STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125033	A. BUILDING: _____ B. WING _____	02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRY AND JEANETTE WEINBERG CARE CEI	45-090 NAMOKU ST KANEOHE, HI 96744

(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 relicensure survey was conducted in conjunction with Healthcare Management Solution, LLC (HMS) from 02/22/21 to 02/25/21. The State Survey Agency was onsite on 02/24/21. The facility was found not to meet the requirements of the Hawaii Administrative Rules, Title 11, Department of Health, Chapter 94.1, Nursing Facilities. The applicable findings from the recertification survey conducted by HMS have been crossed to the state licensure rules.	4 000		
4 115	11-94.1-27(4) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on observation, interview, and review of the facility's policy, the facility failed to ensure a resident's environment promoted their dignity for one of 12 sampled residents (Resident (R) 24). Observation revealed a sign posted above the resident's bed that detailed the residents assisted	4 115		

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Electronically Signed

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4 115	Continued From page 1 needed for transferring from the bed. Findings include: Review of the facility's policy titled, "Resident Dignity-Rehab/Skilled," revised 10/06/20, revealed, " ...Purpose. To maintain the dignity of all residents ...The location will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality ...k. Maintaining an environment in which there are no signs posted in resident's' rooms or in employee work areas able to be seen by other residents and/or visitors that include confidential clinical or personal information (such as information about incontinence, cognitive status). It is allowable to post signs with this type of information in more private locations such as the inside of a closet or in employee locations that are not viewable by the public ..." Review of R24's undated "Admission Record," located in the resident's electronic medical record (EMR) under the profile tab, revealed the resident was admitted to the facility on 11/08/19 with diagnoses which included unspecified dementia. Review of R24's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 01/20/21, revealed the facility assessed the resident to have a "Brief Interview for Metal Status (BIMS)" score of two out of 15, which indicated the resident was severely cognitively impaired. Observation on 02/23/21 at 12:47 PM of R24's room, revealed a sign posted on the wall above	4 115		

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4 115	Continued From page 2 the head of R24's bed that stated, "Resident is total lift." Observation and interview on 02/24/21 at 2:10 PM with the Charge Nurse (CN) revealed the CN confirmed the sign and stated she was not sure why or how the sign was there. The CN stated the sign should not have been on the wall above the resident's bed unless the resident or the resident's family requested it. The CN also stated this was not home like and did not protect the resident's privacy. The CN removed the sign from the wall. Interview on 02/25/21 at 12:05 PM with the Administrator revealed it was her expectation that any posted information would have been the resident's or resident's family request. The Administrator stated the sign was not the facility's standard and should not have been on the wall because it was a dignity concern. Interview on 02/25/21 at 12:09 PM with the Director of Nursing (DON) revealed it was her expectation that the sign related to R24's care assistance would not have been on the resident's wall above her bed. The DON stated this was not the facility's standard of practice.	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;	4 136		

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4 136	Continued From page 3 (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: Based on observations, interviews, and review of the facility's policy, the facility failed to ensure a resident's nebulizer was properly stored when not in use for one of 12 sampled Residents (Resident (R) 3. Observations on 02/24/21 and 02/24/21 revealed R3's nebulizer machine mask unprotected. Findings include: Review of the facility's policy titled, "Nebulizer-Rehab/Skilled," revised 11/12/20, revealed " ...15. Following medication administration clean nebulizer after each use: ...6. Place mask or mouthpiece and cup on paper towel and air-dry until next use. Cover with clean cloth or towel ..." Review of R3's undated "Admission Record," located in the resident's electronic medical record (EMR) under the profile tab, revealed the resident was admitted to the facility on 08/10/17 with diagnoses which included cough and shortness of breath. Review of R3's undated "Order Summary Report," revealed the residents physician ordered "Albuterol Sulfate Nebulization Solution (2.5	4 136		

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4 136	Continued From page 4 MG/3ML) 0.083% 3 ml inhale orally via nebulizer every 4 hours as needed for SOB [shortness of breath] related to SHORTNESS OF BREATH." Observations on 02/23/21 at 12:45 PM and 02/24/21 at 1:48 PM, revealed a nebulizer machine sitting on R3's nightstand with mask uncovered and unprotected. Observation and interview on 02/24/21 at 2:04 PM with the Charge Nurse (CN) revealed the CN confirmed R3's nebulizer on the resident's night stand uncovered and unprotected. The CN stated the nebulizer should have been cleaned, air dried, and then placed in a bag to protect it from debris and germs. Interview on 02/25/21 at 9:35 AM with the Infection Preventionist (IP) revealed the nebulizer mask should have been bagged after it was cleaned and air dried due to possible infection control issues. Interview on 02/25/21 at 12:10 PM with the Director of Nursing (DON) revealed it was her expectation the nebulizer would have been bagged after it was clean and dried. Interview on 02/25/21 at 12:11 PM with the Administrator revealed it was her expectation the nebulizer mask would not have been left out after use and would have been clean and bagged.	4 136		