage areas, wash cloths and resident care. Vital sign equipment and storage areas will be placed on a routine cleaning schedule to ensure sanitation is achieved.</p> <p>IV. Random infection control audits will be conducted monthly X 3 and quarterly X 3. Results of audit findings will be reviewed at facility Performance Improvement</p> <p style="text-align: right;">Continued on page 31</p>	<p>02/20/16</p> <p>04/04/16</p> <p>04/04/16</p>

Hawaii Dept. of Health, Office of Health Care Assurance

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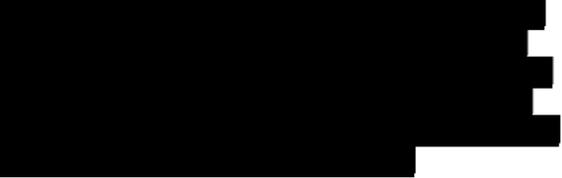
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4 203	Continued From page 30    	4 203	Continued from page 30 Committee meeting. An ongoing semiannual audit through an intra-company process further validating compliance in this area. Responsible Party: Director of Nursing and/or Designee	

Hawaii Dept. of Health, Office of Health Care Assurance

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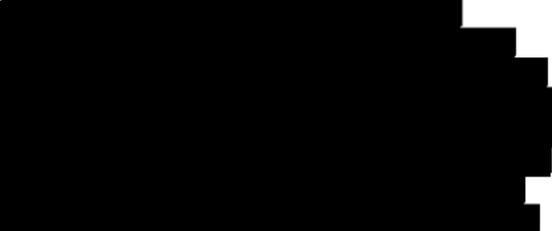
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2016
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NAME OF PROVIDER OR SUPPLIER ANN PEARL NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 45-181 WAIKALUA ROAD KANEHOE, HI 96744
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4 203	Continued From page 32  	4 203		
4 213	11-94.1-54(d) Sanitation (d) Every facility shall maintain an effective pest control program so that the facility is free of pests and rodents. This Statute is not met as evidenced by: Based on resident and family interview the facility failed to maintain an effective pest control program to keep the facility free of rodents. Findings include:	4 213	I. After resident concern was addressed at time of incident there were no other reported or observed issues. II. No residents found to be affected by this alleged deficient practice. There have been no other similar concerns reported during a 6 month lookback period. III. Facility pest control to be monitored daily by all staff and any observed pest issues to be removed immediately as well as verbalized to Administrator/Designee. Extermination provider contacted to tour facility to evaluate and provide recommended services for additional pest control. Monitoring for pests will be added to bi-monthly environmental rounds. Continued on page 34	02/22/16 02/22/16

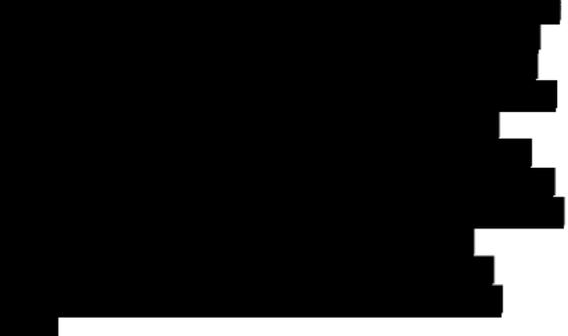
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4 213	Continued From page 33  	4 213	Continued from page 33 IV. Audit of pest management to be performed daily x1 week then bi-weekly x 3 weeks. Then monthly thereafter given no significant findings. Facility extermination services will be initiated with any observed or resident/family concerns. Results of audit findings will be reviewed at facility Performance Improvement Committee meeting. An ongoing semiannual audit through an intra-company process further validating compliance in this area. Responsible Party: Administrator and/or Designee	04/04/16
4 218	11-94.1-55(e) Housekeeping (e) All floors, walls, ceilings, windows, and fixtures shall be kept clean and in good repair. This Statute is not met as evidenced by: Based on observation and interview with facility staff, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Findings include: 	4 218	I. Review of infection and accident log confirmed that no residents were found to be affected by the deficient practice. II. There were no other residents found to be affected by this deficient practice. All fans and vents in the facility were checked for cleanliness and were cleaned as needed. All rails in resident bathrooms were checked for stability and were addressed as needed. Floor waxing and cleaning maintenance was initiated. Concerns identified with duct tape in dining room were addressed and rectified. The flaking and peeling paint were addressed to prevent paint from falling. III. On 3/14/16 a job offer and acceptance was made to an additional maintenance associate to assist facility with deficiencies related to baseboards, cracked tiles, wall repairs, painting, flooring repairs and stained flooring. An inventory of all fans and vents within the facility was conducted. A preventative maintenance log was created to assure proper maintenance and cleanliness of fans and vents within the facility. Facility to implement bi-monthly environmental services rounds to monitor for facility cleanliness and general maintenance needs. Continued on page 35	02/22/16 03/22/16 04/04/16

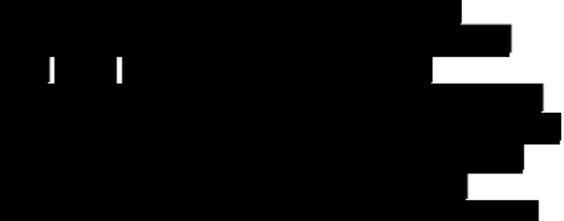
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4 218	Continued From page 34    	4 218	Continued from page 34 IV. Audits of housekeeping and maintenance services will be conducted monthly x3 then quarterly thereafter results of audit findings will be reviewed at facility Performance Improvement Committee meeting. An ongoing semiannual audit through an intra-company process further validating compliance in this area. Responsible Party: Administrator and/or Designee	04/04/16

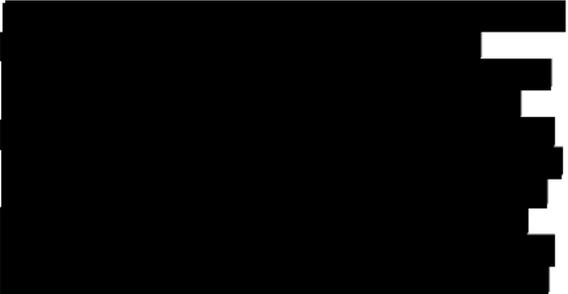
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4 218	Continued From page 35    	4 218		

Hawaii Dept. of Health, Office of Health Care Assurance

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4 218	Continued From page 36     	4 218		

Hawaii Dept. of Health, Office of Health Care Assurance

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4 218	Continued From page 37  	4 218		
4 226	11-94.1-57(d) Life safety (d) Facilities shall have written procedures in case of fire, disasters, and emergencies. This Statute is not met as evidenced by: Based on surveyor review, the facility did not maintain fire exit doors, delayed egress mechanism, fire extinguishing system (kitchen range hood), and fire sprinklers. Findings include: Cross reference to Life Safety Survey, Citations K038; K043; K062; K069; K072.	4 226	I. Exit door was repaired immediately on 2/17/16 upon notification. No residents were found to be affected by the deficient practice. II. All exit doors were immediately inspected for compliance. No other residents were found to be affected by the deficient practice. III. A preventative maintenance program was created which will be conducted monthly which will also assure proper working order of all exit doors. IV. Audits of exit door preventative maintenance will be conducted monthly x3 then quarterly thereafter results of audit findings will be reviewed at facility Performance Improvement Committee meeting. An ongoing semiannual audit through an intra-company process further validating compliance in this area. Responsible Party: Administrator and/or Designee	02/20/16 02/20/16 03/30/16 04/04/16
4 270	11-94.1-65(d)(7) Construction requirements (d) The facility shall have adequate toilet and bath facilities: (7) Each toilet and bath facility shall have a call system that permits the occupant to signal the nursing station in an emergency;	4 270	I. Upon notification hand call bells were immediately made available in adult day health toilet facility. There were no adult day health participants found to be affected by this deficient practice. II. Review of accidents over the last 6 months yielded no results related to adult day health toilet facility. No adult day health participants were found to be affected by this deficient practice. Continued on page 39	02/20/16 03/21/16

Hawaii Dept. of Health, Office of Health Care Assurance

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4 270	Continued From page 38 This Statute is not met as evidenced by: Based on observations and staff interviews, the facility did not ensure each toilet facility have a call system that permits the occupant to signal the nursing station in an emergency for one of 2 toilets for the Adult Day Health clients. Findings include: 	4 270	Continued from page 38 III. Facility to research and purchase appropriate/permanent call light solution for adult day health toilet facility. Staff and Adult day health participants will be in-serviced on use of new system IV. Random audits will be conducted during adult day health operational times to ensure functioning call bell access monthly X3 then quarterly X3, thereafter results of audit findings will be reviewed at facility Performance Improvement Committee meeting. An ongoing semiannual audit through an intra-company process further validating compliance in this area. Responsible Party: Adult Day Health Director and/or Designee	04/04/16 04/04/16
4 277	11-94.1-65(e)(4) Construction requirements (e) The facility shall have resident bedrooms that ensure the health and safety of residents: (4) Single resident bedrooms shall measure at least one hundred square feet of usable space, excluding closets, bathrooms, alcoves, and entryways; This Statute is not met as evidenced by: Based on staff interview, the facility failed to have bedrooms measure at least 100 square feet in single resident rooms in 1 of 6 rooms on one of 4 units in the facility. Findings include:	4 277	Ann Pearl Nursing Facility has a current waiver for room size in Hale Ho'olu 	02/20/16

Hawaii Dept. of Health, Office of Health Care Assurance

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4 277	Continued From page 39 1) One room in Hale Ho'olu unit did not maintain the required square footage for the number of resident occupants. Room #1 measured 78 square feet. Room #1 was a private room for 1 person. Interview with the NOS on the morning of 2/18/16 confirmed that the room size for rooms 1 and 3 were not in compliance with the requirement for appropriate square footage. The NOS confirmed that the facility rooms remained as noted in the previous survey, and therefore were not in compliance with the requirement for appropriate square footage in Room 3 in Hale Ho'olu unit.	4 277		
4 278	11-94.1-65(e)(5) Construction requirements (e) The facility shall have resident bedrooms that ensure the health and safety of residents: (5) Multi-resident bedrooms shall provide a minimum of eighty square feet per bed of usable space, excluding closets, bathrooms, alcoves, and entryways; This Statute is not met as evidenced by: Based on staff interview, the facility failed to have bedrooms measure at least 80 square feet per resident in multiple resident bedrooms in 1 of 6 rooms on one of 4 units in the facility. Findings include: One room in Hale Ho'olu unit did not maintain the required square footage for the number of resident occupants. Room #3 was a multiple resident room.	4 278	Ann Pearl Nursing Facility has a current waiver for room size in Hale Ho'olu [REDACTED]	02/20/16

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4 278	Continued From page 40 Interview with the NOS on the morning of 2/18/16 confirmed that the room size for rooms 1 and 3 were not in compliance with the requirement for appropriate square footage. The NOS confirmed that the facility rooms remained as noted in the previous survey, and therefore were not in compliance with the requirement for appropriate square footage in Room 3 in Hale Ho'olu unit.	4 278		
4 281	11-94.1-65(e)(8) Construction requirements (e) The facility shall have resident bedrooms that ensure the health and safety of residents: (8) Each resident shall be provided with: (A) A separate bed of proper size and height for the convenience of the resident and that permits an individual in a wheelchair to get in and out of bed unassisted; (B) A comfortable mattress with impermeable mattress cover, and a pillow with an impermeable cover; (C) Sufficient clean bed linen and blankets to meet the resident's needs; (D) Appropriate furniture, cabinets, and closets, accessible to and meeting individual resident's needs. Locked containers shall be available upon resident's request; and (E) An effective signal call system at the resident's bedside. This Statute is not met as evidenced by: Based on observation and staff interviews the	4 281	I. Upon notification of the main shower call light not functioning batteries were replaced immediately and staff confirmed proper functioning. The one malfunctioning pager was replaced immediately upon notification and all 3 other pagers on the Hale Ho'olu unit were verified as functioning properly by staff. Hand bells were placed in the main dining room bathrooms until system could be reprogrammed. System was reprogrammed on 2/22/16. II. All call bells were audited to assure proper functioning of call lights and proper functioning/programming of pagers on 2/19/16. Any call bells/pagers found to be malfunctioning were immediately fixed. No other residents were found to be affected by this deficient practice. III. A preventative maintenance program was created based on manufacturers recommendations to address call light batteries, call light bulbs, call cords, call bell computer maintenance, pager batteries, and pager programming. An extra pager was programmed and placed at each nursing station to be available 24/7 to staff in the event that a pager malfunctions. A pager check will be conducted at the change of every shift where a call light will be pulled and pager functionality will be verified. Nursing staff were in-serviced on the availability of extra pagers on each unit and how/when to conduct a pager check. Maintenance staff will check the primary computer for the call bell system for any warnings 3x per week and address any concerns accordingly. Continued on page 42	02/22/16 02/20/16 03/30/16

Hawaii Dept. of Health, Office of Health Care Assurance

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4 281	<p>Continued From page 41</p> <p>facility failed to ensure that the call light system in the secured (HH) unit is functioning properly.</p> <p>Findings include:</p> <p>During the initial tour on 2/16/16 at 08:30 A.M. it was found that the call light in the main shower room of the secured/HH unit and room 5 were not working. Two maintenance staff members stated that the batteries need to be changed.</p> <p>There are 4 pagers in the secured/HH area. One of 4 pagers was not registering any calls from the residents. [REDACTED]</p> <p>Currently, no preventative maintenance (PM) being done for the beepers except to change batteries at least once a month, the last time it was done was on 10/2015 and 01/2016.</p> <p>When surveyor pulled the call light in the bathroom of the main dining room it did not register on all four pagers. The Maintenance staff member and the Director of Operations acknowledged that the system was not set up to accordingly and that they will call the vendor.</p> <p>According to Licensed Nurse, LN #3, during change of shift, the staff do not check whether the beepers are working or not, it is a hand off from shift to shift.</p> <p>The policy on "Preventative Maintenance Schedule For Equipment" was reviewed. Under procedure 1: "The Environmental Services Supervisor is responsible for developing and maintaining a schedule of maintenance services to assure that all equipment are maintained in a safe and operable manner."</p>	4 281	<p>Continued from page 41</p> <p>IV. Audits of call bell system and call bell system preventative maintenance will be conducted monthly x3 then quarterly thereafter results of audit findings will be reviewed at facility Performance Improvement Committee meeting. An ongoing semiannual audit through an intra-company process further validating compliance in this area.</p> <p>Responsible Party: Administrator and/or Designee</p>	04/04/16

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