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
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	12/26/2017

RECEIVED
2018 JAN 31 P 12:20 1:26
STATE OF HAWAII
DEPARTMENT OF HEALTH

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(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
4 000	Initial Comments A recertification survey was conducted by the state agency from December 19, 2017 to December 26, 2017. the facilities census was 110 upon entrance.	4 000	4 054 1. All obstructions to the survey results postings on P3 (third floor) were removed. Because specific members of Resident Council, who were not aware of the survey results posting weren't identified, all alert residents in the facility will be informed of the survey results posting during morning activities.	1/23/2018
4 054	11-94.1-6(d)(1)(2) Licensing (d) The most current licensing statement of deficiencies and plan of correction shall be kept on file in the facility, and the facility shall: 1) Make the statement of deficiencies and plan of correction available for examination in a place readily accessible to residents; and (2) Post a notice of the availability of the statement of deficiencies and plan of correction. This Statute is not met as evidenced by: Based on observation and interview with resident council members, the facility failed to ensure the results of the recent survey conducted by the State Surveyors with the plan of correction are posted and readily available for review. Findings include: A resident council interview was done on 12/21/17 at 9:30 A.M. The council members were asked whether the results of the survey were available for viewing. The council members were not aware of the survey results posting. On 12/26/17 observation found the posting on the third floor was obscured by a hanging quilt. The posting on the second and fourth floor was found on the bulleting board by the elevators. However, resident council members were not aware the	4 054	2. Alert residents will be reminded of the survey results posting during morning activities at least once/month and during Resident Council Meetings. During these meetings alert residents will also be educated on why surveys take place, where the surveys are posted, and where the results are located. 3. a) Social Services will educate Activities and patient care staff on the location of survey results. Staff will also be reminded to ensure there are no obstructions to the posted survey results (i.e. hanging quilt). b) Social Services, Activities, and patient-care staff will review the location of survey results to alert residents and/or Responsible parties, who may have questions. c) The Admissions team will continue to provide information about surveys, including the posting of survey results and location, to the residents and/or Responsible Parties and document accordingly. d) Posting of survey results locations will be added to the Residents Rights and Family Reminders form in the admission's folder. e) A mailer will be sent out to Responsible Parties and a memo given to alert residents informing them of the locations of the survey results. f) Survey, survey results, and its posted locations will be an ongoing agenda item for the monthly Resident Council Meetings and Care Conference meetings. g) Social Services and/or Activities staff, will conduct random audits of alert residents asking, "Do you know where you can view the survey results?". If the resident answers "No", additional education will be provided. Audits will also occur during monthly Resident Council Meetings. 4. Social Services and Activities Coordinator will track random audits for "No" responses. The goal is to have 95% of residents and/or Responsible Parties audited answer "Yes". Statistical data will be presented at the Quarterly QA meetings for discussion.	2/24/2018 and ongoing 2/24/2018 and ongoing 2/24/2018 and ongoing

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Denise Boldeau | TITLE: Administrator | (X6) DATE: 1/31/2018

2.15.18 - copy to SW, bn 12.27.18 Scanned to BN, bn

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4 054	Continued From page 1 results of the surveys are posted for their review.	4 054		
4 095	11-94.1-20(a) In-service education (a) There shall be a staff in-service education program that includes the following: (1) Orientation for all new employees that shall include: (A) Information to acquaint them with the philosophy, organization, program, policies and procedures, practices, and goals of the facility; and (B) Competency evaluation to ensure that staff are able to carry out their respective duties; (2) In-service training for employees who have not achieved the desired level of competence, and continuing in-service education to update and improve the skills and competencies of all employees; (3) In-service training that shall include annually, at minimum, prevention and control of infections, fire prevention and safety, disaster preparedness for all hazards, accident prevention, resident rights including prevention of resident abuse, neglect and financial exploitation, and problems and needs of the aged, ill, and disabled; (4) Competency testing for cardiopulmonary resuscitation to annually certify the nursing staff; (5) Training in oral hygiene and denture care,	4 095		

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4 095	Continued From page 2 which shall be given to the nursing staff at least annually; and (6) Appropriate personal hygiene instructions at regular intervals shall be given to all personnel providing direct care and handling food. This Statute is not met as evidenced by: Based on record review and interview with staff member, the facility failed to ensure annual in-service training for employees was done. Findings include: On the afternoon of 12/26/17 a random sample of employees (10 employees) was provided to the facility for inservice record review. On 12/26/17 at 3:45 P.M. Staff Member #2 provided the completed inservice record. The following employees (5 of 10 employees) did not complete the inservice for needs of the ill aged and disabled: Staff Member #21, Staff Member #54, Staff Member #124, Staff Member #74 and Staff Member #86. Staff Member #58 did not complete an annual infection control inservice. Staff Member #74's last annual inservice for HazMat, Fire and Safety, Accident Prevention, Patient's Right and Problems was done on 12/12/16. Staff Member #86's did not complete inservice for the following: HazMat, Fire and Safety and Accident Prevention. Staff Member #124 did not complete the following inservice training: HazMat, Infection Control, Fire and Safety, Accident Prevention, Patient's Rights and Problems and Need of ill, aged and disabled. Staff Member #2 stated Staff Member #124 has not been scheduled to work	4 095	4 095 1. Staff identified have been given in-service materials to complete prior to returning to next work shift. 2. All staff will complete annual competencies as required by Chapter 94. Staff completion of annual competencies will be maintained in the education tracking log. Staff identified as not attending monthly scheduled compentency training will be notified by administration as being delinquent and will be required to complete their missed training within 30 days. All staff will complete all annual competencies by January 30th of the following year or be removed from the active work schedule. 3. Staff education policy will be modified to address staff who are out due to extended leave, medical necessity, or non-attendance at monthly mandatory trainings. 4. Inservice attendance will be monitored on a monthly basis and compliance reported by Administrator to Quarterly QA.	1/30/2018 2/24/2018 and ongoing 2/24/2018 2/24/2018 and ongoing

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4 095	Continued From page 3 and all employees that are delinquent in the annual inservices will complete the modules prior to returning to work.	4 095		
4 114	11-94.1-27(3) 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: (3) The right to be fully informed, both orally and in writing in a language understood by the resident, or in a manner that allows for the resident's understanding, of the resident's rights and all rules and regulations governing resident conduct and responsibilities; This Statute is not met as evidenced by: Based on resident interviews and interview with the resident council, the facility failed to ensure residents were treated with respect, dignity and care in a manner and an environment that enhances his or her quality of life. Findings include: 1) An anonymous resident interview was conducted on 12/20/17 at 12:45 P.M. The resident reported that staff members speak in the non-dominant language of the facility. The resident further reported that following the complaint, a staff member approached him/her	4 114		

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4 114	Continued From page 4 and asked why this was reported. The resident reported feeling hurt and cried. However, the resident stated that following this incident, he/she does not feel afraid to make complaints. 2) A resident council meeting was done on 12/21/17 at 9:30 A.M. The members of the council reported that staff members are found to speak in the non-dominant language of the facility. A resident reported that he/she is unsure whether the staff members are talking about them. The members also reported that staff members speak loudly while they are in the residents' rooms, especially when there are two or three of them in the room. A resident further reported that the staff members are also laughing which sometimes results in waking the residents. 3) During interview with R #362's spouse on 12/19/17 at 11:10 AM., who said that resident requested incontinence garment change because resident was incontinent of feces and wanted change prior to physical therapy session, the staff refuted resident and denied resident the garment change at that time, and two hours later when incontinence garment was checked, there was dried feces. During interview with staff #53 on 12/21/17 at 14:13 PM who said that resident should only need to wait for three minutes for staff to comply with a request, remembered this incident and claimed to have counseled staff about complying with residents' requests right away. Based on record review and interview with staff member, the facility failed to provide one (R #165) of three randomly selected residents with notice of end of coverage. Findings include:	4 114	4 114 1), 2) 1. Staff members could not be confirmed therefore immediate action could not be accomplished. 2. At the next and future staff meetings for patient care staff we will include reminders of our policy to speak English only in the work place, and discuss speaking at a levels that do not disturb our residents. For repeat offender who desire to use non dominant language (e.g. English) in the patient care area the progressive disciplinary action that will be instituted. 3. Nursing supervisors or designee, and Interdisciplinary Team will conduct random observations of language spoken and noise level throughout the facility of patient care staff. Observation will be conducted on each shift times seven days per week. Thereafter, the observations will be conducted daily randomly for three weeks. Ongoing observation will continue until 100% compliance is achieved. For repeat offenders progressive disciplinary action will be instituted per facility policy. 4. All discrepancies and disciplinary actions will be report to the quarterly QAPI meeting for discussion. 4 114 3) 1. Since the concern expressed by the family was in the past-tense, no immediate corrective action could be accomplished, however the Nursing Supervisor addressed family member's concern directly. 2. All nursing staff were reminded that resident care is priority. Resident call lights should be answered right away and resident care needs (ie: incontinence care, toileting) addressed immediately. 3. All nursing staff and interdiciplinary team members will be re-educated during monthly staff meetings and during morning IDT meetins regarding the importance of making resident-centered care a priority, including addressing resident care needs (ie: incontinence care, toileting) immediately. Resident centered care will be a regular agenda item for all staff meetings and addressed in the monthly Resident Council meetings to those in attendance. 4. DON, Nursing Supervisors, and Department Supervisors will monitor all resident-care interactions to ensure the resident's needs are being met in a timely manner. Any discrepancies will be addressed immediately. Repeated discrepancies may be brought to the Administrator for further follow up. Any problematic trends will be reported at the Quarterly QA meeting for discussion.	N/A 1/26/2018 and ongoing 1/15/2018 and ongoing 1/18/2018 and ongoing 1/22/2018 1/22/2018 2/24/2018 and ongoing 2/24/2018 and ongoing

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4 114	Continued From page 5 On 12/22/17 at 2:54 P.M. Staff Member #2 provided copies of the issuance of "Notice of Medicare Non-Coverage" (NOMNC). The review of the issuance notices found R #166's last day of coverage was 11/13/17 and the notice was signed by the resident's representative on 11/11/17. A review of the notice for Resident #167 found the last day of coverage was 7/7/17 and the resident signed the NOMNC on 6/30/17. The review for R #165's NOMNC found the last day of services was 10/10/17. The signature of the resident's representative to acknowledge understanding of the notice was signed and dated 10/9/17. Staff Member #2 reported the resident's representative was informed of the discharge date and was only able to sign the NOMNC form on 10/9/17. A request was made for documentation of the notification to the resident's representative of the discontinuation of coverage. Staff Member #2 was agreeable to provide the documentation. On the morning of 12/23/17 further information was left in the conference room. A handwritten note was attached to communicate "notes from physical and occupational therapist regarding caregiver training with family (spouse) for discharge on 10/10/17 from therapies". A review of the information that was provided, tabbed and highlighted found documentation "PT - Therapist Progress and Updated Plan of Care" dated 9/22/17 under patient/caregiver training, "caregiver training with patient's spouse on care transfers and ongoing patient training on safe transfers and ambulation". Subsequent note dated 9/21/17 by the physical therapist documents "care transfers training". A review of the occupational therapy note dated 10/6/17	4 114	4 114, NOMNC 1. N/A 2. We will track current system to ensure documentation made for residents and/or responsible parties who are unable to sign in a timely manner is documented as such in the medical record. 3. Weekly audit of anticipated service changes will be implemented to ensure appropriate notices are issued in a timely manner to affected parties, allowing for adequate time to execute signatures and document in record. During daily IDT meeting team will discuss all anticipated resident service changes and ensure appropriate notices are prepared and executed in a timely manner. 4. Monthly audit by HIM supervisor will be conducted for quarterly QA reporting of compliance with NOMNC standards.	12/26/2017 and ongoing 1/2/2018 and ongoing 1/2/2018 and ongoing 1/2/2018 and ongoing

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4 114	Continued From page 6 highlights "ongoing training with staff/family, particularly regarding bathroom activities of daily living and corresponding transfer" was highlighted. The facility failed to provide documentation that R #165 or the resident's representative was informed of the last day of coverage two days prior to the discharge. Based on interview with the resident council members, the facility failed to ensure residents are aware of the procedures for filing a grievance. Findings include: On 12/21/17 at 9:30 A.M. a resident council interview was done. The residents were asked whether they are aware of how to file a grievance. None of the council members were aware of how to file a grievance and reported this right to file a grievance was not reviewed with them. On 12/22/17 at 10:20 A.M. the facility provided a policy for the complaint/grievances process.	4 114	4 114 Resident Council 1. Because specific members of Resident Council, who were not aware of how to file grievances, weren't identified, all alert residents in the facility will be informed of the grievance procedures during morning activities. 2. All alert residents have the potential to be affected by the same deficient practice. Residents will be reminded of the grievance procedures during morning activities at least once/month and during Resident Council Meetings. During these meetings, the Grievance Policy and Grievance Policy Form will be reviewed. 3. a) Social Services staff will educate Activities and patient care staff on the Grievance Policy and Procedures. Social Services, Activities, and patientcare staff will review the Grievance Policy and related forms with alert residents and/or Responsible parties, who may have questions regarding grievances and document accordingly. b) The Admissions team will review the Grievance Policy & Procedures with all new residents and/or Responsible parties and document accordingly. c) The Grievance Policy and Procedures will be an ongoing agenda item for the monthly Resident Council Meetings. Social Services and/or Activities staff, will conduct random audits of alert residents asking, "Are you aware of how to file a grievance?". If the resident answers, "No", additional education will be provided. Audits will also occur during monthly Resident Council Meetings. 4. Social Services and Activities Coordinator will track random audits for "No" responses. The goal is to have 95% of residents and/or Responsible Parties audited answer "Yes". Statistical data will be presented at the Quarterly QA meetings for discussion.	1/23/2018 2/24/2018 2/24/2018 and ongoing 2/24/2018
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	4 115		

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4 115	Continued From page 7 access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on resident interviews, interview with staff and review of documentation, the facility failed to ensure that residents' preferences and choices regarding bathing frequency were supported. Findings: 1) During interview with R #1 on 12/19/17 01:51 PM who said she informed staff that she would like to bathe everyday was told by staff that there was insufficient staff to bathe more than twice a week. 2) During interview with R #362's spouse on 12/19/17 11:06 AM who said that resident said, "Feels dirty because only showers twice a week." Resident's spouse said that staff informed them that there is insufficient staff to bathe resident more than twice a week. 3) During interview with staff # 53 on 12/21/17 14:13 PM who said that residents are given a choice about how often they bathe, are asked on admission about preferences for bathing, and admitted that it was necessary to remind staff to honor bathing on request, especially for new residents. Staff #53 also gave me a copy of the floor's bathing schedule. 4) Resident #1 has activity assessment that shows shower is the bathing preference, and "extra" is written on the form. The form itself does not ask how frequently the resident would like to bathe.	4 115	4 115 1.Nurse manager spoke to staff caring forresident #1 to discuss preferences for bath. Preferences were verified on shower schedule, care plan, and care card. Staff provided bath according residents preferences. 2. All staff were reminded of resident preference regarding bathing schedule. All shower lists care plans and care cards were revised to reflect resident bathing preferences. All staff were reminded to follow resident bathing preferences. 3. Beginning 01/18/2018: Monitoring through resident rounds and nursing/nursing assistant documentation and adherence to care planned shower preference; observation to continue until 3 consecutive months of 95% compliance met. 4. Nursing to provide compliance data reports to quarterly QA committee.	12/27/2017 and ongoing 1/5/2018 and ongoing 1/18/2018 and ongoing 1/18/2018 and ongoing

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4 115	Continued From page 8 5) The bathing schedule provided by staff #53 supports residents' statements that they are only bathed two to three times per week, and the schedule does not indicate residents' preferences for bathing frequency have been supported.	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 observation, record review and interview with staff members, the facility failed to ensure one (R #164) of three sampled residents received the necessary treatment and services to promote the healing of a pressure ulcer. Findings include: R #164 was admitted to the facility on 6/3/13 with unspecified dementia without behavior; chronic kidney disease stage 3 (moderate); anemic in chronic kidney disease; muscle weakness;	4 136		

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4 136	Continued From page 9 unspecified disorder of circulatory system; and vitamin D deficiency, unspecified. On 12/20/17 at 10:09 A.M. a brief record review was done. The review found R #164 with two Stage 2 pressure ulcers to the coccyx. Further review found one of the Stage 2 ulcers progressed to Stage 3. A record review on 12/21/17 at 1:00 P.M. found a "Skin Lesion Assessment" form documenting R #164 was found to have an in-house acquired Stage 2 pressure ulcer, dated 7/26/17. The cause of the wound was "due to incontinence of bowel and bladder". The size was 0.5 cm (length) x 1.7 cm (width) with <0.1 cm in depth. There was no undermining or draining noted. The ulcer margins were open edged and the surrounding skin and wound bed were pink. The treatment include application of aquacel foam to Stage 2 pressure injury after cleansing with normal saline once daily. On 8/1/17 the response to treatment deteriorated, the wound was 2.3 cm (length) x 1.6 cm (width) and <0.1 cm in depth. On 8/3/17 an overlay mattress was added and on 8/7/17 one scoop of protein powder was added for meals (breakfast, lunch and dinner) to aid in the healing of the ulcer. The weekly assessments from 8/8/17 through 8/21/17 documented improvement. On 8/29/17 the ulcer was noted to deteriorate (an increase in size). Documentation was found that R #164's plan of care was updated on 8/29/17; however, a review of the plan of care did not find documentation of updated interventions. The wound measurements were 1.6 cm (length) x 0.6 cm (width) and <0.1 cm in depth. On 9/11/17 the weekly assessment notes the	4 136	4 136 1. Licensed staff re-assessed Resident #164's pressure ulcer and reviewed all documentation regarding assessments and interventions. Care plans and treatment regimen are current and wound is improving. No revisions necessary. 2. Licensed staff will review all care plans and treatment regimens for residents with pressure ulcers to ensure accuracy. For those affected, a root cause analysis will be conducted to determine the underlying reasons for the resident's pressure ulcer. Any root cause analysis findings or discrepancies in the documentation will be immediately rectified and the affected nursing staff notified. Root cause analysis of pressure ulcers will also be conducted during the weekly quality meetings. The treatment nurse will be included in these meetings as he/she is primarily responsible for treatment of pressure ulcers. Any modifications to the treatment regimen will be documented and the affected nursing staff notified. 3. Director of Nursing or designee will re-educate licensed staff regarding pressure ulcer assessment, documentation, and intervention implementation. Licensed staff will also be re-educated on how to conduct a root cause analysis to determine the underlying cause of pressure ulcers including poor food and fluid intake, lack of incontinence care, and positioning/time spent in the wheelchair. Finally, staff will be educated on ensuring interventions are consistent with resident's needs and are monitored and modified as appropriate. Re-education will occur at least quarterly at monthly licensed staff meetings. 4. Director of Nursing, Nursing Supervisors, or designee will monitor resident care plans for pressure ulcer to ensure the underlying causes of the pressure ulcer are being addressed in the interventions and the interventions are monitored and modified as appropriate. Any discrepancies will be addressed immediately. Any problematic trends will be reported at the Quarterly QA meetings for discussion.	12/27/2017 2/24/2018 and ongoing 1/3/2018 and ongoing 2/24/2018 and ongoing 2/24/2018 and ongoing

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AMENDED POC	125043	A. BUILDING: _____ B. WING _____	12/26/2017

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4 136	Continued From page 10 ulcer deteriorated. The assessor noted that the care plan was update on 9/11/17; however, a review of the plan of care found there is no documentation of the updated intervention. The following week (9/19/17) there was noted improvement and no change on 9/26/17. On 10/6/17 the pressure ulcer was noted to be a Stage 3, measuring 1.5 cm (length) x 0.4 cm (width) with 0.1 cm in depth. Also noted there was slough (pinkish/yellow) in the wound bed. The assessment on 10/10/17 notes the ulcer deteriorated, the measurements include 1.5 cm (length) x 0.6 cm (width) with <0/1 cm in depth. There continued to be pink/pale yellow slough. The Interdisciplinary Progress Note dated 10/6/17 notes during treatment, the wound to the coccyx was noted with slough and there was no drainage. The care plan was revised on 10/6/17 to continue interventions with onset date of 7/26/17. On 10/11/17 the intervention added was to cleanse Stage 3 pressure injury to coccyx with saline, apply medi-honey and cover with foam dressing daily and prn when soiled. Based on the recommendation by the Dietitian on 10/16/17, a physician's order was made for addition of multi-vitamin tablets once daily and one packet of juven twice daily at breakfast and dinner for healing of the Stage 3 pressure ulcer. On 10/17/17 the ulcer was noted to deteriorate. The order for juven was put on hold on 10/23/17 due to frequent soft bowel movements. The weekly assessments dated 10/24/17 and 10/31/17 noted improvement. The assessment for 11/7/17 noted deterioration. The treatment was changed on 11/10/17 to cleanse abrasion above coccyx between upper buttocks with normal saline, pat dry, apply bacitracin and cover with aquacel foam daily until healed. Due to	4 136		

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4 136	Continued From page 11 continued deterioration of the ulcer, the treatment order was changed on 11/20/17. The physician's order included medi-honey wound paste, apply to Stage 3 pressure injury after cleansing with normal saline and cover with foam dressing every shift and when wet or soiled due to incontinence (the frequency of treatment was increased from once daily and when soiled to every shift and when soiled). The documentation on 11/28/17 notes the Stage 3 ulcer deteriorated. The measurements were 2 cm (length) x 3 cm (width) and 0.1 cm in depth. The wound was noted to have a small amount of serous sanguineous drainage. On 12/4/17 the order for medi-honey was discontinued. The new order was to apply compound cream (nystatin cream + zinc + bacitracin) to coccyx after cleaning with normal saline and cover with aquacel foam twice a day. Subsequent note on 12/5/17 and 12/7/17 noted improvement with continued drainage. The last documented assessment is dated 12/19/17 which notes continued improvement in response to treatment. A review of the resident's quarterly Minimum Data Set (MDS) with assessment reference date of 9/20/17 noted in Section M. Skin Conditions, the resident had two Stage 2 pressure ulcers. The oldest ulcer was dated at 7/26/17. Further review found Resident #164 was coded as severely impaired for cognitive skills for daily decision making. In Section G. Functional Status, Resident #164 was noted coded as totally dependent on staff with one person physical assist for bed mobility (how the resident moves to and from lying position, turns side to side and positions body while in bed or alternate sleep furniture) and toilet use. The resident was coded as always incontinent of bowel and bladder.	4 136		

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4 136	Continued From page 12 A review of the care plan for Stage 3 pressure ulcer (onset date of 10/6/17) included the following interventions that were continued from 7/26/17 for the Stage 2 pressure ulcer: assess specific risk factors for pressure ulcers; assess and stage pressure ulcer/s; measure the size of the ulcer and note the presence of undermining; describe the condition of the wound; assess for wound exudates, condition of wound edges and surrounding tissues, and pain levels; change resident's position frequently - bed-bound resident every 2 hours and chair bound every hour; and provide thorough perineal hygiene after each episode of incontinence. Further updates to the care plan after 10/6/17 reflected the changes in treatment on 10/11/17, 11/20/17 and 12/4/17. Observation on the morning of 12/20/17 found the resident was receiving morning care and treatment for the pressure ulcer. At 10:35 A.M. Resident #164 was observed up in the wheelchair and was taken to participate in activities. Subsequent observation at 12:34 P.M. (approximately two hours later) found the resident still in the wheelchair having lunch. On 12/22/16 at 8:48 A.M. an interview was conducted with Staff Member #67. The staff member confirmed one of the Stage 2 ulcers (as noted in the MDS) healed. Inquired why R #164's pressure ulcer on the coccyx got worst and not healing. The staff member reported that the facility has changed the treatment orders and the resident is not meeting the fluid intake goals as well as decreased food intake; however, the staff member acknowledged that protein powder was added to the meals to promote healing. The staff member provided documentation of staff members repositioning the resident in bed.	4 136		

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4 136	Continued From page 13 Further queried regarding the time the resident spends in the wheelchair. The staff member confirmed the care plan does not specify the amount of time the resident spends in the wheelchair. The staff member was unable to explain how the resident's position in the wheel chair would be changed every hour. The observation of the resident up in the wheelchair for approximately two hours was shared with Staff Member #67. The staff member acknowledged the care plan is not specific for the amount of time resident is up in the wheelchair to facilitate healing of the pressure ulcer and discussed the possibility that the resident may benefit from a gel cushion in the wheelchair. Concurrent observation with the staff member found the resident does not have a gel cushion in the wheelchair. On 12/26/17 at approximately 12:15 P.M. an interview was done with Staff Member #59. The staff member acknowledged that the resident's healing time is long and worsened, from a Stage 2 to a Stage 3. Inquired why did the pressure ulcer worsen. The staff member responded it is because the resident always has bowel movements so the order to stop taking senna was made by the physician. The staff member explained that the dressing does not ensure urine will not leak under the tape and when the resident has a bowel movement it is all over. Staff Member #59 confirmed that there was a change in the treatment for the resident. The staff member reported that the development and worsening progression of the Stage 2 ulcer would probably have been avoidable if the resident was kept dry and changed frequently. On 12/26/17 at 12:20 P.M. an interview was done with Staff Member #104. The staff member	4 136		

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4 136	Continued From page 14 confirmed the resident is incontinent of bladder and bowel and confirmed the need to change the resident is important due to the pressure ulcer. The staff member reported the resident is checked in the morning and after breakfast for incontinence. Then the resident is checked before and after lunch too. R #164 had a facility acquired Stage 2 pressure ulcer to the coccyx which was identified on 7/26/17 which eventually progressed to a Stage 3 pressure ulcer on 10/6/17. There is documentation of changes in treatment and interventions on 8/3/17 (overlay mattress) and 8/7/17 (addition of protein powder). After the identification of the progression to the Stage 3 ulcer there was a change in the treatment order on 10/11/17 to cleanse with normal saline and apply medi-honey daily and prn. The treatment order was changed on 11/20/17 for the change of dressing every shift and prn. On 12/4/17 the treatment order was changed to discontinue the medi-honey and apply the compound cream (nystatin cream + zinc + bacitracin). Although the treatments were changed, there was no care plan revision based on a root cause analysis (poor fluid and food intake) or lack of incontinence care or positioning/length of time spent in the wheelchair. Therefore, the development of the pressure ulcer and progression of the ulcer was avoidable if the facility had defined and implemented interventions that were consistent with the resident's need(s); monitored and evaluated the impact of the interventions; and revised the interventions as appropriate which resulted in actual harm, worsening of the Stage 2 pressure ulcer to a Stage 3 pressure ulcer and failure to progress towards healing. Based on observation, record review and staff	4 136		

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4 136	Continued From page 15 interview, the facility failed to provide adequate supervision in order to eliminate and/ or reduce the risk of an accident and monitor the effectiveness of the interventions and modify the care plan in accordance with current professional standards of practice for three of five sampled residents (R #89, R #34 and R #362). Findings include: 1) R #89 was admitted to the facility from Wahiawa General hospital in August 2017 after having a fall and serious head injury. The resident was living on the memory care unit at the Plaza in Mililani at the time of the fall. On 12/19/17 at 10:00 AM R# 89 was observed to wheel himself into another female residents room (206). Staff #113 came into the room and told the resident this isn't your room, your room is in 201. Staff #113 removed the resident from the room. Staff #113 said R #89 often wheels himself into other residents room's and we have to keep an eye on him. On 12/20/17 at 08:36 AM Res #89 was observed to wheel himself into room 202, Staff #113 approached the resident saying wrong room, this is a ladies room and assisted R #89 to the dining/ activity room across the hall. During a review of the Medical Record on 12/20/17 at 10:19 AM the admission Minimum Data Set (MDS) with assessment reference date (ARD) of 9/01/17 and Quarterly MDS with ARD of 11/27/17 Section E 0900 wandering-presence & frequency was coded "0" on both assessments indicating wandering behavior not exhibited. Review of the resident's care plan noted an intervention for wandering was implemented on 12/04/17 after a fall. A progress note dated	4 136		

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4 136	Continued From page 16 12/04/17 stated that R#89 was found on the floor in another resident's room. He suffered with mild bleeding and an abrasion on the forehead. The Physician ordered a Physical Therapy (PT) evaluation on 12/04/17 for fall risk due to increased wandering. Further review of the Progress notes did not reveal additional documentation regarding R#89 wandering. On 12/21/17 the Behavior/ Intervention monthly flow record was reviewed, R #89 was being monitored for wandering beginning on 11/01/17 through 12/20/17. From 11/01/17 - 11/30/17 R#89 had episodes of wandering on 22 of the 30 days reviewed. Episodes ranged from 1 to 15 times per shift. Interventions used were redirection and offering fluids. The outcome was unchanged or worsened on 14 of the 30 days reviewed. From 12/01/17 - 12/20/17 R #89 had episodes of wandering on 14 of the 20 days reviewed. Episodes ranged from 1 to 20 times per shift. Interventions used were redirection, 1:1, and Return to room. The outcome was unchanged or worsened on 13 of the 20 days reviewed. The majority of the episodes documented on both of the flow sheets occurred on the evening and night shift. During an interview on 12/21/17 at 1:33 PM with Staff #54, R #89 was moved from the 4th floor in October 2017 to the second floor. Staff #54 stated that when he came to the floor in October it was noticed that he would often wheel himself around the unit and wander into other resident's rooms. We got the wander guard to monitor him so that if he gets close to the elevator or stairway to leave the floor an alarm will sound. When asked if 4th floor nursing staff reported to the 2nd floor nursing staff that R #89 wanders staff #87 stated that the progress notes only mentioned the Resident has edema.	4 136	4 136, 1. 1. Immediate 1:1, 24/7 Supervision was implemented for resident #89 for immediate removal of risk, until coordinated long term arrangements could be made with Office of the Public Guardian and community support resources to relocate resident to a more appropriate community setting. a) Resident #89 remained on 1:1, 24/7 Supervision until Office of the Public Guardian finalized a move to another community setting. 2. Plan included use of community private duty sitters, supplemented by facility staff to ensure resident safety from potential harm or unsafe conditions that may occur due to resident's dementia related restlessness and wheelchair movement in the nursing unit. 3. Assessments will be completed to determine root cause of resident's behaviors. PCP to review resident's medications and primary diagnoses. Social Work will assess for cognitive, mood and behavioral changes related to primary diagnoses. Nursing will assess for safety and fall risk, comfort level related to potential for possible pain. Activities will review and update resident interests and activities for daily quality of life enhancement. a) All direct care disciplines will be re-educated regarding timely completion of accurate assessments and accurate and timely development of care plans for all problems a resident might have, including dementia related behaviors, restlessness, pain, fall risks. 4. The Nursing Supervisor or designee will monitor care plan development on a weekly basis and during quarterly Care Conferences. Any noted discrepancies will be resolved immediately. Any changes in condition or behavior will be resolved immediately. Any problematic trends will be reported at the Quarterly QA meetings for discussion.	12/22/2017 1/4/2018 12/22/2017 and cont'd until 1/4/201 12/26/2017 2/24/2018 and ongoing 2/24/2018 and ongoing

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4 136	Continued From page 17 During an interview on 12/22/17, Staff #2 stated that R #89 pedals around in his wheel chair. The Resident's care plan was shared with Staff #2 and Staff #54 informing them that an intervention for wandering was put on care plan on 12/04/17 the day of the fall. Also discussed that R #89 was transferred from the 4th floor on 10/23/17 and there was no documentation that R#89 wandered. Discussed the facility's lack of assessment, evaluation, and documentation of the resident's wandering and the potential risk for accidents (falls) and potential conflict with other residents. Reviewed one note in the progress notes that stated resident was reminded not to go into other's rooms. Discussed that resident had a fall on 12/04/17 and was wandering at the time. Discussed that R #89 was being monitored for wandering from 11/01/17 to 12/21/17 and that the interventions were not developed until 12/04/17 and the interventions were not effective as evidenced by the resident's monitoring monthly flow record (increase in the episodes of wandering). Staff #2 responded by saying that we're providing the least restrictive environment as possible for this resident, he is not violent has not shown any aggressive behaviors. However, the progress notes dated 11/05/19 documented that R #89 hit a CNA during a shower. The facility failed to identify potential risk for accidents, evaluate and analyze the hazard and the risk. The MDS was inaccurate and no care plan was developed at the time of the admission assessment. implement effective interventions to minimize the risk and monitor the effectiveness and modify the interventions when necessary for R #89. On 12/22/17 at 09:17 AM The Administrator was	4 136		

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4 136	Continued From page 18 informed of an Immediate Jeopardy (IJ) identified under accidents, wandering. The team identified the three components of the immediate Jeopardy. There is a likelihood of potential serious harm and the potential harm can cause serious injury. If not corrected one or more individuals at risk of immediate serious injury, harm, impairment or death. The facility was culpable in that they knew of the situation and did not ensure safeguards. They did not thoroughly investigate the circumstances. On 12/22/17 at 03:02 PM a written plan of Abatement was received from the Administrator, reviewed and accepted by the team. 2) Resident #34 was admitted to the facility on 7/14/15 with the following diagnoses: Parkinson's disease; unspecified dementia without behavior; cerebral infarction due to thrombosis of unspecified artery; and syncope and collapse. On 9/21/17 the facility submitted an Event Report to the State Agency to report an injury for Resident #34. On 9/20/17 at 8:45 A.M. Resident #34 was receiving a shower and slid out of the shower chair and sat on the floor. The aide was unable to prevent the resident from sliding out of the chair. The resident complained of lower back pain on 9/21/17. Resident #34 was sent for imaging and found to have an "age indeterminate L1, L4 and possibly L5 compression fractures". On 12/21/17 at 3:08 P.M. a record review was done for Resident #34. A review of the resident's care plan noted on 5/14/17 the resident slipped down to the floor while sitting in the shower chair. Subsequently on 9/20/17 there was further note documenting Resident #34 slid down to the floor while sitting down in chair inside of the shower room.	4 136		

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4 136	Continued From page 19 A review of Resident #34's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 7/15/17 found in Section G0120. Bathing, the resident was totally dependent on staff with one person assistance for bathing. Subsequent quarterly assessment with an ARD of 10/10/17 (after the fall of 9/20/17) notes no change in the resident's bathing skills. Further review of the quarterly MDS with an ARD of 7/15/17 notes in Section G0300. Balance During Transitions and Walking, Resident #34 was coded "2" (not steady, only able to stabilize with staff assistance) for the following areas: moving from seated to standing position; moving on and off toilet; and surface-to-surface transfer (transfer between bed and chair or wheelchair). Subsequently, the quarterly MDS with an ARD of 10/10/17 documents the resident is now coded with "8" (activity did not occur) in the aforementioned areas. On 12/21/17 a request was made to Staff Member #51 to review the facility's incident report related to the fall on 5/14/17. Further record review with the assistance of Staff Member #5 found no documentation in the progress notes of the incident. A review of the Interdisciplinary Progress Notes (IPN) found an entry dated 9/20/17 at 1300 noting at approximately 0845 a loud noise was heard in the shower room. The writer went into the shower room and found the resident sitting on the floor with the aide behind the resident, holding up the resident's back. The resident was still wet and soapy. No injuries were noted, bruises were noted to the right upper buttock, redness to right buttock and upper left back.	4 136		

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4 136	Continued From page 20 On 9/21/17 Resident #34 was seen by the physician for a follow up to a mechanical fall. The physician notes "at baseline patient is able to assist with transfers and stand with assist...but today, patient was unable to transfer or stand with assist, as patient noted pain to lower back". A lower back x-ray was ordered which revealed an "indeterminate L1-L4 compression fracture and possible L5". The physician also noted an MR of the spine without contrast done on 12/17/13 revealed mild spinal stenosis at L3-4 and L4-5. A review of the Plan of Care documents on 5/14/17 Resident #34 slipped down to the floor while sitting on shower chair. A care plan was developed which included the following interventions: assess level of care functioning; inform resident of actions or care to be done to be able to act upon cuing; remind CNA to call for assistance as needed when transferring, use arjo lift; organize shower needs prior to starting shower, place them within reach maintaining safety or resident; do not leave resident unattended in the bathroom; reassess risk for falls; and two person assist during transfer. Following the fall (slid down to the floor while sitting down in chair inside shower room) on 9/20/17, the resident's care plan was updated to include the following: make sure resident is well positioned while up on shower chair or shower gurney and use the shower chair with safety front lock. On 12/21/17 at 2:01 P.M. an interview was done with Staff Member #51. The staff member reported he/she was not at the facility in May 2017 and could not locate the incident report related to the fall on 5/14/17. However, the staff member reported in May the aide completed the	4 136		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	12/26/2017

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4 136	Continued From page 21 shower, reached for a towel and the resident leaned forward, eventually landing on the floor. Queried the staff member whether the use of a front lock shower chair would have been indicated following the first fall in May to prevent future falls in the shower room. The staff member responded he/she could not speculate whether the inclusion of a front lock shower chair after the fall in May would have prevented the second fall. Upon further query, Staff Member #51 acknowledged that he/she would have updated the resident's care plan to add the use of the front lock shower chair for fall prevention. Interview was done with Staff Member #67 on 12/22/17 at 3:09 P.M. The staff member was queried regarding the use of bed and chair alarm as identified in the resident's care plan. The staff member reviewed the resident's care plan and reported these interventions were discontinued when the resident moved to their floor; however, the care plan was not revised to discontinue these devices. Staff Member #67 also confirmed the compression fracture was the result of the resident's fall on 9/20/17. On 12/22/17 at 10:20 A.M. the facility's policy for "Fall Prevention Program" and "Resident Incident Report" was provided for review. The review of the fall prevention policy notes the following: "4. When a fall occurs, the licensed nurse will thoroughly complete the Incident Report Form to collect data for process improvement. a. The report shall be completed on the shift on which the event occurred and b. The completed reports shall be submitted to the Unit Supervisor to provide information on the incident to the IDT team, as well as completing a root cause analysis." A review of the incident report policy notes reportable events must be reported to	4 136	4 136 2), 3) 1. Resident #34 and #362 were re-assessed for fall risk and a root cause analysis conducted. These resident's care plans were revised to address the root causes and interventions implemented. 2. Nursing Supervisors, Director of Nursing, or designees will review all resident care plans and ensure root cause analysis are conducted and care plans revised to address the root causes. Interdisciplinary team members will also be included in the root cause analysis process to ensure all of the resident's problems and care needs are considered. Root cause analysis will be conducted during weekly quality meetings where discussions such as falls, UTIs, wounds and pressure ulcers, and nutrition are conducted. All care plans will be revised to reflect results of the root cause analysis. 3. The Staff Development Coordinator, Administrator, or designee will re-educate licensed nurses and the Interdisciplinary team regarding how to conduct root cause analysis when developing interventions for resident's care plans. Root cause analysis will be a scheduled topic at the daily Interdisciplinary team meetings, weekly quality meeting, and during resident's Care Conferences. Any modifications to the resident's care plan will be documented and staff notified regarding implementation. 4. The Director of Nursing or designee will monitor resident care plans, at least weekly, to ensure root cause analysis are conducted and interventions reflect results of the analysis. Any discrepancies will be corrected immediately and problematic trends reported at the Quarterly QA meetings for discussion.	1/22/2018 2/24/2018 and ongoing 2/24/2018 and ongoing 2/24/2018 and ongoing

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4 136	Continued From page 22 Administration within 24 hours, reportable events include witnessed and un-witnessed resident falls/slips. The facility failed to revise the resident's care plan based on a root cause analysis following the resident's fall in the shower on 5/14/17. The facility was unable to provide the incident report related to the fall which occurred on 5/14/17 and a review of the resident's record found no documentation of the fall in the progress notes. The failure to provide interventions (i.e. use of the front lock shower chair) to prevent further falls in the shower room resulted in actual harm (compression fractures and decline in activities of daily living). 3) Resident #362 had care plan for falls initiated on 12/7/17 and resident fell from bed on 12/8/17 at 2130 PM and sustained 0.5 cm abrasion to left great toe and care plan for falls was modified that same day. Resident fell a second time from wheelchair without injury on 12/9/17 at 1420 PM, no documentation that fall risks were re-evaluated, interventions were modified and no documentation that supervision needs were reassessed to prevent avoidable accidents after 2nd fall. Care plan for falls was modified on 12/13/17 after a 3rd "assisted fall" from wheelchair to bed. Based on record review and interview with staff members, the facility failed to ensure one (R #75) of four residents sampled received appropriate care and services to prevent urinary tract infections to the extent possible. Findings include: On 12/22/17 at 10:58 A.M. a record review was	4 136		

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4 136	Continued From page 23 done for R #75. A review of the physician's order found a prescription dated 12/5/17 for Bactrim DS tab twice daily, seven days for diagnosis of urinary tract infection (UTI). A subsequent order was made on 12/17/17 to discontinue Bactrim DS and administer ciproflaxin 250 mg. twice daily, seven days for diagnosis of UTI. Further review found a lab reported dated 12/16/17 with urine culture with >100,000 cfu/ml of presumptive escherichia coli. The documentation on the lab report notes Resident #75 currently on Augmentin for bronchitis and Bactrim for UTI. However, the bacteria is Bactrim resistant; therefore, the antibiotic was changed to cipro. Further review found entries documenting resident with temperatures: 11/13/17 (101 degrees), 11/14/17 (100.4 degrees) and 11/15/17 (98.9 degrees). The resident was also noted with coughing and wheezing. A chest x-ray was done on 11/13/17 which was negative. On 11/17/17 the resident was started on doxycycline, 100 mg. twice daily, seven days for bronchitis. Subsequent lab report dated 11/18/17 notes the result of urine culture was 3500 cfu/ml of morganella morganii. Handwritten note on the lab report notes the resident already on antibiotic, doxycycline. A review of the progress notes found documentation dated 10/29/17 that the resident had a temperature of 100.2 degrees and urine with foul odor. No hematuria or dysuria noted. On 10/30/17 R #75 noted with foul odor of the urine. The note for 10/31/17 documents the start of antibiotic, amoxicillin 500 mg. three times a day for UTI. The lab report dated 10/31/17 found >100,000 cfu/ml with "predominant growth of alpha hemolytic streptococci".	4 136		

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4 136	Continued From page 24 A lab report dated 5/18/17 notes the result of the urine culture included, >100,000 cfu/ml of morganella morganii. A handwritten note on the lab report documents, 5/18/17 Bactrim DS twice a day for seven days for diagnosis of UTI. On the afternoon of 12/22/17 a review of the annual Minimum Data Set with an assessment reference date of 11/13/17 notes the resident is totally dependent on staff with one person physical assist for toilet use. The resident is also noted to be frequently incontinent of urine and bowel. Also noted in Section I. Active Diagnosis, R #75 was coded at 12300. Urinary Tract Infection (last 30 days). A review of the comprehensive care plan found no documentation of a plan of care to prevent development of UTIs. There is a care plan for dehydration (potential and history of UTI). The interventions included the following: encourage po fluids and monitor food and fluid intake; encourage fluid intake by offering fluids regularly to cognitively impaired residents; provide preferred beverages i.e. juice if not contraindicated; and encourage family involvement in increasing fluid intake according to resident's fluid consistency. A review of the Care Area Assessment notes R #75 is frequently incontinent of bladder and bowel putting the resident at risk for skin impairment. Also noted, fluid maintenance triggered due to UTIs, putting her at risk for dehydration/fluid maintenance. Encourage 1000 to 1400 cc fluid daily. On 12/22/17 at 1:54 P.M. an interview and concurrent record review was done with Staff Member #67. Queried staff member regarding R #75's urine culture of morganella morganii, asked	4 136	1. Licensed Nurse assessed resident #75 and developed a care plan for the prevention of urinary tract infections. 2. Licensed staff will assess all residents for the potential for urinary tract infections (UTIs). For residents at-risk for UTIs, a care plan will be developed or, if one is already developed, reviewed in a timely manner and revised accordingly. 3. Licensed staff will be re-educated at the next and future staff meetings regarding care plans and ensuring accurate and timely development for all problems a resident might have, including the prevention of UTIs. 4. The Nursing Supervisor or designee will monitor care plan development on a weekly basis and during quarterly Care Conferences. Any discrepancies will be resolved immediately. Any problematic trends will be reported at the Quarterly QA meetings for discussion.	1/22/2018 2/24/2018 and ongoing 2/24/2018 and ongoing 2/24/2018 and ongoing

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4 136	Continued From page 25 the staff member where does this organism come from, the staff member replied he/she could check. Further queried why the resident has frequent UTIs, the staff member reported the resident refuses to use the toilet and is dependent on staff to wipe after urination or bowel movement. Inquired whether a care plan was developed to prevent UTIs, Staff Member #67 confirmed there is no care plan for UTI prevention. The staff member reported, the resident's fluid goal is 1100 to 1400 ml; however, this does not take into account the resident has frequent UTIs. A review of the resident's fluid intake found the resident is being monitored for fluid intake as the resident is not attaining the fluid goal. The documentation of the fluid intake from 11/26/17 through 12/21/17 found the resident's fluid intake ranged from 136 ml to 1780 ml a day. Based on a thorough assessment to identify a thorough assessment to identify probable causal factors contributing to UTIs (abnormal post void residual, referral to urologist for assessment, etc.), the facility failed to develop a care plan for the prevention of UTIs. Based on resident observation, record review and staff interview the facility failed to provide a bedrail that did not pose an entrapment risk for two residents (R#40 and R#80). Findings include: 1) On 12/19/17 at 04:28 PM during resident (R) interview with R#40 noted that resident had a grab bar on the left side of his bed and on the right side of his bed he had a full length bed rail. Inquired with resident why his bed was set up like this and he stated he asked staff to put the	4 136		

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4 136	Continued From page 26 bedrail on the right side of his bed so he can grab it and turn self and he reported that he had a history of falling out of his bed. R#40 stated that staff stand on the left side of his bed to provide care and that is why there is only a grab bar on that side. On 12/22/17 08:22 AM medical record review found that resident has a care plan in place for use of the bedrail on his right side and an Initial Restraint Assessment form was filled out for the bed rail use which shows that the resident requested to have his siderail up when he is in his bed for use of re-positioning self. After reviewing R#40's medical record interviewed staff #53 and discussed the width of openings within the bedrail perimeter and noted that it appeared large. Staff #53 brought a measuring tape and measured an open space within the bedrail perimeter and found it to be 7 3/4 inches. 2) On 12/20/17 at 08:55 AM while observing R#80 in her bed noted that resident had both bedrails up and resident had mittens on both hands. R#80 has the same type of bedrail that R#40 has on his bed. Review of R#80's MDS 3.0 dated 08/23/17 (Admission) and 11/18/17 (Quarterly Assessment) found that resident did not have a BIMS score because resident is mute and diagnosis are: Encephalopathy due to left basal ganglia hemorrhage with hydrocephalus, chronic resp failure, dysphagia, essential hypertension, and pseudomonas pneumonia. Interviewed staff #53 who confirmed that R#80 does have the same bedrails with the 7 3/4 inch openings within the bedrail perimeter. Staff #53 stated that R#80's family requested that staff use bedrails for resident when she is in bed for her safety and this was documented in the resident's Initial Restraint Assessment form and in her care	4 136	4 136 1), 2) Bed Rail 1. a)Bed Rail Risk Assessment will be conducted to determine safe use of bed rails. b)Interventions will be put in place to decrease bed rail entrapment risk (i.e.padded accessories). c) Bed rails will be removed if entrapment risk cannot be abated. 2. a) All residents who either request bedrails, have responsible party who request bedrails, require bedrails (i.e. Seizure Precautions), or other reasons, will have a Bed Rail Risk Assessment conducted BEFORE the bed rail is placed on the bed. b) Depending on entrapment risk, interventions will be put in place before bed rails are placed on the bed. c) If entrapment risk cannot be abated, bed rails will not be placed on the bed. 3. a) A policy and procedure for the use of bed rails will be developed (or modified if one is available). b) A Bed Rail Risk Assessment Form will be developed to ensure the safe use of bedrails and the prevention of bed rail entrapment. c) At-Risk for Bed Rail Entrapment Care Plan will be developed for use with all residents with full bed rails, either one-side or both sides. d) Nursing staff will be educated regarding Bed Rail Entrapment Policy and Procedures, Bed Rail Risk Assessment Form, and At-Risk for Bed Rail Entrapment Care Plan. 4) Nursing Supervisors, Director of Nursing, or designees will monitor resident use of bedrails and completion of documents (i.e. Assessment Form and Care Plan) according to the Policy and Procedures for use of bedrails at least monthly. Any non-compliance will require immediate correction and will be reported at the Quarterly QA meeting.	12/29/2017 1/19/2018 and ongoing 1/19/2018 1/19/2018 1/19/2018 1/19/2018 and ongoing 2/24/2018 and ongoing

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4 136	Continued From page 27 plan. Staff #53 was reassured that bedrails can be used if they are safe and do not pose a risk for entrapment for the resident. Staff #53 was reminded that R#80 is cognitively impaired, does not have the use of her hands since she is wearing mittens and cannot use the call light if she could use it and is mute so cannot call out for help if she were to get entrapped by the bedrail that were on her bed. Staff #53 agreed with this. According to the FDA recommendations, made on page 16, in the Guidance for Industry and FDA Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment they "...recommend a measure of less than 120 mm (4 3/4 inches) as the dimensional limit for any open space within the perimeter of a rail." It was noted on page 15 of the Guidance for Industry ... under the Data from the Retrospective Study that "Adverse events identified as occurring within the rail were reported in bed models where open spaces within the rail were greater than 120 mm (4 3/4 inches).	4 136		
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,	4 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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4 149	Continued From page 28 with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided. This Statute is not met as evidenced by: Based on resident observation, record review and staff interview the facility failed to accurately assess three residents R #80, #89, and #90 to reflect the resident's status. Findings include: 1) On 12/20/17 at 08:55 AM while observing R #80, who was in her room in bed, it was noted that resident had soft mittens on both her hands. Review of residents medical chart found that there was a doctor's order for "Bilateral hand mitten ok for safety release every 2 hours for 15 minutes and may remove if family is present" which was written on 10/02/2017 and renewed monthly on the physician order sheet. Further review of resident's medical record found that she had a care plan problem #10 dated 10/3/2017 in place for use of bilateral hand mittens with interventions. Initial Restraint Assessment for R #80 was completed on 10/3/17 identifying Bilateral Hand Mittens as a restraint because resident cannot remove it. Condition identified that required the use of restraint was "Resident attempted to remove trachea tube, she was able to remove inner cannula."Review of R#80's	4 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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4 149	Continued From page 29 Quarterly MDS dated 11/18/17 found that there was no coding for the use of restraint for this resident. Interview with staff #53 found that R #80 regained enough strength in her arms and she was trying to take out her trachea on 10/02/2017 and that is why there is an order for the use of soft mittens. When quiered about the MDS 3.0 Quarterly Assessment dated 11/18/17 and that use of restraints was not coded for R #80 staff #53 stated that this was "a mistake" and that she would "submit a modification form." 2) The facility failed to identify, analyze and evaluate the potential risk for accidents, wandering for R #89. Both the MDS admission and quarterly assessments were inaccurate to identify the potential accident and hazard risk-wandering for R #89. 3) On 12/19/17 at 02:02 PM reviewed R #90's MDS Quarterly Assessment dated 9/2/17 and MDS Annual Assessment dated 11/28/17 and noted that there was a decline in ADLs. Noted that R#90 had a decline documented in the MDS Annual Assessment on 11/28/17 in Transfer-how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position from a one person physical assist to requiring Two+ persons physical assist. On 12/22/17 at 02:53 PM interviewed staff #53 regarding the decline in ADLs with R#90 and she stated that the coding on the MDS Annual Assessment dated 11/28/17 was "an error" and that she would "submit a modification form." Review of ADL sheet for R#90 confirmed coding error. Based on observation, record review and staff interview, the facility failed to assure that each	4 149	4 149 1), 2), 3) 1. Nursing Supervisor/RAI Coordinator corrected inaccurate MDS and submitted modification form for residents affected by the deficient practice. 2. Nursing Supervisor or designee will check all completed MDS for accurate coding before submitting to CMS, including, restraint use, potential hazard risk – wandering, and decline in ADLs. Any deficiencies will be corrected before submission. 3. All licensed nurses assigned to complete portions of the MDS will be re-educated to ensure they understand the assessments must be accurately completed to reflect current and overall status of the resident. 4. The Nursing Supervisors and Director of Nursing (DON) will initiate a quality monitoring program to randomly check the MDS assessments on a monthly basis and as needed to ensure that they are completed accurately and on a timely basis. Any deficiencies will be corrected immediately and reported at the Quarterly QA meetings for discussion.	1/22/2018 2/24/2018 and ongoing 2/24/2018 and ongoing 2/24/2018 and ongoing

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4 149	Continued From page 30 resident receives an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas and are knowledgeable about the resident's status, needs, strengths, and areas of decline for two of three sampled residents (R # 80 and R#89). Based on record review and interview with staff members, the facility failed to develop a comprehensive care plan for R #75. Findings include: 1) R #75 has history of urinary tract infections which were treated with antibiotics. A review of the resident's record found based on an assessment, the facility did not develop a care plan for the prevention of urinary tract infections. The annual Minimum Data Set with assessment reference date of 11/13/17 notes in active diagnosis, the resident had a urinary tract infection in the last 30 days. The Care Area Assessment also notes the fluid maintenance was triggered due to urinary tract infection. Based on observations, record review and interview with staff members, the facility failed to ensure four (R #34, R#64, R#89 and R#362) resident's care plans were reviewed and revised. Findings include: 1) R #34 slipped out of the shower chair on 5/14/17 which resulted in a care plan; however, the interventions identified was not based on a root cause analysis. The facility failed to provide documentation an incident report was submitted to prompt a root cause analysis to prevent future falls in the shower. Subsequently, the Resident	4 149	4 149 1) 1. Licensed Nurse assessed resident #75 and revised the care plan for the prevention of urinary tract infections adding fluid maintenance as an intervention. 2. Licensed staff will assess all residents for the potential for urinary tract infections (UTIs). For residents at-risk for UTIs, a care plan will be developed or, if one is already developed, reviewed in a timely manner and revised accordingly. Interventions will be added to care plans for residents whose CAA triggered fluid maintenance. 3. Licensed staff will be re-educated at the next and future staff meetings regarding care plans and ensuring accurate and timely development for all problems a resident might have, including the prevention of UTIs, and any interventions triggered through the completion of CAA. 4. The Nursing Supervisor or designee will monitor care plan development on a weekly basis and during quarterly Care Conferences. Any discrepancies will be resolved immediately. Any problematic trends will be reported at the Quarterly QA meetings for discussion. 4 149 1), 4) 1. Resident #34 and #362 were re-assessed for fall risk and a root cause analysis conducted. These resident's care plans were revised to address the root causes and interventions implemented. 2. Nursing Supervisors, Director of Nursing, or designees will review all resident care plans and ensure root cause analysis are conducted and care plans revised to address the root causes. Interdisciplinary team members will also be included in the root cause analysis process to ensure all of the resident's problems and care needs are considered. Root cause analysis will be conducted during weekly quality meetings where discussions such as falls, UTIs, wounds and pressure ulcers, and nutrition are conducted. All care plans will be revised to reflect results of the root cause analysis. continued next page (32)	1/22/2018 2/24/2018 and ongoing 2/24/2018 and ongoing 2/24/2018 and ongoing 1/22/2018 2/24/2018 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	12/26/2017

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4 149	Continued From page 31 #34 slid out of the shower chair on 9/21/17 resulting in compression fractures and decline in ability to stand and bear weight. 2) R #64 had a facility acquired Stage 2 pressure ulcer (identified 7/26/17) which progressed to a Stage 3 pressure ulcer (identified 10/6/17), the care plan was revised to reflect the change in treatment of the pressure ulcer; however, the care plan interventions were not revised based on a root cause analysis that lead to the break down and lack of healing. 3) No care plan interventions were developed for R#89 wandering until 12/04/17 after he had a fall. The interventions were not effective as evidenced by the resident's monitoring monthly flow record (increase in the episodes of wandering). 4) R #362 had care plan for falls initiated on 12/7/17 and resident fell from bed on 12/8/17 at 2130 PM and sustained 0.5 cm abrasion to left great toe and care plan for falls was modified that same day. Resident fell a second time from wheelchair without injury on 12/9/17 at 1420 PM, no documentation that fall risks were re-evaluated, interventions were modified and no documentation that supervision needs were reassessed to prevent avoidable accidents after 2nd fall. Care plan for falls was modified on 12/13/17 after a 3rd "assisted fall" from wheelchair to bed. Based on observations, record review and interview with staff members, the facility failed to ensure sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, psychosocial well-being of each	4 149	continued, 4 149 1), 4) 3. The Staff Development Coordinator, Administrator, or designee will re-educate licensed nurses and the Interdisciplinary team regarding how to conduct root cause analysis when developing interventions for resident's care plans. Root cause analysis will be a scheduled topic at the daily Interdisciplinary team meetings, weekly quality meeting, and during resident's Care Conferences. Any modifications to the resident's care plan will be documented and staff notified regarding implementation. 4. The Director of Nursing or designee will monitor resident care plans, at least weekly, to ensure root cause analysis are conducted and interventions reflect results of the analysis. Any discrepancies will be corrected immediately and problematic trends reported at the Quarterly QA meetings for discussion. 4 149 3) 1. Immediate 1:1, 24/7 Supervision was implemented for resident #89 for immediate removal of risk, until coordinated long term arrangements could be made with Office of the Public Guardian and community support resources to relocate resident to a more appropriate community setting. a) Resident #89 remained on 1:1, 24/7 Supervision until Office of the Public Guardian finalized a move to another community setting. 2. Plan included use of community private duty sitters, supplemented by facility staff to ensure resident safety from potential harm or unsafe conditions that may occur due to resident's dementia related restlessness and wheelchair movement in the nursing unit. 3. Assessments will be completed to determine root cause of resident's behaviors. PCP to review resident's medications and primary diagnoses. Social Work will assess for cognitive, mood and behavioral changes related to primary diagnoses. Nursing will assess for safety and fall risk, comfort level related to potential for possible pain. Activities will review and update resident interests and activities for daily quality of life enhancement. Continued next page	2/24/2018 and ongoing 2/24/2018 and ongoing 12/22/2017 1/4/2018 12/22/2017 and cont'd until 1/4/2018 12/26/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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4 149	Continued From page 32 residident. Findings include: 1) On 12/ 21/17 at 9:30 A.M. the resident council interview was conducted. The residents responded that staff does not respond to the call light in a timely manner. The residents reported the staff members are too busy. The residents reported calling for help to use the toilet or change their personal briefs. The residents stated waiting 10 to 30 minutes. One resident reported the call light is pressed to request for a change of personal brief (urinary incontinence) and the staff take so long that he/she urinates again. A staff member commented that the wait time is dependent on how busy the staff members are, reporting the aides are responsible for two rooms. The residents also reported the ratio is one aide for two rooms (a total of 8 residents), noting the need for more staff. 2) The facility failed to ensure R #164 received the necessary treatment and services to promote the healing of a pressure ulcer. 3) The facility failed to ensure R #75 received appropriate care and services to prevent urinary tract infections to the extent possible. 4) The Facility failed to provide adequate supervision in order to eliminate and/ or reduce the risk of an accident and monitor the effectiveness of the interventions and modify the care plan in accordance with current professional standards of practice for R # 89 wandering; R#34 and R#362 for falls. 5) The facility failed to provide a bedrail that did not pose an entrapment risk for R#40 and R#80.	4 149	4 149 3) continued, a) All direct care disciplines will be re-educated regarding timely completion of accurate assessments and accurate and timely development of care plans for all problems a resident might have, including dementia related behaviors, restlessness, pain, fall risks. 4. The Nursing Supervisor or designee will monitor care plan development on a weekly basis and during quarterly Care Conferences. Any noted discrepancies will be resolved immediately. Any changes in condition or behavior will be resolved immediately. Any problematic trends will be reported at the Quarterly QA meetings for discussion. 4 149 2) 1. Licensed staff re-assessed Resident #164's pressure ulcer and reviewed all documentation regarding assessments and interventions. Care plans and treatment regimen are current and wound is improving. No revisions necessary. 2. Licensed staff will review all care plans and treatment regimens for residents with pressure ulcers to ensure accuracy. For those affected, a root cause analysis will be conducted to determine the underlying reasons for the resident's pressure ulcer. Any root cause analysis findings or discrepancies in the documentation will be immediately rectified and the affected nursing staff notified. Root cause analysis of pressure ulcers will also be conducted during the weekly quality meetings. The treatment nurse will be included in these meetings as he/she is primarily responsible for treatment of pressure ulcers. Any modifications to the treatment regimen will be documented and the affected nursing staff notified. 3. Director of Nursing or designee will re-educate licensed staff regarding pressure ulcer assessment, documentation, and intervention implementation. Licensed staff will also be re-educated on how to conduct a root cause analysis to determine the underlying cause of pressure ulcers including poor food and fluid intake, lack of incontinence care, and positioning/time spent in the wheelchair. Finally, staff will be educated on ensuring interventions are consistent with resident's needs and are monitored and modified as appropriate. Re-education will occur at least quarterly at monthly licensed staff meetings. continued next page,	2/24/2018 and ongoing 2/24/2018 and ongoing 12/27/2017 2/24/2018 and ongoing 1/3/2018 and ongoing 2/24/2018 and ongoing

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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 resident interviews, interview with staff and review of documentation, the facility failed to ensure that 2 residents (R#1 and R # 262) preferences and choices regarding bathing frequency were supported. Findings: 1) During interview with resident #1 on 12/19/17 01:51 PM who said she informed staff that she would like to bathe everyday was told by staff that there was insufficient staff to bathe more than twice a week. Resident #1 has activity assessment that shows shower is the bathing preference, and "extra" is written on the form. The form itself does not ask how frequently the resident would like to bathe. 2) During interview with resident #362's spouse on 12/19/17 11:06 AM who said that resident said, "Feels dirty because only showers twice a week." Resident's spouse said that staff informed them that there is insufficient staff to bathe resident more than twice a week. During interview with staff # 53 on 12/21/17 14:13 PM who said that residents are given a choice about how often they bathe, are asked on admission about preferences for bathing, and	4 175	4 149 2) continued 4. Director of Nursing, Nursing Supervisors, or designee will monitor resident care plans for pressure ulcer to ensure the underlying causes of the pressure ulcer are being addressed in the interventions and the interventions are monitored and modified as appropriate. Any discrepancies will be addressed immediately. Any problematic trends will be reported at the Quarterly QA meetings for discussion. 4 149 5) R #40 & R #80 1. a)Bed Rail Risk Assessment will be conducted to determine safe use of bed rails. b)Interventions will be put in place to decrease bed rail entrapment risk (i.e.padded accessories). c) Bed rails will be removed if entrapment risk cannot be abated. 2. a) All residents who either request bedrails, have responsible party who request bedrails, require bedrails (i.e. Seizure Precautions), or other reasons, will have a Bed Rail Risk Assessment conducted BEFORE the bed rail is placed on the bed. b) Depending on entrapment risk, interventions will be put in place before bed rails are placed on the bed. c) If entrapment risk cannot be abated, bed rails will not be placed on the bed. 3. a) A policy and procedure for the use of bed rails will be developed (or modified if one is available). b) A Bed Rail Risk Assessment Form will be developed to ensure the safe use of bedrails and the prevention of bed rail entrapment. c) At-Risk for Bed Rail Entrapment Care Plan will be developed for use with all residents with full bed rails, either one-side or both sides. d) Nursing staff will be educated regarding Bed Rail Entrapment Policy and Procedures, Bed Rail Risk Assessment Form, and At-Risk for Bed Rail Entrapment Care Plan. 4) Nursing Supervisors, Director of Nursing, or designees will monitor resident use of bedrails and completion of documents (i.e. Assessment Form and Care Plan) according to the Policy and Procedures for use of bedrails at least monthly. Any non-compliance will require immediate correction and will be reported at the Quarterly QA meeting.	2/24/2018 and ongoing 12/29/2017 1/19/2018 and ongoing 1/19/2018 a), b), c), d) 2/24/2018 and ongoing

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4 175	Continued From page 34 admitted that it was necessary to remind staff to honor bathing on request, especially for new residents. Staff #53 also gave me a copy of the floor's bathing schedule. The bathing schedule provided by staff #53 supports residents' statements that they are only bathed two to three times per week, and the schedule does not indicate residents' preferences for bathing frequency have been supported.	4 175	4 175 1), 2) 1. Nurse manager spoke to staff caring resident #1 to discuss preferences for bath. Preferences were verified on shower schedule, care plan, and care card. Staff provided bath according residents preferences. 2. All staff were reminded of resident preference regarding bathing schedule. All shower lists care plans and care cards were revised to reflect resident bathing preferences. All staff were reminded to follow resident bathing preferences. 3. Beginning 01/18/2018: Monitoring through resident rounds and nursing/nursing assistant documentation and adherence to care planned shower preference; observation to continue until 3 consecutive months of 95% compliance met. 4. Nursing to provide compliance data reports to quarterly QA committee.	12/27/2017 1/5/2018 and ongoing 1/18/2018 and ongoing 1/18/2018 and ongoing
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 staff interview and record review the facility failed to maintain an infection prevention program designed to help prevent the development and transmission of communicable diseases and infections. Findings include: 1) On 12/26/17 at 09:10 AM met with staff #2 and staff #51 to discuss the facility's Infection Prevention and Control Program, Antibiotic Stewardship Program and infections that the residents at the facility had acquired. Staff #2 and #51 shared that their Infection Control Consultant (ICC), who compiled the facility's information on infections provides a report to the facility every quarter. The reports reviewed at this meeting	4 203		

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4 203	Continued From page 35 were from the 1st quarter (Jan.-Mar. 2017), 2nd quarter (April-June 2017) and 3rd quarter (July - Sept. 2017). Review of the reports found that the facility had the following infections by quarter: 1st Quarter Month UTI RTI Wound/Skin EENT GI Jan. 1 2 5 0 1 Feb. 2 3 2 0 0 March 1 9 1 0 0 Total 4 14 8 0 1 2nd Quarter Month UTI RTI Wound/Skin EENT GI April 2 4 1 3 0 May 2 2 0 0 0 June 0 1 1 1 0 Total 4 7 2 4 0 3rd Quarter Month UTI RTI Wound/Skin EENT GI July8 10 5 0 0 Aug. 7 10 6 0 0 Sept. 5 3 4 0 0 Total 20 23 15 0 0 Review of this information provided found that the facility had a significant spike in Urinary Tract Infections (UTI), Respiratory Tract Infections (RTI) and Wound/ Skin infections in the 3rd quarter of 2017 (July - Sept.). When compared to the 1st and 2nd quarters the 3rd quarter had a 5 time increase in the number of UTIs going from only 4 in the 1st and 2nd quarter to 20 in the 3rd quarter. Notable increase in the 3rd quarter was	4 203	4 203 1. N/A - No individual residents were identified. 2. All residents will be monitored by nursing staff for infection prevention and control. Residents with infections will be included in weekly Quality of Care Nursing meeting for root cause analysis, trending, and appropriate interventions per infection control policies. The Director of Nursing will be the coordinator of this process as she is the Infection Control Preventionist for the facility and responsible for the Infection Prevention Program. 3. All reports from the Infection Control Consultant (ICC) will be verified with statistical data in the facility for accuracy. Any discrepancies will be immediately reported to the ICC for revision of report. All data from verified reports will be used to develop action plans for the facility. A root cause analysis will be conducted for all statistical data outside of normal limits and interventions, including the development and/or revisions of current infection control policies and procedures, will be implemented. Affected staff will be notified of any new or changes to current infection control policies and procedures. The Director of Nursing will be the coordinator of this process as she is the Infection Control Preventionist for the facility and responsible for the Infection Prevention Program. 4. The Director of Nursing will present all infection control statistics, outside of normal limits, at the Quarterly QA meetings, including any changes to Infection Control Policies and Procedures, for discussion.	2/24/2018 and ongoing 2/24/2018 and ongoing 2/24/2018 and ongoing

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4 203	Continued From page 36 the spike in RTIs going from 14 in the 1st quarter to 7 in the 2nd quarter and 23 in the 3rd quarter making that more than 1.5 times the number of RTIs from the first quarter and more than 3 times the number from the 2nd quarter. Another significant spike in infections was with Wound/Skin infections. There were 8 Wound/Skin infections in the first quarter, 2 in the second quarter and 15 in the 3rd quarter. This makes a more than 2 times the number of Wound/Skin infections in the 3rd quarter compared to the 1st quarter and a more than 7 times the number of Wound/Skin infections when comparing the 2nd and 3rd quarters. It was noted that all of the infections in the ICC's report were identified as facility acquired infections. Upon closer review of the 3rd quarter infections (UTI, RTI and Wound/Skin) report submitted to the facility by the ICC found that there were a high number of URIs and UTIs that occurred on the 4th floor. During interview with staffs #2 and #51 there was no mention of the spike in infections in the 3rd quarter, no mention of a high percentage of the URI and UTI infections occurring on unit 4 and no explanation of a root cause analysis being performed by the facility to find why this was occurring with their residents. During the interview with staff#2 and staff #51 they shared that there was training provided throughout the year with facility staff and provided the training schedule. It was noted that the facility provided Infection Control/Prevention training in February 2017, Blood Borne Pathogens and Diseases training in March 2017 and Personal Hygiene/Infection Prevention/Sanitation training in November 2017. When asked about staff who might have missed this training staff #2 stated that those staff would go through the training binder before the end of the year to make up the	4 203		

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4 203	Continued From page 37 training they missed. When asked if there was any monitoring of staff with hand hygiene and use of PPEs staff #51 stated that this was ongoing with various facility staff involved. When asked about the spike in infections from the 3rd quarter in 2017 and what was being done to bring down the numbers staff #51 stated that they are still in the planning phase of this part of their Infection Control Program. It was noted that staff #51 did show surveyors her documentation of tracking of the identified infections per unit with the antibiotics being used to treat the identified 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 a sanitary environment for their residents, staff and the public. Findings include: 1) On 12/19/17 at 11:28 AM prior to observing resident R #90, who was resting in his bed, went to pull back privacy curtain to introduce self to the resident when it was noted that there were multiple large brown stains on the privacy curtain. Staff, who came to assist R #90, was asked what the facility's procedure is if the resident's privacy curtain is dirty and she was able to state that staff would notify maintenance to take the curtain down and have it cleaned. This staff member was shown the multiple large brown spots on the resident's privacy curtain and she stated that she	4 218	11-94. 1-55 (e) Housekeeping 1) 1. Identified stained curtains were immediately removed and replaced with clean curtains. Stained curtains were sent to facility's laundry department for cleaning. 1/23/2018 2. All resident curtains will be checked for staining by the Maintenance department. Any identified curtains will be immediately removed, replaced with clean curtains, and sent to the facility's laundry department for cleaning. 3. A Preventive Maintenance Program for the resident's curtains will be developed. All curtains will be checked daily for staining. 12 curtains (3 resident rooms) will be changed on a daily basis, in addition to those where staining has been identified. Monthly random audits will be conducted by the Maintenance Supervisor or designee to ensure curtains are free of staining. Any deficiencies will be immediately addressed. 4. Maintenance Supervisor will track deficiencies in the Preventive Maintenance Program for the resident's curtains on a quarterly basis. The goal is to have zero curtains with staining during the random audits. Statistical data will be presented at the Quarterly QA meetings for discussion.	1/23/2018 2/24/2018 and ongoing 2/24/2018 and ongoing 2/24/2018 and ongoing

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4 218	Continued From page 38 would notify maintenance to take care of this. 2) On 12/26/17 at 11:29 AM interviewed staff #17 in shower room B on the 4th floor and quiered what was the black matter that was on the wall, floor and shower head and staff #17 stated that it was "mildew" and that she cleans the shower rooms "after lunch" with a green brush and A-456 II Disinfectant by Ecolab. Staff #17 stated that the staff do not use the shower head when bathing the residents, they use the hand held shower. Staff #17 stated that the "mildew" appears everyday. On 12/26/17 at 01:11 PM met and interviewed staff #9 on the 4th floor, as we walked and looked at shower rooms B and C. Quiered of staff #9 how does the housekeeping staff clean the blackened area between the floor and wall tiles and he stated that they use a grease cleanser and use a green scrub brush. When asked how he takes care of the orange areas below the door frames near the ground, such as the areas in shower room B, he stated that they "dremel it and apply rust-oleum." Based on resident interview, staff interview and review of facility policy the facility failed to provide reasonable care for the protection of resident (R) #40's property from loss. Findings include: On 12/19/17 at 11:49 AM during interview with R #40 he stated he was "missing plenty of items", reported that he was "missing shirts and socks". Res acknowledged that these items were sent to laundry and "never came back." R #40 stated that he reported the loss of items to staff #17 and the staff member told him that she could not find his	4 218	11-94. 1-55 (e) Housekeeping 2) 1. 4th Floor Shower B and C were cleaned immediately removing black matter (mildew) from the walls, floor, and shower heads and the orange areas below the door frames near the ground. 2. All shower rooms will be checked for mildew and staining by the Maintenance department. Any identified areas will be immediately cleaned using approved cleaning products. 3. A Preventive Maintenance Program for mildew and staining in the shower rooms will be developed. A deep scrub of each shower room will be conducted on a bi-monthly basis by the housekeepers. Random audits will be conducted by the Maintenance Supervisor or designee to ensure shower rooms are free from mildew and/or staining. Any deficiencies will be addressed immediately. Housekeepers will continue daily scrubbing of shower rooms. Maintenance supervisor will conduct random audits, at least weekly, to ensure no mildew and/or staining is occurring. Any deficiencies will be corrected immediately. 4. Maintenance Supervisor will track deficiencies in the Preventive Maintenance Program for the shower rooms on a quarterly basis. The goal is to have zero shower rooms with mildew or staining during the random audits. Statistical data will be presented at the Quarterly QA meetings for discussion.	12/29/2017 2/24/2018 and ongoing 2/24/2018 and ongoing 2/24/2018 and ongoing

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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
4 218	Continued From page 39 personal items that were missing. R #40 stated that he reported the loss to staff #17 because she "does the laundry." Review of resident's MDS 3.0 BIMS summary score on his quarterly report dated 10/14/2017 was 15. On 12/22/17 at 08:30 AM interviewed staff #182 who stated that R#40 did not report to her any lost items. Staff #182 was able to provide the facility policy "Lost/ Damaged Article Investigations". On 12/22/17 at 08:34 AM interviewed staff #181 by phone. Staff was able to state the facility's process for laundering resident's laundry. Staff #181 stated that his department picks up the residents personal items, which are separated by the floor staff, and the laundry is washed separately, dried and delivered back to the floor after it is folded. The unit staff then return the clothes to the residents. Staff #181 denies that he was told of R #40's missing personal clothing items by staff #17. After hanging up with staff #181 interviewed staff #53 who denied being told of R#40's missing personal clothing items by resident or staff. On 12/26/17 at 11:29 AM interviewed staff #17 who reported that R#40 did report to her that he had missing clothing items, she had looked through the lost and found items and could not find these items. Staff #17 stated that she reported this to "the nurse" and pointed at staff #53. Review of the facility's policy "Lost/ Damaged Article Investigations" states "Purpose: To ensure any incident of lost or damaged articles are investigated and compensated in a consistent manner." Also "Procedure: 2. Upon reporting of a	4 218	1. A "Lost/Damage Report Form" was completed for all items stated missing by resident. 2. All residents have potential for lost or damaged items. Staff will immediately complete a "Lost/ Damage Report Form" when notified of any lost or damaged items by residents and/or responsible parties. Adjudication of lost/damage items will be done in accordance with existing policy. 3. All staff will receive in-service to review policy and procedures in place for the protection of resident personal property from loss or theft. 4. All "Lost/Damage Reports" will be complete, logged and tracked for trends by the Administrator. Data will be reported to QA Committee on a quarterly basis. Any trends identified will be immediately addressed with appropriate department staff.	12/27/2017 12/27/2017 and ongoing 2/24/2018 12/27/2017 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	12/26/2017

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4 218	Continued From page 40 missing or damaged article, the staff should complete the "Lost/Damage Report Form. 3. The investigation shall include the following. a. The reporter shall provide a clear and detailed description of the lost/damaged article(s). b. The reporter will identify the date and location when article was last seen." The facility failed to provide reasonable care for the protection of resident (R) #40's property from loss and failed to follow the facility policy in reporting and investigating of these lost items.	4 218		