Hawaii Dept. of Health, Office of Health Care Assuranc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125048	A. BUILDING: _____ B. WING _____	02/24/2017

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2017 MAR 17 P 4: 10
STATE OF HAWAII
DEPT. OF HEALTH

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN PEARL NURSING FACILITY	45-181 WAIKALUA ROAD KANEOHE, HI 96744

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4 000	11-94.1 Initial Comments A licensure survey was conducted from 2/21/17 through 2/24/17.	4 000	This Plan of Correction is prepared and submitted as required by law. By submitting this plan of correction Ann Pearl Nursing Facility does not admit that the deficiencies listed exist nor does the community admit to any statements, findings, facts or conclusions that form the basis of the alleged deficiencies. Ann Pearl Nursing Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the alleged deficiency.	
4 115	11-94.1-27(4) Resident rights and facility practices 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: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 1 (Resident #85) of 26 residents in the Stage 2 sample received care in a manner that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. Findings include: On 2/23/17 at 8:00 A.M. observed Resident #85 seated in the dining room eating breakfast with three other female residents at the table. Staff Member #59 brought the resident's medications to the table. While standing at the threshold to the dining room, Staff Member #59 was overheard saying "this is your fiber so you don't get constipated".	4 115	1. Nurse was in-serviced on dignity. Responsible Party: Director of Nursing Services or Designee 2. No other residents were identified as being affected by this deficient practice after conducting dining room observations, review of the concern grievance log, and resident council minutes for past 6 months. Responsible Party: Administrator or Designee 3. Med Pass times will be reviewed to ensure minimal impact on residents quality of life. Licensed nursing staff will be re-educated on privacy and dignity during medication pass. Responsible Party: Director of Nursing Services or Designee 4. Administrator or designee will conduct weekly observations of dignity/privacy practices during medication pass. Results of observations will be documented and presented to the Quality Assurance Performance Improvement (QAPI) team, for outcomes review and follow-up regarding the continued frequency of observations, to ensure each resident is treated with dignity and respect of individuality. Responsible Party: Administrator or Designee	03/01/2017 03/15/2017 03/31/2017 03/31/2017

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nolan Nanba — TITLE: Administrator — (X6) DATE: 3-17-17

3/20/17: Copy to KW; kgb 3/24/17: Sent to MN; kgb

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4 115	Continued From page 1 On 2/24/17 at 9:35 A.M. interview was done with Staff Members #145 and #144. The staff members acknowledged Staff Member #59 discussing the resident's issue with constipation is not dignified or respectful.	4 115		
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; (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. This Statute is not met as evidenced by: Based on observations, medical record review, staff interview and facility policy review, the facility failed to provide the necessary services and interventions to treat pressure ulcers for 2 of 3 (Resident #s 80 & 19) residents reviewed. The facility failed to provide assistive devices to prevent accidents for 1 (Resident #59) of 2 residents sampled for accidents of 26 residents in the Stage 2 sample. Findings include:	4 136	1. Resident #19 no longer resides at the facility. Resident #80 will have a skin assessment completed. Results of assessment and current resident status will be communicated to family, physician and wound care educator. Care plan team will meet and update status, goals and interventions to ensure necessary services are being provided. Responsible Party: Director of Nursing Services or Designee 2. Residents with current Stage II or higher pressure ulcers have been re-assessed and coordination and implementation of necessary services completed. Responsible Party: Director of Nursing Services or Designee 3. Pressure Ulcer program will be reviewed and revised as needed to ensure proper care and services are rendered to our residents. Nursing staff will be re-educated on the program with a focus on accurate, timely assessments throughout the duration of the healing process, proper turning and positioning, and use of preventative/treatment devices. Responsible Party: Director of Nursing Services or Designee 4. Director of Nursing Services or Designee will complete wound rounds weekly. At this time the Continued on page 3	02/22/2017 03/18/2017 03/31/2017 03/31/2017

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4 136	Continued From page 2 1) Resident #80 was admitted to the facility on 1/5/15 with diagnoses which included adult failure to thrive, stage 4 pressure ulcer, and chronic kidney disease. During the survey period (2/21/17 - 2/24/17) it was noted that Resident #80's stage 4 pressure ulcer made very little progress and had not yet healed. Observation of Resident #80 on the morning of 2/21/17 at approximately 10:30 A.M. found her in the hallway in a reclined Geri chair in front of a TV. Her eyes were closed and she was dressed in personal clothing and had blankets on her lap and chest. Resident #80 was sitting on a blue cushion which was placed on the seat of her Geri chair. At approximately 10:45 A.M. a Certified Nurses Aide (CNA) moved Resident #80 from the hallway to the Activity Room. Observation of Resident #80 during the lunch hour on 2/22/17 at approximately 12:45 P.M. found her sitting on the blue cushion in her Geri chair in the dining room. The resident's daughter was feeding her lunch. The resident's daughter stated that Resident #80 does not eat very well and therefore she comes during lunch to assist her. Observation of Resident #80 on the morning of 2/23/17 at approximately 11:30 A.M. found her in the Activity Room seated on the blue cushion in her Geri chair. Her eyes were closed. Observation of Resident #80 during the lunch hour of 2/23/17 found the resident's daughter with her in the dining room, feeding her. The resident was again sitting on the blue cushion on the Geri chair. Observation of Resident #80 on the afternoon of 2/23/17 at approximately 1:30 P.M. found her in the Activity Room seated on the blue cushion in her Geri chair. She had a lap blanket which she picked at, causing the blanket to bunch up in the center of her lap. During the observation period,	4 136	Continued from page 2 . status, healing progress, treatments, and care plan interventions will be audited. Areas requiring immediate attention will be updated upon completion of rounds. Additionally, Director of Nursing Services or Designee will conduct random routine audit of turning and repositioning of at risk residents as well as proper utilization and implementation of prevention and treatment devices. Results of the audits will be given to the QAPI team, for outcomes review and follow-up regarding the continued frequency of audits, to ensure resident receive necessary services for pressure ulcer treatment. Responsible Party: Director of Nursing Services or Designee	

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the resident remained up in the Geri chair and did not get frequent, hourly repositioning. An interview of Staff #144 on the afternoon of 2/23/17 at approximately 2:00 P.M. revealed the blue cushion was brought in by the family for "positioning" of her upper body. Staff #144 stated that Resident #80 was supposed to sit on a pressure reducing cushion, which was under the blue cushion during the above observations.

A medical record review for Resident #80 on the afternoon of 2/22/17 found she was admitted to the facility on hospice for a stage 4 pressure ulcer and adult failure to thrive on 1/5/15. In September 2015, Resident #80 was taken off hospice for improvement of the pressure ulcer and she also gained weight. On 9/11/15, laboratory blood tests were conducted indicating: low albumin; low red blood cells; low hemoglobin and hematocrit; and high glucose. Since September 2015 no further laboratory blood tests were conducted. An interview of Staff #145 on the afternoon of 2/23/17 at approximately 2:00 P.M. revealed no further blood tests were done because Resident #80 was on "Comfort Care".

Resident #80 was seen by her physician in December 2015 when the physician noted, "left a message for the wound nurse to discuss possible use of Flagyl for wound odor". The Nurse Practitioner, NP, was the provider who visited next on 4/10/16 when she noted that Resident #80's pressure ulcer was, "Chronic with very poor healing and foul smell at times." The plan was to continue with local care and prevention of sepsis. The physician then followed up on 4/13/16 when she stated the pressure ulcer was, "Stable and to continue wound care". A physician did not see the resident again until 10/24/16, when medical care was transferred to another physician due to

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change of insurance. On 10/24/16, the physician noted, "Stage four to coccyx with red base. Wound care. Expect prolonged recovery." The next physician's visit was on 12/22/16 when he noted, "Wound over coccyx area with beefy red base". Plan was topical wound care. The physician again visited on 1/9/17 when he noted, "Sacral wound red". The plan was for pain management.

A review of Resident #80's weekly wound assessments found minimal progress from the 2/7/16 to the 2/21/17 assessments. On 2/7/16, the assessment noted Resident #80's pressure ulcer treatment was: "Clean with wound cleanser, lightly pack with calcium alginate, pack with wet to dry gauze, cover with foam dressing or abd pad & secure with tape every other day and as needed." The 2/7/16 assessment noted the wound measured 1.4 cm L x 3.8 cm W x 0.7 cm Depth. The 2/7/16 assessment noted undermining measuring: 2.3 cm @ 3 o'clock; 1.6 cm @ 7 o'clock; 2.4 cm @ 9 o'clock; and 3.2 cm @ 12 o'clock. The wound edges were macerated and fragile; Odorous; Painful; Heavy serosanguineous drainage; and the status did not change. The most current assessment dated 2/21/17 found the pressure ulcer treatment was: "Clean with normal saline, pack with triple helix collagen, pack opening with normal saline gauze to maintain wound opening, cover with foam dressing, change every day and as needed." The 2/21/17 assessment noted the wound measured 2.0 cm (1.4 on 2/16) L x 0.5 cm (3.8 on 2/16) W x 0.8 cm (0.7 on 2/16) Depth. The 2/21/17 assessment noted undermining measuring: 0.5 cm @ 6 o'clock; 1.0 cm (3.2 on 2/16) @ 12 o'clock; 0.2 cm (2.3 on 2/16) @ 3 o'clock; 2.3 cm (2.4 on 2/16) @ 9 o'clock; 1.8 cm (1.6 on 2/16) @ 7 o'clock; and 2.6 cm @ 11 o'clock. The wound

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4 136	Continued From page 5 edges were white, rubbery, thick, macerated tissue with surrounding skin intact; Foul odor; No pain; <25% dressing saturated with serous drainage; and the status was no change. Over one year, Resident #80's pressure ulcer made very little, if any, improvements. A review of Resident #80's care plans found one for "Stage IV pressure ulcer". The goal stated, "Pressure ulcers will begin to show signs of healing through next review (3/17)". Interventions included, "11/23/16 Wound specialist consultation". An interview of Staff #50 on the afternoon of 2/22/17 at approximately 2:00 P.M. revealed she worked with a Wound Consultant for oversight of wound care in the facility. Staff #50 noted that Resident #80 has made very little progress in the healing of the pressure ulcer. Staff #50 further noted the resident stayed up in her Geri chair most of the day "per the family's request". Staff #50 stated that the Wound Consultant thinks that the tunneling and undermining of Resident #80's pressure ulcer is "scarred". She stated that the scarring therefore inhibits the healing of the wound. Staff #50 stated that Resident #80 may benefit from debridement. She further noted the resident has not been referred for consultation/debridement of the wound. Staff #50 noted that Resident #80 does not feel pain when the pressure ulcer dressing is changed, possibly due to neuropathy. Currently, Staff #50 noted the opening of Resident #80's wound has decreased in size but the tunneling and undermining was still present. Staff #50 stated the treatment changed on 2/21/17 to include packing of the wound with wicking at the opening to avoid closure because of the continued presence of tunneling and undermining. Staff #50 was asked to provide notes from the Wound Consultant. Staff #50	4 136		

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stated the notes were not available in the electronic medical record and instead were kept in the emails of Staff #145.

On the morning of 2/23/17 at approximately 8:30 A.M., Staff #145 was asked to provide notes from the Wound Consultant. At approximately 10:30 A.M., Staff #145 provided the consultant's "Patient Order Sheets" for 11/23/16, 12/19/16, 1/17/17, and 2/13/17. The "Patient Order Sheet" noted the wound characteristics (location, measurements) and the products used for dressing changes. It appeared like an invoice. One "Wound Care Skin Integrity Evaluation" form was included for 11/23/16 but was printed on the facility's stationary. On 2/23/17 at approximately 1:30 P.M. Staff #s 144 and 145 provided copies of the rest of the Wound Consultant's notes. The Wound Consultant's notes indicated the wound size, drainage, and recommended treatment. There was no mention of referral for debridement.

On the afternoon of 2/23/17 at approximately 1:13 P.M. and 2:05 P.M., the Surveyor attempted to contact the facility's Wound Consultant and left a message for her. On the afternoon of 2/23/17 at approximately 2:30 P.M. Staff #144 informed the Surveyor that the Wound Consultant was fearful of speaking with the Surveyor. The Wound Consultant called the Surveyor back on 2/24/17 at approximately 8:23 A.M. when she informed her that she was not a consultant for the facility. The Wound Consultant stated that she provided education and inservices to the facility. The Wound Consultant further noted that her company provided dressing supplies to the facility. The Wound Consultant noted that she didn't actually see Resident #80's wound and instead took the information documented by the facility staff and plugged that information in to

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4 136	Continued From page 7 order the necessary supplies. The role of the Wound Consultant stirred confusion. An interview of Staff #s 144 and 145 on the morning of 2/24/17 at approximately 8:00 A.M. explained the goal for utilizing a Wound Consultant included having outside consultation for the wound care; determine resident's progress; and consider change in treatments. Staff #145 noted Resident #80's wound was slow healing and stated that the goal was not to totally heal the wound. Staff #145 then stated that Resident #80 was on "Comfort Care" and that the goals were pain management and keeping the wound clean. Staff #s 144 and 145 both stated that the family of Resident #80 wanted to keep her comfortable. On 2/24/17 at approximately 12:00 P.M., Staff #144 provided a copy of the facility's agreement with the Wound Consultant which confirmed her role to provide, "wound care education, to include, but not limited to, wound care prevention, assessment, treatment plans, dressing change protocols and documentation pertaining to the wound care products [Consultant Agency] provides." During the survey period, 2/21/17-2/23/17, Resident #80 was observed on multiple occasions up in the Geri chair in the Activity room. An interview of Staff #116 on the afternoon of 2/23/17 at approximately 12:45 P.M. revealed Resident #80 was up in the Geri chair all day every day. She reported that the resident returned to her bed only when she felt tired. An interview of Staff #48 on the morning of 2/21/17 at approximately 10:45 A.M. revealed Resident #80 was out in the Activity room all day per the family's preference. A review of the Interdisciplinary Team (IDT)	4 136		

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4 136	Continued From page 8 meeting notes for Resident #80 on the morning of 2/24/17 revealed the resident's family did not attend any of the meetings over the past year. The IDT meeting on 12/15/16 noted, "Per nursing, resident continues with Stage IV coccyx with new treatment added". Family did not attend the meeting. The IDT meeting on 9/28/16 noted, "[Resident #80] continues with wound to sacrum, treatment applied daily as ordered". The family did not attend the meeting. The IDT meeting on 7/28/16 did not mention Resident #80's pressure ulcer. The family did not attend the meeting. The IDT meeting on 5/4/16 noted, "Continues with stage IV pressure ulcer to sacrum. Treatment applies as ordered. [Resident] continues to utilize a Geri chair for comfort and to maintain her safety." The family did not attend the meeting. An IDT meeting for February 2016 was not available at the time of survey. The facility was unable to provide documentation of discussions/meetings with Resident #80's family members which would demonstrate their desire to maintain the pressure ulcer by keeping it clean, free of infection and pain. Additionally, the facility was unable to provide documentation from the family indicating their preference for the resident to be out of bed all day in the Activity room. On the morning of 2/24/17, a review of the facility's policy titled, "Pressure Ulcer Problem Identification and Treatment" dated 7/22/05 noted, "B. Clinicians can reasonably expect a clean pressure ulcer with adequate innervation and blood supply to show evidence of healing within 2 to 4 weeks. Failure to do so should prompt a re-evaluation of the plan of care, and evaluation of adherence to the plan, and a possible modification of the plan. For example, draw labs, check albumin level, suspect colonization of bacteria." The policy further	4 136		

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noted, "Sitting individuals should be repositioned at least every hour and should shift their weight every 15 minutes if possible. If hourly repositioning is not feasible, the individual should be returned to bed.

An interview of Staff #149 on the afternoon of 2/23/17 revealed the care for Resident #80's pressure ulcer would depend on her overall condition. She stated that since the resident was older, it may not be feasible to do wound debridement. However, Staff #146 stated that her expectation was for staff to do routine, frequent repositioning.

In summary, the facility failed to maintain the highest practicable well being for Resident #80's pressure ulcer based on her current condition with consideration and documentation of the facility's, resident's and/or family's goals and/or expectations.

2) Resident #19 was admitted to the facility on 11/9/16 from an acute hospital. A review of the resident's record on 2/21/17 at 2:00 P.M. found an admission note dated 11/9/16 with documentation of the following: right heel deep tissue injury 4 x 3 cm; left foot 2.5 x 3 cm; left foot base great toe 1 x 1 cm; Stage II healing ulcer; left center abdominal fold with 1 (one) cm skin tear; and coccyx area excoriation on left buttock 4 x 3 cm, center area with 1 (one) x 0.5 cm, right buttock 2 x 2 cm.

A record review on the morning of 2/22/17 found a comprehensive Resident Assessment Instrument with an assessment reference date of 11/15/16 which documents in Section M. Skin Conditions, Resident #19 is noted to have two Stage 2 pressure ulcers which were present on

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admission. Further review found documentation of the facility's "Weekly Skin Rounds". An assessment was done on 11/16/16 which notes a Stage II pressure ulcer to coccyx and a Stage II pressure ulcer to the left buttock. The ulcer to the coccyx measured 0.5 x 0.5 with no odor, pain or drainage. The ulcer to the left buttock measured 0.8 x 0.4 cm. with no odor, pain or drainage.

On 2/22/17 at 1:30 P.M. an interview and concurrent record review was done with Staff Member #50. The staff member confirmed Resident #59 was admitted on 11/9/16 with two Stage II pressure ulcers, one to the coccyx and one to the left buttock. At the time of admission, the resident was a hospice recipient. A review of the physician's order notes a prescription dated 11/17/16 for sensi-care, apply to the coccyx and buttocks three times a day until resolved, diagnosis Stage II pressure ulcer. A review of the resident's care plan found an episodic care plan, created 11/10/16 with the goal to resolve the Stage II pressure ulcers over 21 days. The interventions included the following: apply sensi-care as ordered; turn resident Q1 hour to prevent further injury; update physician if unresolved; weekly skin assessment; and weekly wound rounds. Further review found a care plan to address no further pressure related skin breakdown through the next review. The interventions include: extensive assistance with bed mobility; hospice to provide air mattress; provide incontinent care, PRN; and weekly skin assessment by the CN.

Further review with Staff Member #50 found no documentation of a skin assessment on admission (11/9/16), the first documentation was dated 11/16/16, a week after the resident's admission. There was no further documentation

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ANN PEARL NURSING FACILITY	45-181 WAIKALUA ROAD KANEOHE, HI 96744

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4 136	Continued From page 11 of subsequent weekly skin assessments to determine the status of the resident's pressure ulcers prior to discharge on 12/5/16. The staff member assisted in the review of Resident #59's treatment/medication administration of applying sensi-care three times a day; there is documentation the resident received sensi-care as ordered with a start date of 11/17/16. Interview with Staff Member #50 confirmed Resident #59 was admitted with two Stage II pressure ulcers without admission orders for treatment. The staff member also confirmed the physician's order and care plan intervention for weekly skin assessments was not documented. The staff member was queried whether the facility would provide treatment for pressure ulcers while the resident receives hospice services. The staff member replied for residents on hospice with pressure ulcers, treatment will be provided. A review of the facility's policy and procedure related to pressure ulcers was provided on 2/24/17 at 9:30 A.M. The procedure for "Pressure Reduction & Prevention Program" includes the "Pressure Ulcer Risk Assessment tool will be used upon admission..." Although Resident #59's admission notes documented the presence of Stage II pressure ulcers, the facility failed to assess the resident's skin integrity upon admission; therefore, delaying treatment of the pressure ulcers. The facility also did not ensure the physician order and care plan for weekly skin assessment/wound rounds was being done, there is no documentation of subsequent assessments after the initial assessment of 11/16/16 until the resident's discharge on 12/5/16.	4 136		

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4 136	Continued From page 12 3) A record review was done on 2/23/17 at 7:35 A.M. Resident #59 was admitted to the facility from home on 8/26/13 with the following diagnoses: [redacted], unspecified; anemia, unspecified; malignant neoplasm; hyperlipidemia; and gout, unspecified. On 2/22/17 at 12:30 P.M. observed Resident #59 seated in a chair at a table eating his lunch in the dining room. There was no chair alarm attached to his chair. Subsequent observation at 2:30 P.M. found the resident sitting on a chair in the activity room holding a baby doll. No chair alarm was observed. On 2/23/17 at 7:50 A.M. Resident #59 was observed in the dining room having breakfast. He was observed to attempt to stand, then Resident #59 stood up at the table, he walked to the middle of the room where he was met by Staff Member #59. The resident was redirected back to his seat. An alarm did not sound at this time and observation found no chair alarm was attached. Interview with Staff Member #73 was done on 2/21/17 at 11:35 A.M., the staff member reported Resident #59 had a fall on 2/18/17. The resident was sitting on a stool and when he attempted to stand, fell on his buttocks. He reportedly had an abrasion to the right knee. Further record review on the morning of 2/23/17 found a progress note dated 2/18/17 regarding Resident #59's fall. The resident's fall was witnessed, the resident was in the dining room when a staff member observed the resident standing and while enroute to the resident, he lost his balance and fell to the floor, hitting his buttocks. On 2/23/17 at 7:35 A.M. a record review found a progress note of 10/22/16 documenting Resident #59 had a witnessed fall in the dining room.	4 136		

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4 136	Continued From page 13	4 136		

Resident #59 ambulated to the dining room and while standing at the threshold a resident in front of him abruptly changed direction and bumped into Resident #59. Resident #59 stumbled backward and collapsed "in a heap to the floor rather slowly". Further documentation notes the assigned Certified Nurse Aide (CNA) was assisting another resident and the other CNA was on dinner break.

A review of the resident's care plan identified the goal for the resident to demonstrate the ability to ambulate/transfer without fall related injuries over the next 90 day period (revised 4/17). Interventions included: ambulate with extensive assist of 1-2 staff; footwear will fit properly and have non-skid soles; keep areas free of obstructions to reduce the risk of falls or injury; offer and assist with toileting routinely; use chair sensor alarm due to resident standing unassisted; assist resident to dining area first; and frequent visual observations.

On 2/23/17 at 9:26 A.M. Staff Member #81 was asked whether Resident #59 has a chair alarm, the staff member replied that he/she didn't think the resident has a chair alarm. Interview was done with Staff Member #121, the staff member checked the resident's care plan (kardex), concurrent review of the resident's record found the care plan specified a bed sensor alarm. At 9:29 A.M. concurrent observation was done with Staff Member #81, the staff member placed her hands under the resident's sheets and replied the resident does not have a bed sensor alarm.

On 2/23/17 at 12:56 P.M. an interview was done with Staff Member #59. The staff member reported that is is unclear why Resident #59 would have a care plan for a bed alarm as the

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4 136	Continued From page 14 resident stays in bed and has not fallen out of bed. The staff member further reported a chair alarm may be helpful; however, does not feel it is needed as staff members always keep the resident in the "line of sight". The facility failed to ensure Resident #59's interventions identified in the plan of care (chair sensor alarm) was consistent with the information in the direct care staff's kardex (bed sensor alarm). The facility also failed to implement interventions for fall prevention, chair sensor alarm and/or bed sensor alarm.	4 136		
4 175	11-94.1-43(c) Interdisciplinary care process (c) The overall plan of care shall be reviewed periodically by the interdisciplinary team to determine if goals have been met, if any changes are required to the overall plan of care, and as necessitated by changes in the resident's condition. This Statute is not met as evidenced by: Based on observations, medical record review, staff interview and facility policy review, the facility failed to provide appropriate services/interventions to treat pressure ulcers. Findings include: Cross reference to §11-94.1-30 for Resident #80. Resident #80 was admitted on 1/5/15 for hospice with diagnoses which included adult failure to thrive, stage 4 pressure ulcer, and chronic kidney disease. In September 2015, Resident #80 was taken off hospice for improvement in the pressure	4 175	1. Resident #80 will have a care plan review to ensure current status is accurate and that pressure ulcer interventions and goals are reflective of that status. Responsible Party: Director of Nursing Services or Designee 2. Residents with current Stage II or higher pressure ulcers have been audited to ensure their clinical status is accurate and appropriate interventions and goals are in place for their skin integrity. Responsible Party: Director of Nursing Services or Designee 3. Current pressure ulcer documentation process will be reviewed as revised as need to ensure proper status and interventions are correctly documented. The care plan team will be re-educated regarding updating and revising residents with pressure ulcers status and implementing appropriate interventions and goals for that status. Responsible Party: Director of Nursing Services or Designee Continued on page 16	02/22/2017 03/18/2017 03/31/2017

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4 175	Continued From page 15 ulcer and weight gain. During the survey period, 2/21/17-2/24/17, Resident #80's stage 4 pressure ulcer was not yet healed. On the morning of 2/22/17, a review of Resident #80's care plans found one for "Stage IV pressure ulcer". The goal stated, "Pressure ulcers will begin to show signs of healing through next review (3/17)". Interventions included: Treatment as ordered by wound rounds RN and MD; Air pressure mattress to bed; Extensive assistance with bed mobility; Pain medication; Treatment orders; and Wound specialist consultation. An interview with Staff #s 144 and 145 found that Resident #80's family and physician were noting she was on "Comfort measures" only. The care plan did not reflect Resident #80's current status and the interventions maintained the facility would work towards healing the wound rather than comfort measures. The facility failed to accurately reflect the current status and goals for Resident #80 in her pressure ulcer care plan.	4 175	Continued from page 15 4. Director of Nursing Services or designee will audit residents with pressure ulcers care plans monthly for proper updates to status, interventions, and goals. Results of the audits will be given to the QAPI team, for outcomes review and follow-up regarding the continued frequency of audits, to ensure proper services and interventions are provided. Responsible Party: Director of Nursing Services or Designee	03/31/2017
4 203	11-94.1-53(a) Infection control (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. This Statute is not met as evidenced by: Based on observation and staff interview the	4 203	1. No residents were identified to be affected by this practice. Laundry and Rehab departments will be provided with Updated Infection Control Manuals. Responsible Party: Administrator or Designee 2. Through review of the infection tracking tools no residents were found to be affected by this deficient practice. Responsible Party: Administrator or Designee Continued on page 17	03/18/2017 03/18/2017

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4 203	Continued From page 16 facility failed to maintain an infection control program to control, to the extent possible, the onset and spread of infection within the facility by providing written standards, policies, and procedures to the Housekeeping and Rehab Unit to be followed to prevent spread of infections. Findings include: 1) On 02/24/2017 at 8:24 AM met with Staff Member (SM) #33. Surveyor asked SM #33 what the facility's policies are for infection prevention/control when laundering linens and he gave surveyor a binder of Infection Control policies that were dated from 1999. SM #33 was unable to tell surveyor where he would get the updated Infection Control policies for the facility. SM #33 was not able to explain the procedure to prevent the spread of infection while laundering facility linens. SM #33 denied knowing what the manufacturer's recommendations are for the use of the washer and dryer at the facility. 2) On 02/24/2017 at 08:52 AM met with SM #145 and when asked how everyone has access to the facility's Infection Control policies she stated that each department has their own binder with the Infection Control policies that are written by the facility's corporate office. The DON was not aware that housekeeping did not have an updated binder on Infection Control policies for the facility. 3) On 02/24/2017 at 9:39 AM Surveyor asked SM #148 if he would ever bring in a resident who was positive for C.diff into the rehab unit to work with the PT and he stated that he would. After he saw surveyor's expression he clarified that he would "if staff cleared the resident". When asked where the binder with the infection control policies for	4 203	Continued from page 16 3. Infection control manuals will be reviewed and revised as needed. Staff will be re-educated on infection control processes affecting each of their departments. Responsible Party: Administrator or Designee 4. Facility will monitor infection control logs and staff practices routinely. Managers for Environmental services and Rehab. Will report findings regarding staff practices monthly to the QAPI team along with review of the infection control logs for follow-up to ensure proper standards are being followed to prevent the spread of infections. QAPI team will determine need for the continuation of monthly reporting of staff practices. Responsible Party: Administrator or Designee	03/31/2017 03/31/2017

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4 203	Continued From page 17 the facility was kept in his department SM #148 looked on the shelf and then stated he did not know where it was and asked a co-worker, SM #149 and she handed him a binder that was labeled "MSDS". Surveyor looked inside of binder with SM #148 and there were no facility policies on infection control in the binder. The facility failed to provide written standards, policies, and procedures to the Housekeeping and Rehab Units to be followed to prevent the spread of infections.	4 203		
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 staff interview the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. Findings include: 1) On 02/21/2017 at 08:03 AM during the Initial Tour on the Pikake unit, observed the "Shower Room" with dark gray grout throughout the tiled floor and near the wall. When leaving the Pikake unit, "Shower Room" surveyor stepped into the hallway and observed the wooden blinds in the alcove area that were disarrayed and very dusty. On 02/21/2017 at 8:48 AM while finishing up the Initial Tour on Maile unit it was observed that the "Shower Room" and "Toilet Room" both had dark gray patches of grout throughout the tiled floor.	4 218	1. Maile, Pikake and Ilima toilet and shower rooms have been deep cleaned and stains removed as able. Chipped tiles in Maile shower room were identified and scheduled as high priority for repair. Pikake blinds, jalousies and screens have been cleaned as indicated. Resident 59 has had their room cleaned and pest inspection/abatement completed as indicated. Responsible Party: Administrator or Designee 2. Facility wide observation was conducted to identify any urgent environmental issues and were addressed at the time of discovery. Bathing and Toilet rooms will be audited by environmental services weekly to ensure sanitation and general condition of areas are acceptable. Resident rooms will be inspected to ensure cleanliness standards are being met. Responsible Party: Administrator or Designee 3. Chemical vendor will review current products and make recommendations regarding the most effective Continued on page 19	03/18/2017 03/18/2017 03/31/2017

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4 218	Continued From page 18 There was chipped tile in the "Toilet Room" tiled floor and baseboard. There was chipped paint on the metal poles that separated the toilet stalls in the Maile unit "Toilet Room". There were orange colored drip marks on the tiles below one of the sinks. On 02/23/2017 at 1:19 PM while doing a walk through on the Pikake unit with Staff Member (SM) #33 he acknowledged the dark gray patches of grout on the tiled floor. When asked how long he has been working in his position he stated "just under a year". SM #147 was present for this walk through and explained that the facility is in the process of remodeling the shower and toilet rooms but they are waiting for new bids to come in as the estimated cost for the changes had been underestimated last year. After leaving the Pikake "Shower Room" SM#33 acknowledged the "dirty blinds, dirty jalousies and screens" stating "We're not doing what we need to do. We need to do better." Walk through continued over to the Ilima unit where SM #33 acknowledged the floor in the Ilima "Shower Room" was noted to have dark gray patches of grout as well. Walk through continued over to the Maile unit shower and toilet room. As SM #33 and surveyor walked into the "Toilet Room" he acknowledged the unused trash bags hanging from the wall mounted gloves rack. SM #33 acknowledged dark gray patches of grout in the tiled floor and broken tile and backboard in the "Toilet Room". On 02/23/2017 at 2:06 PM did a walk through on the Maile unit with SM #41 and he acknowledged the railing in the hallway near the nurses station is missing paint that has peeled or chipped off. He was also able to show surveyor where tile in the Maile "Toilet Room" was chipped.	4 218	Continued from page 18 products to utilize to improve conditions in the toilet and shower rooms. Work flows will be reviewed and revised as needed to ensure timely room cleaning. Environmental Services will be re-educated regarding cleaning standards and work flow timing. Non-environmental staff will be re-educated on their role in maintaining a sanitary, orderly, and comfortable interior. Responsible Party: Administrator or Designee 4. Environmental services director or designee will audit room shower and toilet rooms weekly to ensure proper sanitation and room integrity. Environmental services director or designee will round the community common areas resident rooms routinely and audit a random sample weekly to ensure compliance. Results of the audits will be given to the QAPI team, for outcomes review and follow-up regarding the continued frequency of audits, to ensure a sanitary, orderly, and comfortable interior. Responsible Party: Administrator or Designee	03/31/2017

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4 218	Continued From page 19 The facility did not maintain sanitary toilet and shower rooms. 2) Observation on 2/21/17 at 9:28 A.M. found a dead cockroach on the floor by the right side of Resident #59's bed. The cockroach was smashed and there was a black smattering of substance next to the dead cockroach on the floor. Subsequent observations at 9:28 A.M. and 11:51 A.M. found the dead cockroach still on the floor. Concurrent observation was done with Staff Member #121 at 2:11 P.M. The staff member confirmed the presence of the dead cockroach on the floor. Inquired when are the residents' rooms cleaned, the staff member replied the rooms are cleaned after the staff member completes the cleaning of the dining room after lunch. Observation of the dining room found no staff member present and the room was cleared of dishes, food and the tables were wiped. On 2/23/17 at 12:46 P.M. an interview was done with Staff Member #33. The staff member reported the shift for housekeeping staff begins at 11:00 A.M. and ends at 7:30 P.M. The staff member further reported the housekeeping staff will start with room cleaning when they arrive on their shift. The staff member explained that a family member brought in a box and the facility staff were not aware of and believes the cockroach came in with the box. The staff member confirmed seeing the dead cockroach on the floor, commenting that somebody flattened the cockroach and it was not picked up. Upon query, Staff Member #33 was not sure what the black substance was next to the dead roach.	4 218		

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4 277	Continued From page 20	4 277		
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 observation and interview with staff member, the facility failed to ensure a single resident bedroom shall measure at least one hundred square feet of usable space. Finding includes: On the morning of 2/21/17, observation found Room #1 is a single resident room on the Hale Ho'Olu unit. Room #1 is currently occupied by one resident. This room does not meet the requirement for 100 square feet for a single resident room. Room #1 is measured at 78 square feet. On 2/21/17 at 8:07 A.M. the entrance conference was conducted with Staff Member #146. At this time, the staff member confirmed that there has been no changes to Room #1 on the Hale Ho'Olu unit. On 2/21/17 at 8:55 A.M., the facility provided a copy of waiver request dated 3/22/16 to the State Agency in regard to the non-compliance withe the requirements for the square footage for Room #1 (single occupancy).	4 277	See attached waiver request submittal.	
4 278	11-94.1-65(e)(5) Construction requirements	4 278	See attached waiver request submittal.	

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4 278	Continued From page 21 (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 observation and interview with staff members, the facility failed to ensure a multi-resident bedroom shall provide a minimum of eighty square feet per bed of usable space. Finding includes: Observation on 2/21/17 found Room #3 on the Hale Ho'Olu unit is occupied by three residents. This room does not meet the required footage for three residents, 80 square feet per resident. On 2/21/17 at 8:07 A.M. the entrance conference was conducted with Staff Member #146. At this time, the staff member confirmed that there has been no changes to Room #3 on the Hale Ho'Olu unit. On 2/21/17 at 8:55 A.M., the facility provided a copy of waiver request dated 3/22/16 to the State Agency in regard to the non-compliance withe the requirements for the square footage for Room #3 (multiple occupancy).	4 278		