STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125048	A. BUILDING: _____ B. WING _____	02/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN PEARL NURSING FACILITY	45-181 WAIKALUA ROAD 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 by the Office of Health Care Assurance from 02/04/21 through 02/17/21. At the time of entrance there was a census of 65 residents. The facility's adult day health services program was not in operation due to the COVID-19 pandemic. The facility was found not to meet the requirements for Hawaii Administrative Rules, Title 11, Department of Health, Chapter 94.1, Nursing Facilities.	4 000		
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 interview with residents and staff member, the facility failed to verbally provide a notice of rights and services prior to or upon admission for a newly admitted resident and the	4 114	This plan of correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission	3/27/21

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4 114	Continued From page 1 facility also failed to ensure residents were provided with a notice of their rights during their stay. Findings include: Resident Council interview on 02/08/21 at 12:04 PM, R54, a new admission, admitted on 01/29/21, stated she does not remember anyone going over Resident Rights upon admission. R16 stated he did not receive a copy of the Resident Rights and R52 stated he does not remember. R16 further noted that the facility may have the Resident Rights posted but does not know where it is located. Interview with Social Worker (SW) on 02/10/21 at 11:16 AM, reported that Resident Rights is briefly reviewed during admission " ...because the admission packet is sixty pages ...we show them where it's at and if they have any question ...," they can go over it with them. The admission packet is reviewed by SW or Social Services Aide (SSA) during admission.	4 114	that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. 4114 Residents 16 and 52 were given copies of the resident rights. Resident 54 no longer resides at the facility. Facility residents have the potential to be affected by the alleged practice. Social Services were re-inserviced by Administrator regarding reviewing residents□ rights with new admissions. Inservices will be ongoing as needed. Residents were reminded in resident council by the Social service Director of where resident rights are posted on each unit. A copy of residents□ rights were placed at each residents□ bedside and will be provided for new admissions on admission by Social Services / designee. Social Services/ designee will monitor/audit with new admissions and resident council where residents□ rights are posted every month x 3 months to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	
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	4 115		3/27/21

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4 115	Continued From page 2 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 observations and interview with resident, the facility failed to treat residents with dignity during dining. Residents who require assistance with their meals were observed to wait for assistance as their meals were set before them. The facility also failed to ensure residents are provided with an environment that is respectful of residents' information as evidenced by staff members communicating via radio regarding residents' personal care. The facility also failed to ensure adequate privacy for residents while using the toilet facilities Findings include: 1) Interview with Registered Nurse (RN) 1 on 02/10/21 at 09:49 AM stated during dining there are three staff members to help with dining and five residents who need assistance during dining. On 02/09/21 at 11:47 AM observed residents with their lunch in front of them. On this unit, there are five residents that need assistance with meals and two Certified Nurse Aids (CNA) and one reliever staff assisting three residents with lunch. R14 was receiving assistance decided she	4 115	Residents 11, 14, 57, and 58 were reassessed for assistance needs with dining. Assistance is being provided as needed to ensure appropriateness and timeliness of meals. Resident 5 was interviewed by Social Services and issues with staff using radios and bathroom with privacy curtains were addressed and resolved. Residents requiring assistance with dining have the potential to be affected by the alleged practice. Facility residents have the potential to be affected by the alleged practices. Staff were re-inserviced on appropriateness of assistance and timeliness of meal service by Staff Development Coordinator / designee (SDC). Inservicing will be ongoing as needed. Facility residents were reviewed for level of assistance by Dietitian / DON /designee. Meal-times were reassessed and addressed as needed. Staff were re-inserviced in the appropriate use of the radios and privacy during toileting by	

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4 115	Continued From page 3 wanted to go on a walk outside before eating her meal, the reliever staff provided supervision during her walk. Observed R57 waiting for assistance with her meal in front of her, her food was uncovered. At 11:55 AM, observed R57 sitting alone and still waiting for assistance. R57 appeared restless and attempted to use a spoon to scoop her food with several failed attempts. At 12:05 PM, observed R14 return from her walk and sit down at the dining table where her meal was left, the reliever staff offered R14 coffee before leaving the unit. At 12:07 PM, observed a CNA finish assisting R58 with her meal and proceeded to assist R57. R57 waited a total of 20 minutes for assistance while her meal was in front of her. At 12:10 PM, observed RN1 bring R11 into the dining room for lunch and provide R11 assistance. At 12:20 PM, R14 is observed looking around waiting for assistance with her meal. R14's meal was served to her at 11:47 AM and returned from her walk at 12:05 PM. At 12:20 PM, approximately 15 minutes later she was still waiting for assistance. 2) Record Review (RR) of R5's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) on 10/28/2020 documents R5's Brief Interview for Mental Status (BIMS) is a 15, indicating R5's cognition is intact. On 02/04/2021 at 10:45 AM, conducted an	4 115	SDC/designee. Inservices will be ongoing as needed. Administrator / DON/ designee will monitor/audit dining 3 x weekly x 12 weeks to ensure compliance with appropriateness assistance and timeliness of meals. Administrator / DON/ designee will monitor/audit radio usage and bathroom privacy 3 x weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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4 115	Continued From page 4 interview with R5. During the interview R5 explained there were several situations which occur frequently which caused R5 to feel embarrassed. R5 stated staff use radios to communicate with each other. When staff communicate over the radio, the resident's room and bed number is used to identify residents. R5 stated he/she feels embarrassed and ashamed when staff uses his room and bed number over the radio and discuss care staff is providing, especially care related to incontinent issues, because other residents are able to figure out who staff is talking about with the identifiers used by staff. R5 shared he/she is able to identify other residents by their room and bed number and feels uncomfortable with information he/she hears over the radio. Additionally, R5 pointed out that the bathrooms in the rooms do not have doors, instead there are curtains which hang from the ceiling. R5 stated the curtains do not provide enough privacy for both the resident using the bathroom and other residents who share the room, especially, when he/she is able to "hear someone making diarrhea and the smell is bad."	4 115		
4 116	11-94.1-27(5) 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:	4 116		3/27/21

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4 116	Continued From page 5 (5) The right to access all records pertaining to the resident, including current clinical records, and to purchase copies of those records at a cost not to exceed community standards; This Statute is not met as evidenced by: Based on interview with resident and staff members and review of email correspondences between facility staff and the resident, the facility failed to ensure a resident was able to exercise the right to access personal and medical records pertaining to him or herself in a form and format as agreed to by the facility and the individual. Findings include: Interview with Resident (R)5 was done on 02/04/21. R5 reported that he requested to view his medical record, signed a paper, and was asked to fill out a release form. R5 further reported facility staff would come to review his medical record when he was sleeping. R5 then requested to schedule a date and time; however, is still waiting to have access to his records. On 02/10/21, the Health Information Management Coordinator (HIMC) provided a copy of R5's request which was signed by the resident on 11/16/20. A review of the "Authorization to Request and/or Release Medical Information" documents the following, "Unless otherwise revoked, this authorization will expire on the following date or event: 11/17/20 (handwritten)". Interview with the HIMC found that initially R5 requested to review the entire record. R5 was unable to pay the fees to obtain a physical copy so R5 narrowed down the time frame for May 2016. The facility was agreeable to allow R5 to	4 116	Resident 5 was given access to review his chart. The Health Information Management (HIM) Coordinator assisted resident. A nurse was available nearby in case the resident had questions. Residents wishing to review their medical record have the potential to be affected by the alleged practice. The HIM Coordinator / Administrator / DON were inserviced by the regional nurse regarding resident□s right to review their medical record. Inservices will be ongoing as needed. Residents may review their records online with written request within 24 □ 72 hours with assistance as needed and a nurse nearby to answer questions as needed. HIM Coordinator / designee will monitor/audit compliance with resident requests to review their medical records every month x 3 months. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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4 116	Continued From page 6 review his medical record on a computer to avoid fees. HIMC and Director of Nursing (DON) arranged to meet with the resident, two times R5 did not respond and didn't want to speak with the DON and the third time he was asleep. HIMC reported R5 does not want the DON to be present while reviewing the medical record; however, the DON reportedly needs to be present to answer any clinical questions. Following the third attempt to meet with the resident, he did not pursue another meeting. HIMC provided copies of email correspondences with R5. On 11/13/20, R5 requested to review his record for the period of 05/06/16 to 05/25/16. Correspondence from HIMC on 11/23/20 from R5 documents question of why HIMC is refusing to get his records and ignores him. HIMC responded on 11/24/20 at 08:26 AM to explain that arrangements have been made to view the records online to avoid charge fee and the DON would be available to review his record. A follow-up to the email of 11/24/20 at 08:40 AM HIMC offers to meet on 11/24/20 at 01:00 PM. On 12/02/20 at 09:44 AM, HIMC reached out to R5 to re-schedule. HIMC documents when they (HIMC and DON) came to meet on 11/24/20 at 01:00 PM, R5 was sleeping.	4 116		
4 130	11-94.1-29(a) Resident abuse, neglect, and misappropriation (a) The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	4 130		3/27/21

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4 130	Continued From page 7 This Statute is not met as evidenced by: Based on a review of the facility's policy and procedures, review of reported allegations of abuse, and interview with staff members, the facility failed to include in their policy and procedure that as mandated reporters, all alleged violations involving abuse, neglect, and exploitation of residents and misappropriation of resident property are reported to Adult Protective Services (APS). The facility did not assure that APS is contacted to determine whether their agency would open and conduct an independent investigation. This deficient practice has the potential for more than minimal harm and is a systemic failure that has the potential to affect a large portion of the facility's residents. The facility did not report two of four allegations of abuse. Findings include: Cross Reference to §11-94.1-29(b). The facility did not report two allegations of sexual abuse to APS for independent investigation. Review of the facility's investigation of an allegation of sexual abuse for Residents 58 and 19 found no documentation of the facility reporting the allegations to Adult Protective Services (APS). A review of the policy and procedure entitled "Abuse Reporting and Investigation" found under the section entitled "Reporting and Timely Investigations", "Any alleged violations should be reported immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious injury or abuse, or not	4 130	Reports on Residents 19 and 58 were called into APS (Adult Protective Services) Both reports were not accepted by APS. Abuse Prevention Policy was updated to include reporting to APS. The Interdisciplinary team (IDT) was inserviced on updated Abuse policy by the Administrator. Facility residents have the potential to be affected by the alleged practice. Facility staff were inserviced on updated abuse policy by SDC/designee. Inservicing will be ongoing as needed. Social Services / designee will monitor / audit incident reporting to ensure APS reporting 3 x weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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4 130	Continued From page 8 later than 24 hours if the events that cause allegation do not involve abuse and does not result in serious bodily injury. Any alleged violations will be thoroughly investigated as well as ensuring the prevention of any further abuse". Furthermore, "The results of the investigation and all reports of abuse must be reported to the Administrator, State licensing agency, resident/guest's physician, as well as the resident/guest's representatively immediately, within 24 hours of the occurrence of such an incident". A review of the Abuse and Neglect power point used for training staff members notes to report to: Administrator/executive Director or Assistant Administrator, Director of Nursing, immediate supervisor, and social service manager or social worker/designee. And if abuse is committed, report to the Professional Licensing Bureau and Attorney General's Office. The training did not include information to report to APS. Interview with the Social Worker (SW) on 02/09/21 at 02:10 PM, the SW reported the facility reports to APS when their investigation results in findings. Further requested a copy of the facility's abuse/neglect policy and procedure that addresses the following: screening, training; prevention; identification; investigation; protection; and reporting/response. On 02/09/21 at 03:31 PM, the Social Worker provided a policy and procedure entitled "Elder Justice Act and Abuse Prevention Policy". Review of the policy and procedures found no procedure to report allegations to adult protective services to determine whether an investigation will be pursued by their agency. On 02/11/21 at 03:00 PM concurrent review of the	4 130		

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4 130	Continued From page 9 policies and procedures related to abuse/neglect provided by the facility were reviewed with the Administrator. The Administrator confirmed the policy and procedure did not include reporting allegations to adult protective services. Further queried whether the facility contacts APS for consultation to determine whether they will open an investigation. Administrator shared the facility doesn't report all allegations to APS. On 02/17/21 during the extended survey, the Administrator provided an updated policy and procedure entitled "Elder Justice Act and Abuse Prevention Policy" which was revised to include for reporting: "Should the investigation reveal that suspected or actual abuse occurred, the Administrator, or appointed designee, must report such findings to the resident/guest's representative, and as required by current State and Federal Laws, to such agencies as the local police department, Ombudsman, APS and the State licensing agency".	4 130		
4 131	11-94.1-29(b) Resident abuse, neglect, and misappropriation (b) All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source or origin, and alleged misappropriation of resident property shall be reported immediately to the administrator of the facility, and to other officials in accordance with state law through established procedures. This Statute is not met as evidenced by: Based on review of the facility's policy and procedures and staff interview, the facility failed to	4 131	Reports on Residents 19 and 58 were called into APS (Adult Protective Services)	3/27/21

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4 131	Continued From page 10 immediately report allegation of abuse to the adult protective services (APS) in accordance with State Law for two of four facility reported incidents related to allegations of abuse. Findings include: Cross Reference to §11-94.1-29(a). As it is not the facility's practice to report allegations of abuse, neglect, exploitation of residents and misappropriation of resident property, the facility's policy and procedure was reviewed. The review found that the policy and procedure does not include reporting the APS. 1) The facility submitted an Event Report to the State Agency regarding an allegation of sexual abuse. On 11/30/19 at 03:20 PM, Resident (R)19 reported a Portuguese guy opened her brief, wiped, and touched her "private part", stating she got "raped" last night. The facility completed an investigation and was unable to substantiate the allegation. A review of the facility's documentation found a thorough investigation was completed. A review of the facility's "Incident Report" and "Event Report" submitted by the facility found this allegation was not reported to APS. A review of the facility's policy and procedure for abuse and neglect entitled "Abuse Reporting and Investigation" found the policy and procedure does not include reporting allegations to APS. On 02/09/21 at 02:59 PM interviewed the Social Worker (SW). SW confirmed a report was not made to APS regarding this allegation. Inquired whether the facility has another policy and procedure for abuse and neglect that includes	4 131	Both reports were not accepted by APS. Abuse Prevention Policy was updated to include reporting to APS. The Interdisciplinary team (IDT) was inserviced on updated Abuse policy by the Administrator. Facility residents have the potential to be affected by the alleged practice. Facility staff were inserviced on updated abuse policy by SDC/designee. Inservicing will be ongoing as needed. Social Services / designee will monitor / audit incident reporting to ensure APS reporting 3 x weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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4 131	Continued From page 11 requirements for screening employees, training of employees, prevention, investigation, protection of resident, and reporting/response. The SW was agreeable to follow up. On 02/09/21 at 03:31 PM, the SW provided a policy entitled "Elder Justice Act and Abuse Prevention Policy". A review of the policy found the facility will encourage residents, families, and staff to immediately report any knowledge of allegations of abuse to Administrator, Director of Nursing, Immediate Supervisor and/or Social Service Director. Also included reporting to law enforcement agency if there is a reasonable suspicion of a crime against a resident (Elder Justice Act of 2010) and reporting to the State Agency. There is no documentation of reporting to APS. 2) Cross reference to F607 On 02/09/21 at 02:19 PM, interview with Social Worker (SW) confirmed that APS was not called for the sexual abuse allegation incident on 06/08/20 regarding R58. SW explained that during their investigation "...there were no findings, that is the reason we did not report it." SW would usually be the person to call APS and if she is not available a Nursing Manager would assist.	4 131		
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:	4 136		3/27/21

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4 136	Continued From page 12 (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: Based on observations, interviews with staff members and record reviews, the facility failed to provide services that address resident's care needs to attain and maintain the highest practicable health and medical status. The facility failed to: 1) assist a dependent resident with their meal; 2) apply splints for residents with contractures; 3) provide adequate supervision for a resident at high risk for falls and secure a resident's smoking paraphernalia; 4) provide interventions to prevent urinary tract infections; and 5) provide services for a resident receiving hemodialysis related to their access site. Findings include: 1) The facility failed to revise Resident (R)47's care plan to address the decline in activities of daily living. Review of R47's progress notes on 01/08/21, R47 was hospitalized on 01/08/21, the progress note stated "...resident standing by door making BM, assisted to toilet and noticed clay colored loose stool. Resident noted with increased generalized weakness r/t inability to stand or walk	4 136	Residents 47, 58, and 164 had care plans developed/updated. MDS Coordinator was re-inserviced regarding care planning by the SDC/designee. Residents 15 and 19 were reassessed by therapy for splinting needs. Care plans updated to reflect splinting schedules. Nursing staff were re-inserviced regarding splinting schedules by SDC/ designee. Resident 6□s cigarettes and lighter are being stored at nursing station. Resident has been inserviced regarding signing in and out the supplies by the SDC/designee. Inservices will be ongoing as needed. R164 has been moved to a green zone and his door is open for easier observation. Both resident care plans have been updated. Nursing staff were re-inserviced regarding smoking safety and high-risk fall assessment / observations while on isolation by SDC / DON / designee. Inservices will be ongoing as needed. Resident 54 no longer resides at the facility. Facility residents have the potential to be affected by the alleged practice.	

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4 136	Continued From page 13 independently. Resident known for refusal of meals and has been strictly consuming supplements only. MD ordered to send resident to an [name of acute facility] for diagnosis hypotension, dehydration, and altered mental status" Review of R47's care plan regarding End-of-Life Care, on 01/09/21, R47 was re-admitted to the facility with hospice services. The hospice diagnosis is senile depression of the brain with behaviors with life expectancy of 6 months or less if disease persists. Review of Resident (R) 47's significant change Minimum Data Set (MDS) with assessment reference date of 01/14/21, in Section G. Functional Status, R47 needs extensive assistance with one-person physical assist in eating. In comparison to R47's previous quarterly MDS with assessment reference date of 10/20/20, R47 required supervision with set-up assistance in eating. On 02/04/21 at 12:12 PM, observed R47 drinking Boost supplement out of a straw in the dining room, during lunch. At 12:23 PM Certified Nursing Assistant (CNA) 38 noticed R47 not eating her meal and verbally cued her to eat while passing by. R47 did not acknowledge the verbal cue. At 12:34 PM, R47 continued to sit at the dining table without eating her food. Second observation on 02/05/21 at 11:54 AM, observed R47 at the dining room, with her lunch in front of her, not eating her meal or drinking the supplement. At 12:01 PM, R47 leaned back on her wheelchair and caught the attention of CNA39, who is assisting another resident. CNA39 attempted to encourage R47 to drink her	4 136	The IDT team was re-inserviced regarding care planning by the SDC or designee. Inservices will be ongoing as needed. Current residents with splints had care plans and schedules reviewed and updated as needed. Nursing staff were re-inserviced regarding splinting schedules by SDC / DON/ designee. Inservices will be ongoing as needed. Current residents were reviewed for potential changes at the weekly risk meeting. Residents who smoke were reassessed to ensure smoking supplies were at nursing station and being signed out/in. Residents on isolation who are at risk for falls were reassessed to ensure observation signage / process was in place. Nursing staff were re-inserviced regarding smoking safety and high-risk fall assessment / observations while on isolation by SDC / DON / designee. Inservices will be ongoing as needed. Current dialysis residents were reviewed for compliance and updates were made as needed. Nursing staff were re-inserviced on documentation and assessment for dialysis residents by the SDC/designee. Inservices will be ongoing as needed. MDS Coordinator / designee will monitor / audit weekly risk meeting to ensure significant change submissions / care planning weekly x 12 weeks to ensure compliance. The DON/designee will monitor/audit splinting / schedules/care plans 3 x weekly x 12 weeks to ensure compliance. The DON/designee will monitor/audit smoking supplies and high fall risk residents on isolation 3 x weekly x	

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4 136	Continued From page 14 supplement. R47 continued to sit at the dining room table without eating her supplement or food. Interview with Registered Nurse (RN) 1 on 02/09/21 at 12:20 PM, RN1 stated, R47 refused her food most of the time and does not need assistance with her meals but needs encouragement or cueing, sometimes hand-over-hand assistance is provided. 2) Resident (R)19 was admitted to the facility on 08/06/15. Diagnoses include unspecified dementia without behavioral disturbance; type 2 diabetes mellitus without complications; hemiplegia and hemiparesis followed by unspecified cerebrovascular disease affecting left non-dominant side; cerebral infarction, unspecified; peripheral vascular disease, unspecified; anxiety disorder; and metabolic encephalopathy On 02/04/21 during the initial tour, observed Resident (R)19 in bed watching television, her left hand was clenched in a fist. At lunch on 02/04/21, R19 was observed in bed with her meal tray (did not observe application of splint/hand roll). On 02/05/21 at 07:40 AM, R19 was being wheeled out of the shower room, observation found there was possible limited range of motion to bilateral lower extremities. On 02/08/21 at 11:00 AM, R19 was observed in bed without a splint/hand roll. Observation on 02/09/21 after breakfast found R19 in bed without a splint. A review of the quarterly Minimum Data Set with assessment reference date (ARD) of 11/12/20 found R19 was coded with functional limitation in range of motion to the upper extremity (impairment on one side) and lower extremity (impairment on both sides). In Section O. Special	4 136	12 weeks to ensure compliance. DON / designee will monitor / audit dialysis residents documentation weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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4 136	Continued From page 15 Treatment and Program, the coding for Restorative Nursing Program found R19 was coded 0 (zero) for the number of days each of the following restorative programs were performed for at least 15 minutes a day in the last 7 (seven) calendar day, passive range of motion, active range of motion, and splint application. A review of the care plan notes contractures to left knee, shoulder, elbow, and lower extremities. The interventions include apply splints as ordered, monitor skin around splints for bruising or pressure, range of motion as tolerated, and therapy evaluation/screening as indicated. R19 has the following physician order: apply left elbow splint and hand roll on at 0900 and off at 1500, twice a day at 0900 and 1700; apply splint left elbow, left resting hand splint on at 1500 off at 1900; apply splint left knee at 0830 and off at 1130; and apply left knee splint one time daily, on at 0830 and off at 1130. On 02/08/21 following observation of resident at 11:00 AM without a splint, an interview was done with Registered Nurse (RN)40 regarding application of splints. RN40 reported physician order for application of splint include left hand and elbow splint on at 09:00 AM and off at 03:00 PM, left elbow on at 03:00 PM and off at 07:00 PM, and knee splint on at 08:30 AM and off at 11:30 AM. RN40 reported R19 does not like the knee splint. RN40 reported the Certified Nurse Aides (CNA) will document application of splints in their software. During the interview, CNA6 was walking by and was asked when is R19's splint applied. CNA6 replied the splint should be on at 11:00 AM to 02:00 PM (this is not congruent with the	4 136		

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physician's order). Subsequently observed CNA6 attempt to apply R19's hand splint. R19's fingers were tightly fisted as CNA6 attempted to extend the resident's fingers to place the splint in her palm, R19 was observed to yell "ouch".

On 02/10/21 with the assistance of CNA40, R19's record was reviewed. CNA40 reported entries are made when R19's splints are applied. Inquired whether the software includes documentation for refusal. CNA demonstrated that they are able to document refusal. Requested for CNA40 to check on 02/09/21 to see whether there is documentation that the splint was applied. CNA40 confirmed there is no documentation of splint application. Further queried whether there is documentation that R19 refused application of splint. There was no documentation of refusal.

On 02/09/21 at 02:38 PM, requested documentation from Director of Nursing (DON) of splint application or range of motion was performed for R19. The DON did not provide documentation; therefore, on 02/10/21 at 11:25 AM, a request was made to the Infection Preventionist (IP) of CNA documentation of splint application and or range of motion was done for R19. No documentation was provided by the DON or IP prior to the team's exit.

3) R15 was admitted to the facility on 02/06/2020 with diagnoses which include cerebral infraction, and hemiplegia and hemiparesis of the left non-dominant side.

On 02/04/21 at 10:00 AM and 12:15 PM and on 02/05/21 at 09:47 AM and 10:20 AM, observations were made of R15 with no splint applied to the left hand. Inquired with R15

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regarding not wearing the splint. R15 stated the splint is in the personal storage located approximately 3-4 feet away from R15's bed and needs staff to get the splint. R15 was aware the splint should be applied and stated they don't always put it on. A sign located on the wall near R15's bed read, Apply splint to L hand.

A review of the quarterly Minimum Data Set (MDS) with and Assessment Reference Date (ARD) of 11/06/2020, notes in Section O. Special Treatments and Programs R15 was coded zero for the number of days the restorative program was performed in the last 7 calendar days for splint or brace assistance, active range of motion (ROM), and passive ROM.

On 02/08/21 at 08:05 AM, conducted a review of the physician orders. The physician orders documents an order to apply compression stocking (left arm) with special instructions for Occupational (OT) to provide left hand splint on at 07:00 AM and off at 1:00 PM was ordered on 07/27/20 and discontinued on 02/06/21 due to R15 being transferred to the hospital.

4) R164 was a 73-year-old male with Type 2 diabetes, chronic kidney disease on dialysis, with long-term current use of insulin. He had peripheral vascular disease, left below the knee amputation, and an unhealing wound on the right great toe. R164 was hospitalized from 01/01/21-01/23/21 for necrosis/gangrene of the right great toe and had an amputation of the toe on 01/19/21. Post-surgery, R164 was discharged back to the facility on intravenous antibiotics. R164 required assistance or supervision for mobility/transfer to his wheelchair and had an unsteady balance. He had documented unwitnessed falls on 10/16/20, 11/16/20,

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4 136	Continued From page 18 11/20/20, and 02/02/21. When R164 returned to the facility he was placed on the unit (Pikake) designated for residents diagnosed with COVID-19, person under investigation (PUI), and new admissions. The facility had implemented additional infection precautions that included closed doors to reduce the potential of transmission of any infection. On observation, it was noted that the doors on the unit did not have a window to observe the residents. During survey, there were no COVID-19 positive or PUI in the facility, and the only residents on Pikake were new admissions who were kept on the unit for a 14 day quarantine. Due to the fact that R164 had a history of multiple falls and identified as high risk for falls, the facility should have conducted a risk/benefit analysis to determine if the door should be closed, or additional measures were needed to reduce the potential for a another fall. RR revealed R164's most recent "Fall Risk Assessment Tool" dated 02/02/21 described him as; "Altered awareness of immediate physical environment, impulsive and lack of understanding of one's physical and cognitive limitations." RR of R164's care plan (CP) documented the problem he was at risk for falls due to generalized weakness and impulsiveness with the start date of 10/22/20. The falls on 11/16/20 and 11/20/20 were documented on the CP, but the 02/02/21 fall was not. RR revealed the CP had been revised after the 11/16/20 and 11/20/20 falls to include the following interventions: 11/24/20: "PT (Physical Therapy) eval for strength training with transfers"	4 136		

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4 136	Continued From page 19 12/04/20: "Trial removing wheelchair from bedside to prevent self-transfer for 3 days (until 12/7/20). If effective, remove wheelchair from bedside permanently. The CP was not revised after the fall on 02/02/21. There was no documentation the three-day trial of removing the wheelchair had been done with the response/effectiveness of the trial. In addition, there was no documentation the PT evaluation had been completed. The facility Director of Nursing (DON) said the facility had a weekly meeting they call the "at risk" meeting discuss residents that are at risk or need additional monitoring. She said it may include residents with history of recurring falls, disruptive behavior, and wounds. The DON said these discussions are not documented in the resident's medical record, but the discipline responsible for implementing any new interventions would implement the intervention and update the CP. Review of the "at risk" meeting minutes revealed the following entries regarding R164: 10/16/20; "Fall on 10/13-phone fell on ground, attempting to catch it." 10/23/20; "2nd fall in week; self-transferring back to bed; stated bed wasn't locked. Unsteady on feet; bed alarm added; personal alarm on w/c (wheelchair). Reminded to call for assistance." 11/23/20; "11/16 Resident self-transferred and had a fall. No injury. Rehab (rehabilitation/PT) screen." When request was made, the facility was unable to produce documentation the PT screen had been completed. On 02/11/21 the facility provided an updated copy	4 136		

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of R164's CP that was revised on 02/09/21 to include the 02/02/21 fall and the intervention "In-house PT evaluation submitted."

Review of the facility policy titled "Falls, Assessing (undated)," directed staff to "Update the Resident's care plan and educate staff members as necessary after a fall."

5) On 02/04/2021 at 12:37 PM, conducted an interview with R6 who was identified as a smoker. During the interview, R6 stated he stores his lighter and cigarettes in a drawer next to his bed. Observed R6 open a drawer (no locking mechanism installed) and show this surveyor a functioning lighter and a pack of cigarettes. R6 confirmed he attends outside dialysis appointment every Tuesday, Thursday, and Saturday from 4:00 PM to 9:30 PM during which the lighter and cigarettes are unattended,

RR of R6's care plan (CP) documented R6 did not have a care plan for smoking. Thus, there were no goals or interventions which identified a R6's capabilities and deficits related to the smoking assessment which was conducted on 06/07/2020.

Review of the facility Smoking policy and procedure states the resident/guest will be required to return smoking material (lighter/cigarettes) to the Charge Nurse or designee upon returning from the smoking area. In an interview on 02/08/2021, the Director of Nursing (DON) confirmed R6's lighter and cigarettes should be not be stored in an unsecured drawer in R6's room and should be turned into staff for safety.

6) Review of R58's progress notes indicated the

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4 136	Continued From page 21 resident had a UTI on 12/24/20 and 01/05/21. Interview with Registered Nurse (RN)1 on 02/08/21 at 02:00 PM stated, R58's last UTI was on 01/05/21. RN1 further explained, R58 has a history of UTI and has frequent orders for urinalysis (UA), " ...whenever she has increase agitation, we check to rule it out ..." When asked what type of UTI prevention care is used for R58, RN1 replied, good peri care, frequent toileting, and encourage 1440 milliliters (mLs) of fluids daily. RN1 was not able to confirm if changes were made to R58's care plan after R58's last UTI on 01/05/21 because she stated she does not know how to navigate the care plan. Interview with Infection Preventionist (IP) on 02/08/21 at 03:25 PM, inquired about interventions used for R58 to prevent UTIs, IP stated that staff encourages R58 to drink at least 1200 ml of fluids daily and to also provide standard peri care. Concurrent review of the resident's care plan, IP confirmed the care plan was not revised after the last UTI on 01/05/21 to include additional interventions and treatment to prevent UTIs. IP also provided suggested interventions that could be incorporated in R58's care plan to provide treatment and prevention, such as encourage fluids, incorporate cranberry juice or use UTI-Stat (A ready-to-drink medical food providing Cranberry Concentrate with added nutrients for UTI health), timely peri care, include Vitamin C, and limit caffeine. Findings include: 7) Resident (R)54 was admitted to the facility on 01/19/21. Diagnoses include: infection following a procedure, unspecified, subsequent encounter; iron deficiency anemia secondary to blood loss (chronic); type 2 diabetes mellitus with diabetic	4 136		

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nephropathy; hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease; dependence on renal dialysis; major depressive disorder, recurrent, unspecified; and atherosclerosis of coronary artery bypass graft(s) without angina pectoris.

Interviewed R54 on 02/05/21 at 09:23 AM. R54 reported she goes to an outside dialysis facility for hemodialysis on Tuesday, Thursday, and Saturday. The facility arranges transportation and there is a communication binder for the facility and the dialysis entity. Subsequent interview with R54 on 02/10/21, R54 reported her access site is not assessed upon her return to the facility.

The facility provided copies of the "Dialysis Communication Record" forms from 01/23/21 through 02/06/21. A review found the dialysis nurse did not complete the documentation related to the access site condition after treatment for the following dates, 01/26/21, 01/28/21, 02/04/21, 02/06/21 and one record that is not dated.

Interview with Registered Nurse (RN)40 on 02/10/21 at 01:30 PM inquired what happens when the resident returns and the communication record is not completed. RN40 responded, the facility will call the dialysis entity and request to complete the form and fax it back. RN40 also reported the resident's access site is assessed upon return to the facility.

Further review found no documentation the resident's access site was assessed on 01/28/21 (this is the same treatment day that the dialysis entity did not document the resident's condition of access site upon completion of treatment).

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4 159	Continued From page 23	4 159		
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on observations, staff interview, and review of the facility's policy and procedure the facility failed to ensure food products were discarded before the expiration date as evidence by an expired bottle of salad dressing and two plastic bags of expired food. The facility also failed to ensure cold food was held at appropriate temperature. Findings include: 1) On 02/04/21 at 08:58, conducted an initial survey of the kitchen with the Food Service Supervisor (FSS). Observed an opened bottle of salad dressing with an expiration date of 12/26/2020 in the main refrigerator. The FSS confirmed the bottle of salad dressing was expired and discarded the bottle. Observed approximately twenty plastic bags with cooked food in the freezer. The FSS stated the bags of food are previously cooked food which are frozen and reheated as an alternative meal for residents.	4 159	Expired products were discarded. Pot roast was discarded. Dietary manager re-inserviced the involved dietary staff. Inservices will be ongoing. Facility residents have the potential to be affected by the alleged practice. Dietitian / Dietary manager / designee re-inserviced the dietary regarding expired food products, labeling and maintaining food temperatures. Inservices will be ongoing as needed. Dietitian / Dietary manager / designee will monitor / audit food products and supplies and food temps 3 x weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	3/27/21

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4 159	Continued From page 24 Observed a plastic bag labeled Ham 11/13 and Stuffed Chicken 12/26. Inquired with the FSS regarding expiration of the bag of ham and stuffed chicken. The FSS confirmed the bag of ham and stuffed chicken should have only been kept for a month after the date written on the bag and the food should have been discarded. 2) On 02/10/21 at 09:40 AM observed kitchen staff preparing lunch. There was a covered metal pan containing cooked pot roast and a smaller plastic container with cubed cooked pot roast. Dietary Staff (DS)5 reported the meat was from the refrigerator and would be heated in the oven for lunch. At this time, there was a pan of scalloped potatoes being heated in the oven. DS5 explained the cubed meat would be used for pureed diets. Requested DS5 to take temperature of the meat. The temperature of the whole pot roast piece and the cubed pot roast was 53 degrees Fahrenheit. Interview with Dietary Supervisor (DS) was done on 02/10/21 at 10:15 AM. The observation of the pot roast sitting out at room temperature and measuring at 53 degrees Fahrenheit was shared. DS responded DS5 usually brings out the meat, chops for puree then heats in a half pan. Inquired whether the expectation is that food items goes from refrigerator to the oven. DS replies, it usually does and was agreeable to follow-up with DS5.	4 159		
4 173	11-94.1-43(a) Interdisciplinary care process (a) A comprehensive assessment shall be completed for each resident by an interdisciplinary team at least annually and	4 173		3/27/21

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4 173	Continued From page 25 updated as appropriate, based on the resident's condition. This Statute is not met as evidenced by: Based on record review (RR) and staff interviews, the facility failed to identify a significant change for 1 (Resident 51) of 20 residents in the sample. Resident (R)51 had two areas of decline in activities of daily living, change in urinary continence and significant weight loss. Findings include: 1) RR for R51 documents he/she was admitted to the facility on 08/23/2019 with a diagnoses including L4 vertebral compression fracture with back pain and a history of Schizophrenia, Hypertension, and Cerebral Infraction due to occlusion or stenosis of small artery, anemia, and anxiety disorder (01/08/2021). On the morning of 09/07/2020, R51 had an unwitnessed fall and was found by staff on the ground beside the commode. Upon initial assessment post fall, staff documented there were no observable injuries. However, R51 did complain of new pain to the left leg. On 09/30/2020 at 11:00 AM, R51 was discharged to the hospital and underwent surgery to repair a left intertrochanteric hip fracture. Post fall documentation described that R51 did not have any visible injuries but did complain of new left leg pain (10/10, severe pain). On 09/07/20, an x-ray was taken, findings documented no hip dislocation, mild hip joint effusion and soft tissue swelling. A second x-ray was done on 09/25/2020 which documented findings of a left hip intertrochanteric hip fracture.	4 173	Resident 51 had a significant change completed and submitted by the MDS Coordinator. Resident 51□s care plan was updated by the MDS Coordinator. MDS Coordinator was re-inserviced regarding the significant change processes and care planning updating by the SDC/designee. Facility residents have the potential to be affected by the alleged practice. The IDT team was re-inserviced regarding the significant change processes and care planning updating by the SDC or designee. Inservices will be ongoing as needed. Current residents were reviewed for potential significant changes at the weekly risk meeting and submitted as needed. MDS Coordinator / designee will monitor / audit weekly risk meeting to ensure significant change submissions / care planning updates weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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4 173	Continued From page 26 Conducted a comparative review of R51's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/23/2020 and quarterly MDS with an ARD of 09/16/2020 for Section G: Functional Status. R51 experienced an overall decline in ability to self-perform activities of daily living (ADLs) and an increase in R51's need for staff support for completing ADLs. For bed mobility and transferring between surfaces R51 required limited assistance with one person physical assist (annual) to increased to extensive assistance with two or more person physical assist (quarterly). R51 required limited assistance with one person assist (annual) for walking in room/corridor to activity did not occur in the quarterly MDS. Locomotion on/off unit, R51 needed supervision only with one person physical assistance (annual) to being totally dependent on staff with one person assist (quarterly). R51 required one person assistance with staff providing only weight bearing assistance with toileting needs (how the resident uses the toilet, commode; transfers on/off toilet; and cleanses self after elimination) to requiring two person assist. Review of Occupational Therapy (OT) daily treatment notes document on 09/07/2020, R51 complained of significant left lower extremity pain and completed supine in bed bilateral upper extremity exercise. On 09/10/2020, R51 was cleared for standing and weight bearing exercises and tolerated treatment well for toilet transfer and bedside commode with four-wheel walker (FWW). On 09/11/2020, documents after R51 attempted to sit up and move his/her legs, R51 refused to continue due to back and left leg pain. On 09/14/2020, R51 complained of severe left lower extremity pain sitting at the edge of the bed, but willing to continue with therapy. Patient	4 173		

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4 173	Continued From page 27	4 173		

required total max assist over feet due to pain. Attempted to stand to pull up over hips, but R51 was unable to stand with assistance due to pain and requested to go back to bed. R51 received pain medication and requested for Charge Nurse to discuss pain management options with the doctor. On 09/15/2020, TO documents R51 has difficulty standing with complaints of left lower extremity (LLE) pain, nursing was informed and R51's progress continues to be limited by decreased standing ability due to LLE pain. On 09/16/2020, despite being pre-medicated for pain with Oxycodone 10 mg, but after LE movement, R51 requested to transfer back to bed. On 09/21/2020, R51 continued to compliant of LLE pain and declined therapy from start of care due to fall. On 09/25/2020, TO treatment was withheld due to pending x-ray results.

Review of nursing progress notes on 09/01/2020 at 07:08 PM, prior to the fall, documented R51 was able to ambulate with a steady gait using a four wheel walker (FWW) with supervision, was observed by staff to ambulate short distances without a FWW, continent, and able to use the bedside commode and toilet. Nursing progress notes on 09/07/2020, post fall, document R51 became unable to change positions in bed, appearing fatigued, had incidents of incontinence, and refused staff's attempts to provide incontinent care despite educations and encouragement. Nursing progress notes post fall documented R51's decline and increased need for staff assistance with transfers, position changes in bed, and decline of care which would require movement of the left lower extremities (LLE).

Review of Section H: Bowel and Bladder. Review of the Annual MDS with an ARD of 07/23/2020, R51 was always continent of bladder and bowel

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4 173	Continued From page 28	4 173		

and did not have any appliances (indwelling catheter, external catheter, ostomy, or intermittent catheterization). However, review of the Quarterly MDS with an ARD of 09/16/2020, documented R51 was intermittently catheterized and had two or more episodes of bowel incontinence and seven or more episodes of urinary incontinence.

Review of R51's physician orders documented an order for a straight catheter, as needed, if no void in 8 hours (started on 07/27/2020, discontinued on 10/07/2020). On 09/09/20, a Foley catheter was ordered due to urinary hesitancy. The Treatment Administration Record (TAR) documented after the fall, R51 needed to be straight cathetered six times (09/09, 09/11, 09/24, 09/25, 09/27, and 09/28).

On 02/10/21 at 01:30 PM, inquired with the Director of Nursing (DON) as to how the facility identifies residents who are at risk for significant changes. DON stated the facility holds "At Risk" meetings which consist of the medical director, administrator, nursing staff, social worker, and dietician. The At Risk meetings review residents at risk for nutrition, with significant weight loss or gain, skin, behaviors, falls, and any other clinical concern. The DON stated R51 significant weight loss was identified and was being addressed by the dietician and MD1. Review of the "At Risk" meeting minutes for 09/11, 09/18, and 09/25 primarily focused on R51's significant weight loss and did not address R51's decline in mobility, increased need for physical assistance with ADLs, or the use of a Foley and straight catheter, and increase in bowel and bladder incontinence.

On 02/10/21 at 10:33 AM, conducted a telephone interview with Nursing Administration (NA)3, who

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4 173	Continued From page 29 is the primary MDS coordinator. NA3 simultaneously reviewed R51's chart during the telephone interview. NA3 confirmed R51 did have changes in bowel/bladder continence, performance/assistance with ADLS, and significant weight loss. NA3 stated according to the Resident Assessment Instrument (RAI) Manual, R51 did experience decline in two or more areas of ADLS and a MDS for significant change should have been completed but was not. Review of the Quarterly MDS with an ARD of 09/16/2020 documented V00200B2 was not completed.	4 173		
4 174	11-94.1-43(b) Interdisciplinary care process (b) An individualized, interdisciplinary overall plan of care shall be developed to address prioritized resident needs including nursing care, social work services, medical services, rehabilitative services, restorative care, preventative care, dietary or nutritional requirements, and resident/family education. This Statute is not met as evidenced by: Based on observations, record review (RR), and staff interviews the facility failed to ensure a comprehensive person-centered care plan was developed with measurable objectives and individualized interventions for 3 of 20 residents in the sample. (Residents 6, 51 and 41). A care plan was not developed for: a resident that smokes; a resident experiencing dental problems, mood, and cognitive loss/dementia; and a resident with wandering behavior. As a result of this deficient practice, residents are at risk of not attaining or maintaining their highest practicable physical, mental, and psychosocial well-being and	4 174	Residents 6, 41, and 51 had care plans developed R6 / smoking care plan, R41 / wandering care plan and R51 / cognition & dementia and dental hygiene. MDS Coordinator was re-inserviced regarding updating care plans by the SDC/designee. Facility residents have the potential to be affected by the alleged practice. The IDT team was re-inserviced regarding care plan updating by the SDC or designee. Inservices will be ongoing as	3/27/21

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4 174	Continued From page 30 potential of a negative impact on the resident's quality of life, as well as quality of care and services received. Findings include: 1) Resident (R)6 was admitted to the facility on 04/15/19 with a diagnoses that includes End stage renal disease, dependence on renal dialysis, peripheral vascular disease, partial traumatic amputation at level between the knee and ankle, and anemia in chronic kidney disease. On 02/02/2020 at 12:37 PM, during an interview, R6 was identified as a resident who smokes. R6 stated staff assist the resident to the smoking area because he often becomes fatigued, especially on the days R6 attends dialysis appointments and needs help with the wheelchair due to below knee amputation. Additionally, R6 prefers to smoke when it is dark outside, between 1:00 AM and 03:00 AM. R6 reported he keeps the lighter and cigarettes in an unlocked drawer next to the bed. R6 later showed this surveyor the lighter and cigarettes. Review of R6's care plan, last reviewed/revised on 02/03/21 at 2:28 PM, did not include a care plan for smoking or interventions related to smoking. On 02/10/21 at 1:35 PM, inquired with the Director of Nursing (DON) if smoking should be addressed in R6's care plan. The DON confirmed R6's did not have a care plan for smoking and it should have been included. The DON stated nursing stores the resident's lighter and cigarettes and was unaware R6 stored kept his in an unlocked bedside drawer.	4 174	needed. Current residents were reviewed for potential care plan updates at the weekly risk meeting as needed. MDS Coordinator / designee will monitor / audit weekly risk meeting to ensure care plan updates weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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4 174	Continued From page 31 Review of the facility's policy and procedure on smoking documents residents who smoke should undergo quarterly reassessment to determine resident's cognitive ability, judgement, manual dexterity, and mobility for safety purposes which will be documented in the care plan to reflect resident's smoking status. Requested copies of all R6's smoking assessments. The DON provided one smoking assessment, completed on 06/07/2020, was not completed within the quarterly timeframe. IN addition, the smoking assessment documented R6 is able to transport self to and from smoking area which is not congruent with R6's reported ability. 2) R51 was admitted to the facility on 08/23/2019 with a diagnoses including L4 vertebral compression fracture with back pain and a history of Schizophrenia, Hypertension, and Cerebral Infraction due to occlusion or stenosis of small artery, anemia, and anxiety disorder (1/08/2021). Review of R51's most recent quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/16/20, in Section V. Care Area Assessment (CAA) Summary, no care areas were identified. A review of R51's most recent annual MDS with an ARD of 07/23/20, Section V. CAA Summary, documented cognition loss/dementia and dental care were triggered in the CAA and the interdisciplinary team (IDT) decided to develop a care plan for those areas. Review of R51's medical records documented on 8/28/20, R51's tooth (top front tooth) fell out while eating breakfast. R51 did not have any pain or discomfort. Review of R51's comprehensive care plan, last reviewed/revised on 02/04/21, documented there	4 174		

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4 174	Continued From page 32 is no care plan of individualized interventions for cognition loss/dementia or dental care. Also, there is no no documentation regarding assessments and the facility's rationale for not proceeding with care planning for cognition loss/dementia and/or dental care. 3) On 02/04/21 at 12:19 PM observed R41 finish his meal and leave the dining room after lunch. R41 attempted to enter an all-female room, with a stop banner across the door. Registered Nurse (RN) 1 struggled to redirect R41 and tell him it is not his room. R41 continued to stand in front of the room. At 12:21 PM, while RN1 attended to another resident in the hallway, R41 tore down the stop banner and attempted to go in the room again. RN1 returned to R41 to redirect him again, by reminding him that his room is elsewhere, and she will help him find his room. R41 put his foot down on the ground to prevent RN1 from to pushing his wheelchair away from the room. R41 attempted two more times to go in the room with failed redirection from RN1. RN1 called another staff for assistance who asked R41 if he wanted to rest and successfully redirected him to his room. Interview with RN1 on 02/04/21 at 9:13 AM, inquired about the stop banner in front of the female rooms. RN1 stated it is to prevent three of the male residents from wandering into the females' rooms. RN1 included R41 as one of the male residents who wander. Review of R41's quarterly Minimum Data Set (MDS) with an assessment reference date of 12/30/210, Section E 0900. Wandering-Presence & Frequency, behavior of this type occurred daily, wandering in the past 7 days. Review of R41's annual MDS with an assessment reference date	4 174		

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4 174	Continued From page 33 of 10/02/20, in Section V. Care Area Assessment, Behavioral Symptoms was triggered for wandering and the interdisciplinary team decided to develop a care plan for wandering. Review of R41's care plan last reviewed/revised on 01/03/21, there is no care plan with interventions individualized and address R41's wandering behavior.	4 174		
4 175	11-94.1-43(c) Interdisciplinary care process (c) The overall plan of care shall be reviewed periodically by the interdisciplinary team to determine if goals have been met, if any changes are required to the overall plan of care, and as necessitated by changes in the resident's condition. This Statute is not met as evidenced by: Based on observations, interviews and record review (RR) the facility failed to ensure that six (Residents 25, 164, 58, 126, 51, and 47) of a sample size of 20 had their comprehensive care plans reviewed and revised by an interdisciplinary team (IDT) who had knowledge of the resident and their needs. There was lack of evidence the CP was evaluated for effectiveness and revised following the IDT meetings. As a result of this deficient practice R25 had ongoing negative behavior; R164 was at risk of additional falls; R58 did not have additional interventions implemented to reduce the potential for recurring urinary tract infection (UTI); R51 fell and experienced increased pain, increased weight loss, decrease in range of movement (ROM) of the left leg and a decline in mobility of the left leg; and R47's decline in eating were not addressed. Also, for	4 175	Residents 25, 47, 51, 58, and 168 had care plans developed/updated. Resident 51 had a significant change completed and submitted by the MDS Coordinator. MDS Coordinator was re-inserviced regarding the significant change processes and care planning by the SDC/designee. Facility residents have the potential to be affected by the alleged practice. The IDT team was re-inserviced regarding the significant change processes and care planning by the SDCor designee. Inservices will be ongoing as needed. Current residents were reviewed for potential significant changes at the weekly	3/27/21

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4 175	Continued From page 34 R126 there was no participation by nursing in the development of the resident's care plan. There is potential that the lack of CP revisions could affect any resident in the facility and prevent them from reaching their highest practicable physical, psychological and social well being. Findings include: 1) R25 is an 87-year-old with a history of a stroke, intracranial hemorrhage, severe dementia with combativeness and chronic impairment in activities of daily living. He receives anti-anxiety and antidepressant medication for episodes of agitation, crying, yelling, and hitting staff. R25 had impaired decision making related to impaired cognition from the stroke. He required assistance to ambulate and was out of bed daily in a wheelchair for meals and activities. During the survey, there were three observations of R25 spitting. Two occurrences on 02/04/21 and one on 02/10/21. On 02/04/21 at 12:30 PM, observed R25 sitting in a wheelchair with an overhead table positioned over him in the hallway by the nursing station. R25 expelled an inordinate amount of bubbly saliva on the floor which covered an area of the hallways approximately two foot by two foot, as well as on the floor under the overbed table, on the overbed table legs, and the table extension arm. At that time, observed the RN partially clean the bodily fluid up. On 02/05/21 at approximately 01:45 PM during an interview with the Housekeeper (HK)1, inquired if she had cleaned up the spill the previous day, and she said, "Yes, it wasn't a problem, I'm use to it, it happens a lot with him (R25)."	4 175	risk meeting and submitted as needed. MDS Coordinator / designee will monitor / audit weekly risk meeting to ensure significant change submissions / care planning weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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4 175	Continued From page 35 RR of R25's CP revealed the problem "Resident with behavior of coughing and spitting sputum on floors and walls" was added on 11/19/20. The short-term goal with the target date of 12/02/20 was "Spitting behaviors will resolve with treatment." The following approaches were added: Administer medications as ordered. Update NP (Nurse Practitioner)/MD (physician) if ordered interventions are ineffective: 11/18/20 Glycopyrrolate 1 mg (milligram) PO (oral) q (every) 12 hours x 3 days see T.O. (telephone order) . . . Glycopyrrolate 1 mg po q 12 hours (H) PRN (as needed) dx: Hypersecretion. See T.O. Attempt non-pharmacological interventions. Treatment as ordered. Update NP/MD if ordered interventions are ineffective: Oral care TID (three times a day). See T.O. There were no specific non-pharmacological interventions identified in the CP last revised 12/03/20 for nursing staff to implement to help control the behavior. RR of the physician (MD)3 progress notes on 11/18/20, revealed that following entry; "Today, staff asked patient (R25) to be seen for excessive spitting and F/U skin rash... Per staff patient recently seen increased spitting onto the facility floor. Per staff patient in a day will spit enough to cover ~ 25% of the wing's floor. Staff constantly cleaning." MD3 documented; "Disturbance of salivary secretion. Increased amount of spitting. Plan: -Monitor -Oral care Q (every) shift and PRN -Glycopyrrolate 1 mg PO Q 12H (hours) x 3 days, then Q 12H PRN. On 02/09/21 at approximately 10:30 AM, during an interview with the RN3, she said she thought R25's spitting was a behavior issue versus	4 175		

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4 175	Continued From page 36	4 175		

hypersalivation. When asked why she felt it was behavioral, RN3 said, "He does it when he gets bored and is left alone. We got an order for medication at one time, quite a while ago. I think the PRN (medication) had a stop date (no longer active order). I don't think it was used a lot." When inquired why, RN3 said, "I don't have an answer for that." RN3 said she thought there were better ways, other interventions that would be better than medication. When asked what these would be, she said, "He likes to sing, be wheeled around. Everyone takes turns when they can." Asked RN3 if she had discussed this with anyone, and she said she had not. RN3 went on to say she thought the family had paid for a 1:1 sitter at one time but could not continue to pay. RN3 said, "There aren't enough staff to get to him as there are other higher priorities."

RR of the care planning meeting documented on the Observation Detail List Report dated 02/02/21 revealed there was no discussion of R25's spitting behavior, or that MD3 saw him at the request of the nursing staff and provided new medication orders with the request to monitor for effectiveness. The attendance at that care planning meeting was not documented, but notes were entered by Dietary, Activities, and Social Services. There were no notes or indication that nursing had a representative at that meeting.

R25's behavior of spitting continued, yet the frequency and amount had not been monitored and documented by nursing staff. There was no indication the behavior had been discussed at the CP meetings or that the CP had been reviewed or revised. The problem continued without being properly addressed.

2) RR of R164's CP documented the problem at

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4 175	Continued From page 37 risk for falls due to generalized weakness and impulsiveness with the start date of 10/22/20 after a fall on 10/16/20. The falls on 11/16/20 and 11/20/20 were documented, but the fall on 02/02/21 was not. RR revealed the CP had been revised after the 11/16/20 and 11/20/20 falls to include the following interventions: 11/24/20: "PT (Physical Therapy) eval for strength training with transfers" ; 12/04/20: "Trial removing wheelchair from bedside to prevent self-transfer for 3 days (until 12/7/20). If effective, remove wheelchair from bedside permanently. The CP was not revised after the fall on 02/02/21. There was no documentation the three-day trial removing the wheelchair had been done with the response/effectiveness of the trial. In addition, there was no documentation the PT evaluation had been completed. The facility Director of Nursing (DON) said the facility had a weekly meeting they call the "at risk" meeting to discuss residents that are at risk or need additional monitoring. She said it included residents with a history of recurring falls, disruptive behavior, and wounds. The DON said the discussions were not documented in the resident's medical record, but the discipline responsible for implementing any new interventions would update the CP. Review of the "at risk" meeting minutes revealed the following entries regarding R164: 10/16/20; "Fall on 10/13-phone fell on ground, attempting to catch it." 10/23/20; "2nd fall in week; self-transferring back	4 175		

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4 175	Continued From page 38 to bed; stated bed wasn't locked. Unsteady on feet; bed alarm added; personal alarm on w/c (wheelchair). Reminded to call for assistance." 11/23/20; "11/16 Resident self-transferred and had a fall. No injury. Rehab (rehabilitation/PT) screen." When request was made, the facility was unable to produce documentation the PT screen had been completed. Review of the facility's policy titled "Falls, Assessing (undated), directed staff to "Update the Resident's care plan and educate staff members as necessary after a fall." On 02/11/21 the facility provided an updated copy of R164's CP that was revised on 02/09/21 to include the 02/02/21 fall and the intervention "Inhouse PT evaluation submitted." 3) The MDS (minimum data set) forms the foundation of a comprehensive assessment and is completed for all residents. On 02/10/21 during a telephone interview with the MDS coordinator (MDSC), she said she relocated to the Big Island in October, and the facility was training a new MDSC. The MDSC went on to say when an assessment is completed, the areas that require in person assessment are done by nursing at the facility. The MDSC reviewed the documentation of R126's care planning meeting on 02/02/21 and confirmed there was no documentation by nursing or notation a nursing representation was present. When asked whose responsibility it was to attend and update the CP, the MDSC said, "It was my understanding the plan was for the DON (Director of Nursing) to do it during the transition."	4 175		

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4 175	Continued From page 39 On 02/08/21 during an interview with the DON, reviewed the CP meeting document (Observation Detail List Report) for R126 dated 12/02/20. The DON agreed the meeting did not have attendance documented or notes from a nursing representative. The DON said she was not familiar with the new care planning template/form and had not used it. The form had an area to indicate the CP was in place and reviewed, which was blank. The form also had areas to document code status reviewed, pain, and restraint use with review of risks/benefits. All these areas were blank. The DON said she would have to "check with RN20, as "she is the one that usually attends those meetings." Inquired how the facility coordinates the meetings with the MDSC not on site, and how she ensures a nursing representative is present and CP's are updated. The DON said they had divided the responsibilities to gather the data for the MDS assessments amongst the nursing administrative team. The DON later provided a document titled "Interim Plan for MDS," which assigned responsibility to individuals to collect assessment data as well as other tasks. The interim plan identified the DON responsible to complete the pain assessment, and RN20 was responsible to attend the care planning meetings and "Update Care Plan Meeting form in Matrix (new electronic medical record system)." The care plan meetings lacked sufficient documentation that comprehensive assessments were coordinated and that all areas were assessed. With the absence of a MDSC on site and the change of computer systems, the interim plan was not monitored to ensure comprehensive assessments, planning and revisions were documented in the medical record and the CP.	4 175		

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4 175	Continued From page 40 4) R51 was admitted to the facility on 08/23/2019 with a diagnoses including L4 vertebral compression fracture with back pain and a history of schizophrenia, hypertension, and cerebral infraction due to occlusion or stenosis of small artery, anemia, and anxiety disorder (1/08/2021). RR of R51's quarterly MDS with an ARD of 09/16/2020, documented in Section V. Care Area Assessment (CAA) Summary, Section V02000A and V0200B, no care areas were triggered, and no care areas were developed in the care plan. Review of R51's most recent annual MDS with an Assessment Reference Date (ARD) of 07/23/20, Section V. Care Area Assessment (CAA) Summary, Section V02000. CAA and Care Plan (CP) decision, documented cognition loss/dementia, urinary incontinence, mood state, falls, nutritional status, dental care, pressure ulcer, psychotropic drug use, and pain triggered and was identified to develop a care plan. Conducted a RR of R51's care plan (CP), last reviewed/revised on 02/04/21, documented care plans for urinary incontinence, falls, nutritional status, psychotropic drug use, and pain were not developed and implemented on R51's comprehensive care plan with interventions and measurable timeframes within 7 days after the completion of the comprehensive assessment. Urinary incontinence was developed in the care plan on 09/17/20, falls on 09/07/20, nutritional status on 08/28/20, psychotropic drug use on 10/14/20, and pain on 08/04/20. Requested documentation of R51's care plan conferences for July 2020 to October 2020 from the Director of Nursing (DON). The facility provided the August 2020 Care Conference. Review of the August 2020 care conference,	4 175		

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4 175	Continued From page 41	4 175		

conducted on 08/05/20, did not include documentation of the IDT team's rationale for not developing a care plan for the care areas identified in the annual MDS (ARD 07/23/20). Disciplines which participated in the August Care Conference included social services, activities, dietary, and nursing. The DON stated the facility has weekly "At Risk" meeting which discuss residents that are at risk or need additional monitoring. The DON stated it included residents who are monitored changes, residents with history of risk, and residents who experience significant changes. The DON said the discussions were not documented in the resident's medical record, but the discipline responsible for implementing any new interventions and update the CP.

Review of R51's medical records did not document the IDT team's decision to not develop a care plan for the care areas identified in the annual MDS (ARD 07/23/20). Progress notes documented R51 had an unwitnessed fall and was found on the ground beside the bedside commode on 09/07/20. As a result of the fall, R51 had a decline in mobility and range of motion (ROM), significant weight loss of due to loss of appetite, bowel and bladder incontinence, use of a straight and Foley catheter related to new severe left leg pain which started as a result of the fall. On 09/30/20, R51 was subsequently transferred to the hospital for a left hip fracture which required an open reduction and internal fixation (ORIF) with long medullary nail.

Review of R51's Medication Administration Record (MAR) documented an order for Aripiprazole 10 mg, once a day, was ordered on 07/27/20 for diagnosis of Schizophrenia. A care plan for psychotropic drug use was not developed

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4 175	Continued From page 42 and implemented until 10/14/20. The MAR also documented an order for Tramadol 100 mg, three times a day; Acetaminophen 1000 mg as needed three times a day; Oxycodone 10 mg, every four hours as needed, for moderate/severe pain 8-10/10; Oxycodone 5 mg every 4 hours as needed for mild pain 6-7/10 (all started on 07/27/20 and discontinued on 10/07/20). Pain was not developed on the care plan until 08/04/20. Review of the facility policy titled "Care Planning", last updated 01/10/10, documented "The care plan should be developed no later than seven (7) days following the completion of the comprehensive assessment." 5) Review of R58's progress notes indicated the resident had urinary tract infections (UTIs) on 12/24/20 and 01/05/21. Review of R58's care plan regarding "Potential for infection r/t (related to) UTI" started on 12/29/20 and last reviewed/revised on 02/04/21, found no revised interventions to prevent or provide treatment for UTI after R58's last UTI on 01/05/21. Intervention included in the care plan starting 12/29/20 is "Offer PO (oral) fluids." Interview with Infection Preventionist (IP) on 02/08/21 at 03:25 PM, and concurrent review of the resident's care plan, IP confirmed the care plan was not revised after the last UTI on 01/05/21 to include additional interventions and treatment to prevent UTIs. IP also provided suggested interventions that could be incorporated in R58's care plan to provide treatment and prevention, such as encourage fluids, incorporate cranberry juice or use UTI-Stat	4 175		

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4 175	Continued From page 43 (A ready-to-drink medical good providing Cranberry Concentrate with added nutrients for UTI health), timely peri care, include Vitamin C, and limit caffeine. 6) R47 was hospitalized on 01/08/21 and readmitted to the facility with hospice services. A comparison of R47's Minimum Data Set (MDS) for significant change with assessment reference date of 01/14/21 and quarterly MDS with assessment date of 10/20/20 notes a decline in eating. R47 went from requiring supervision with set up to extensive assistance with one-person physical assist. Interview with Registered Nurse (RN) 1 on 01/09/21 at 12:20 PM, RN1 stated, R47 refused her food most of the time but does not need assistance with her meals. She " ...needs encouragement or cueing, we sometimes do hand-over-hand ..." assistance. Review of R47's care plan for ADL (Activities of Daily Living) Functional/ Rehabilitation start date 07/27/20 and reviewed/revised date on 01/23/21 does not address R47's change in function, requiring extensive assistance with one-person physical assist with eating. The approach for eating continues to be "Assist of 1 Cue ..."	4 175		
4 195	11-94.1-46(l) Pharmaceutical services (l) All drugs, including drugs that are stored in a refrigerator, shall be kept under lock and key, except when authorized personnel are in attendance. The facility shall be in compliance with all security requirements of federal and state laws as they relate to storerooms and	4 195		3/27/21

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4 195	Continued From page 44 pharmacies. This Statute is not met as evidenced by: Based on observations and interviews with staff members, the facility failed to ensure one of the medication storage rooms was locked. The Illima medication room was observed to have the door wide open and not secured. This allowed access to medications not stored in the locked refrigerator or cabinet to unauthorized individuals. As a result of this deficient practice medications are accessible to unauthorized individuals including residents who potentially may ingest medications that could cause significant adverse consequences. Findings include: 1) On 02/08/21 at 03:15 PM observed the Ilima nursing station door open with no staff in the station. On entry to the nursing station, observed the medication room door wide open, which allowed access to all unlocked medications as well as supplies in the room, which included syringes and intravenous fluids. The medication room contained bins of multiple bottles of medication on both counters visible on entry to the room. The room had a small refrigerator with medications that was also not locked and accessible. After approximately 5 minutes, RN5 entered the station and noticed surveyor inside the medication room. At that time asked RN5 if he had forgotten to lock the medication room. RN5 said he thought the other nurse was there. RN5 said he was unaware that both the nursing station and medication room doors had been left open.	4 195	Medication room door was secured. Albuterol inhaler was discarded. New one was opened and dated. Nurses involved were inserviced by SDC/designee. Inservices will be ongoing as needed. Residents receiving medications have the potential to be affected by the alleged practice. Licensed nurses were re-inserviced on medication labeling and med room security by the SDC/designee. Inservices will be ongoing as needed. DON / designee will monitor / audit medication labeling and med room security weekly x 12 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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4 203	Continued From page 45	4 203		
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 observations, interviews, and record reviews, the facility failed to establish a prevention control program to provide safety and protection for the residents of the facility. Immediate Jeopardy (IJ) was identified on 02/09/21 at 01:06 PM, the facility failed to isolate and place a resident on droplet precautions when the resident presented with signs and symptoms (fever, nausea, vomiting, and chills) of COVID-19 and screened positively for a person under investigation. The facility's noncompliance could result in serious adverse outcomes (spread of COVID-19 to facility staff and other residents and possibility of COVID-19 related deaths). The need for immediate action was required to prevent a COVID-19 outbreak. The facility also failed to assure: residents were prevented from entering the yellow zone (unit reserved for newly admitted residents or residents under investigation for COVID-19; staff members did not don and doff appropriate personal protective equipment while on the yellow zone; staff member did not demonstrate proper technique for cleaning of bodily fluids; staff member utilized proper hand hygiene practices; proper set up of room for resident on contact	4 203	Resident 15 and roommates were tested for COVID and all were negative. Facility staff and physician were inserviced regarding following the mitigation plan by the DON/SDC/designee. Resident 32 did not enter the yellow zone. Residents are redirected from entering yellow zone by any staff member as needed. Staff were inserviced regarding not allowing entrance into yellow zones by the DON/SDC/designee. RNs 3 and 6 were counseled and re-inserviced regarding infection control measures, PPE, and cleaning up spills by the DON/SDC. Resident 25□s activity supplies are now stored appropriately. Resident 30□s trash bins were relocated. Administrator and Social Services were re-inserviced by the regional nurse regarding appropriate locations for resident council. Thickener was discarded and replaced with individual serving packages. Facility residents have the potential to be affected by the alleged practice. Facility staff were inserviced regarding	3/27/21

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4 203	Continued From page 46 isolation (the biohazard bin for doffing personal protective equipment was placed outside of the room); storing activity item in an unsanitary location; and storing scoopers in powder. Findings include: 1) R15 was admitted to the facility on 02/26/20 with a diagnoses which include cerebral infarction with hemiplegia and hemiparesis affecting the non-dominant side, dysphagia, Type 2 diabetes mellitus with hyperglycemia, hyperlipidemia, and hypertension. On 02/05/21 at 07:55 AM, observed Certified Nurse Aide (CNA)23 exiting R15's room with an emesis basin. CNA23 later confirmed R15 had vomited and was not feeling well. During the observation, this surveyor noted there were no isolation precaution or droplet precaution signs posted outside of R15's room. In addition, staff did not don the personal protective equipment (PPE) while assisting R15 and roommates and no PPEs located outside of R15's room for staff use. On 02/08/21 at 09:00 AM, reviewed R15's medical record. It was documented in the progress notes on 02/05/21 at 07:36 AM, R15 first presented with two (2) episodes of emesis, a temperature of 99.6° Fahrenheit (F), nausea, and chills. At 7:30 PM, R15 had emesis, temperature of 100.9°F, staff administered Acetaminophen 650 mg, and rechecked R15's temperature (99.5°F). At 11:45 PM, R15 had a fourth episode of emesis and a temperature of 101°F. Nursing staff administered a COVID-19 test on 02/06/21 at 00:29 AM which was negative. On 02/09/21, conducted a review of R15's COVID-19 Screening Tool, completed by the	4 203	infection control practices, mitigation plan, zoning for isolation, donning and doffing PPE, appropriate PPE, and cleaning of spills by the SDC/DON/designee. Inservices will be ongoing as needed. Administrator / DON / SDC / designee will monitor and audit infection control practices and adherence to the mitigation plan daily x 12 weeks. The results of these audits will be brought to QAPI monthly x 3 months for review and recommendations.	

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4 203	Continued From page 47 Infection Preventionist (IP) on 02/05/21, due to R15's elevated temperature, vomiting, nausea, and chills. The screening tool evaluates four (4) clinical features and epidemiological risk, which includes other symptoms associated with COVID-19 and at risk for severe disease. The IP circled chills and nausea/vomiting as other symptoms. According to the evaluation instructions R15 should have been considered a positive screen for a person under investigation (PUI). If the screen is positive, staff is prompted to first report findings the primary care physician (PCP), IP, Medical Director (MD), and the Director of Nursing (DON) to determine if criteria is met for PUI, then isolate the resident. On 02/09/21 at 09:15 AM, conducted an interview with the DON and the IP. It was initially explained to this surveyor the screening tool includes a dialogue with the MD and PCP then they use the tool to decide if the resident is a PUI. However, later in the interview, the IP stated the screening tool is used to assist nursing staff with reporting to the physician in an SBAR (Situation, Background, Assessment, Recommendation) format. Inquired if there is a process for completing the COVID-19 Screening Tool in the facility's COVID-19 Mitigation Plan. IP stated the COVID-19 Screening Tool is just a tool used to identify if the criteria for a PUI is met. If they are identified as a PUI then they are isolated for suspected COVID-19. Inquired if staff should immediately isolate a resident who presents with signs and symptoms associated with the COVID-19 virus, prior to calling the MD, PCP, IP, and DON to immediately contain the potential spread of the COVID-19 virus to staff and other residents. The IP and DON confirmed R15 was not immediately isolated and had R15 tested positive for the virus, there was the potential for	4 203		

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4 203	Continued From page 48 an outbreak of the COIVD-19 virus throughout the facility. On 02/09/21 at 10:39 AM, conducted an interview with the Medical Director (MD)2. Inquired with MD2 the process used to identify a potential PUI. MD2 stated staff report a resident's symptoms to the resident's PCP and the MD, then it is determined if the resident is a potential PUI. Inquired how the MD uses the facility's COVID-19 Screening Tool in determining a potential PUI. MD2 stated that prior to the surveyor mentioning the COVID-19 Screening Tool, MD2 was unaware the facility had implemented a COVID-19 screening tool or that staff was using it to evaluate residents. Inquired about identifying R15 as a potential PUI, MD2 stated R15 was not initially identified as a potential PUI because R15 did not have any respiratory symptoms and was not immediately concerned that R15's fever, vomiting, nausea, and chills are associated with the COVID-19 virus. MD2 stated the presence of respiratory symptoms is an important symptom when evaluating a resident for COVID-19. Inquired regarding the decision to test for the COVID-19 virus almost seventeen (17) hours after the onset of R15's symptoms. MD2 stated R15 had two (2) recorded temperatures over 100°F which prompted the testing to rule out COVID-19. MD2 also stated although COVID-19 was considered at first, maybe it should be considered initially for all residents, due to the wide range of different signs and symptoms a resident could experience. Additionally, MD2 stated, maybe a COVID-19 test should be implemented as a routine response to immediately rule out COVID sooner than later. If R15 had tested positive for the COVID-19 virus, it could have meant a facility wide outbreak. MD2 confirmed a resident should be isolated and	4 203		

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4 203	Continued From page 49 droplet precautions implemented prior to contacting the doctors to evaluate if a resident is a PUI. Review of the facility's COVID-19 Risk Mitigation Plan (revised 12/30/2020) documented a resident is only isolated and droplet precautions implemented once a resident is identified as a PUI. Additionally, the COVID-19 Screening Tool was not in the mitigation plan. The facility was notified of the Immediate Jeopardy (IJ) on 02/09/21 at 1:06 PM. The facility provided an acceptable plan for removal of the IJ on 02/09/21 at 4:46 PM to the survey team. The corrective measure included: 1) Inservice for nursing staff regarding COIVD-symptoms, testing, isolation and reporting on 02/09/21. Inservice will be ongoing as needed. Nurses will not be allowed to work until training is completed; 2) Residents will be assessed every shift for signs/symptoms (s/sx) of COVID. If temperature is greater than 100°F or two or more other symptoms are present, residents will be given a point of care (POC) test and isolated as indicated by testing. Other symptoms include: Temperature greater than 100, chills, muscle/body aches, headaches, sore throat, nausea/vomiting, new loss of taste, fatigue, congestion/runny nose, and diarrhea. If positive resident has roommates, other roommates will be isolated for 14 days and will be tested every 4-5 days while quarantined. If asymptomatic and negative on the 14th day, then isolation will be terminated; 3) DON/IP/RCM will monitor for compliance through auditing vital sign sheets, medical record documentation and COVID-19 screening tools daily for a minimum of 12 weeks or until compliance is achieved; and 4) Audits will be a part of the Quality Assurance Performance	4 203		

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4 203	Continued From page 50 Improvement Committee for a minimum of 3 months or until substantial compliance is achieved. 2) The facility developed a COVID-19 plan that would immediately isolate a positive COVID resident from the other residents. The plan was to utilize room 126 in the designated COVID unit area, Pikake (rooms 125-127). The plan included, "If needed to expand the COVID unit, we would relocate the residents from rooms (122-124) . . ." One of the strategies to prevent transmission was to place new/readmissions and PUI's under observation (quarantine) in these rooms to be monitored for signs and symptoms of COVID-19. When the unit does not have any positive COVID-19 residents, it is designated as a "Yellow zone" which required additional transmission-based precautions and was considered a restricted area to authorized staff only. No resident or visitor were to enter the area without face shield/eye protection and mask. The facility had a Courtyard accessible to residents to go outside. Some residents were assisted to the Courtyard area by staff and others had the ability to self-propel in the wheelchair or ambulate. The Courtyard had two walkways that had a door at each end. Two of the doors opened into the recreational lanai area and the other two open directly into the hallway of the Pikake unit. On 02/09/21 at 01:14 PM, observed R32 entering the Pikake unit through one of the Courtyard doors. R32 was in a wheelchair unaccompanied and self-propelled himself to the door, opened it and was preparing to enter the unit. There were no unit staff visible in the area. A dietary staff member saw R32 trying to get in and assisted	4 203		

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4 203	Continued From page 51	4 203		

him. On entry, R32 did not appear familiar with his surroundings and the dietary staff realized he was in the wrong unit, assisted him back through the courtyard door and to the other side of the facility.

3) The IP said the facility requirement for transmission-based precautions for personal protective equipment, (protective items or garment) to prevent cross contamination in the yellow zone included gown, mask, face shield and gloves when entering the resident room. PPE equipment was available outside each room on the Unit and the staff had been provided with face shields.

On 02/10/21 at observed RN6 pass the morning medications to the residents on Pikake. RN6 did not put on a gown when she entered the rooms to administer medications. When RN6 administered meds to Room 124, she was within approximately 2 feet and did not have her face shield down. This practice did not follow the facility policy or CDC guidelines.

On 02/10/21 at 01:05 PM during an interview with the IP, she said it was the expectation the RN's wear face shields and put on gowns when entering the room.

4) On 02/04/21 at 12:30 PM, observed R25 sitting in a wheelchair with an overhead table positioned over him in the hallway by the nursing station. RN3 was standing in front of the medication cart within sight. R25 had expelled (spit) an inordinate amount of bubbly saliva on the floor which covered an area of approximately two foot by two foot which included under the overbed table, on the table legs, the table extension arm and extended into two different hallways. RN3 did not

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4 203	Continued From page 52	4 203		

immediately respond. When she did, she pulled some wipes from the purple container on the med cart, put on gloves, bent over, and proceeded to clean up some of the saliva and throw the wipe into the trash next to the nursing station door. She then pulled a rolling chair through some of visibly remaining saliva on the floor and positioned it so she could assist feeding R25. Prior to sitting, RN25 threw a wipe on the floor and with her foot moved the wipe back and forth to clean up the remainder of the fluid on the floor.

The housekeeper (HK)1 walked toward the area, and said, "Oh, there's a spill," and immediately pulled a yellow safety cone from the holder on the wall next to the nursing station and placed it to warn others of a wet floor. When surveyor left the area, there was still visible saliva under the table and on the table leg and extension while RN3 was assisting to feed R25.

On 02/05/21 at approximately 01:45 PM during an interview with the HK1, inquired if she had cleaned up the spill the previous day, and she said, "Yes, its not a problem, I'm used to it, it happens a lot with him (R25). HK1 went on to say she moved R25 in his wheelchair to another location so she could clean the area and the overbed table.

Review of the facility Isolation Policy's dated 01/11/20 included the statements:
page 3: "spills of blood or other body fluids should be removed, and the area decontaminated using the facility-approved spill kit.
Page 6: "resident/guest care equipment and environmental surfaces can become contaminated. Proper cleaning/disinfecting is important in the prevention of spreading infections. . . Environmental surfaces (to include

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4 203	Continued From page 53	4 203		

floors and tabletops) will be cleaned on a regular basis, if spill occurs, and if visibly soiled.

5) On 02/08/21 at 11:30 AM the resident council interview was held. The surveyors were escorted through double doors on the Pikake Unit to Room 127. On arrival, the residents were already seated in the room. Room 127 is located across the social services office. The residents were escorted out of the room, through the double doors.

On the facility map, the Pikake unit has been designated as a COVID-19, yellow unit for newly admitted residents and for residents under investigation. This unit is also designed to transform into a red COVID unit with the use of zip walls to cohort positive COVID residents. At the time of entrance (02/04/21) the facility had a census of six residents on the Pikake unit.

On 02/08/21 at 03:00 PM,interview with the Infection Preventionist (IP) confirmed residents should not have been taken on the Pikake unit. The IP stated the interview would have been better if it was held outside.

6) During lunch meal on 02/05/21, observed R25 being assisted with his meal by Registered Nurse (RN)3. RN3 was wearing gloves and was handed a face shield. RN3 did not remove the gloves and put on the face shield which had a drawstring at both ends of the band that needed to be pulled to tightly affix the face shield. RN3 did not change her gloves/hand sanitize and continued to assist R25 with his meal.

7) On 02/08/21 at 01:51 PM observed a red trash bin, lined with a clear bag outside of R30's room (next to the door). Concurrent observation and

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4 203	Continued From page 54 interview with RN1 confirmed R30 is on contact precaution. RN1 also confirmed the red trash bin should be placed in the resident's room to doff personal protective equipment (gloves, gown) before exiting the resident's room. Interviewed the IP on 02/08/21 at 03:00 PM. The IP reported R30 is on contact precaution for MRSA in a wound. The IP confirmed the red trash bin should be placed in the resident's room. Further queried whether the facility utilizes red trash liners to indicate the contents are biohazard materials. The IP replied the facility does not utilize red bags to indicate contents are biohazard materials. Biohazard materials/waste are double bagged then these bags are disposed in the designated bin for biohazard materials. 8) On 02/10/21 at 08:20 AM observed a colorful round disk stored in the excess catcher of the alcohol-based hand sanitizer dispenser. RN40 stated the disk, with a manufacturer's label Simon Says is for R25. Inquired whether the disk should be stored on the waste catcher of the ABHS gel dispenser. RN40 responded, no and agreed to return it to activities. 9) Medication storage observation was done on 02/10/21 at 10:10 AM. Concurrent observation with RN1 found a container of thickener with the scoop stored in the powder. Second observation at 10:40 AM with RN40 found no scooper in the container of thickener, RN40 reported the scooper has been missing so disposable spoons are used as a scoop. The scooper was stored in the fiber powder.	4 203		
4 206	11-94.1-53(b)(3) Infection control	4 206		3/27/21

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4 206	Continued From page 55 (b) The facility shall have provisions for isolating residents with infectious diseases until appropriate transfers can be made. (3) The facility shall ensure that visual observations of the resident can be made in each isolation room: (A) By means of the view window in each isolation room; or (B) By an approved mechanical system e.g., closed circuit television monitoring; This Statute is not met as evidenced by: Based on observation, the facility did not have visual observation of the residents in the designated isolation room and the other rooms designated for expansion for residents that required isolation. As a result, there is increased risk to the resident as the staff can not observe the resident to identify an immediate need. Findings include: The facility developed a COVID-19 plan that would immediately isolate a positive COVID-19 resident from the other residents. The plan designated room 126 in the Pikake unit as the initial isolation room and if additional rooms were needed they would utilize other rooms on Pikake. The plan stated, "If needed to expand the COVID unit, we would relocate the residents from rooms (122-124) . . ." Observed the rooms in the Pikake unit, designated to be isolation rooms, did not have any means for visual observation of the residents.	4 206	None of the rooms through the facility have a viewing window as the rooms are residents□ homes. With COVID precautions, many rooms are put into isolation for the protection of the residents. Visual cues indicating isolation are outside of isolation rooms to alert staff of need to monitor residents frequently while maintaining isolation. Facility residents on isolation have the potential to be affected by the alleged practice. Staff were inserviced on isolation signage and need to monitor frequently. Inservices will be ongoing as needed. SDC/designee will monitor / audit isolation rooms for compliance weekly x 12 weeks. Results of audits will be brought to QAPI monthly for three months for review and recommendations	

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4 277	Continued From page 56	4 277		
4 277	11-94.1-65(e)(4) Construction requirements (e) The facility shall have resident bedrooms that ensure the health and safety of residents: (4) Single resident bedrooms shall measure at least one hundred square feet of usable space, excluding closets, bathrooms, alcoves, and entryways; This Statute is not met as evidenced by: Based on requested entrance documentation, the facility failed to ensure a single resident bedroom measured at least one hundred square feet of usable space, excluding closets, bathrooms, alcoves and entryways for one of six rooms on a unit. Findings include: Room HH1 on the Hale Ho'olu unit accommodates one resident. HH1 does not measure at least one hudred square feet of usable space for the resident occupying this room. The facility currently has been issued a waiver for this room.	4 277	The facility has a current waiver for this room.	3/27/21
4 278	11-94.1-65(e)(5) Construction requirements (e) The facility shall have resident bedrooms that ensure the health and safety of residents: (5) Multi-resident bedrooms shall provide a minimum of eighty square feet per bed of usable space, excluding closets, bathrooms, alcoves, and entryways;	4 278		3/27/21

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4 278	Continued From page 57 This Statute is not met as evidenced by: Based on requested entrance documentation, the facility failed to ensure a multi-resident room provides a minimum space of eighty square feet per bed of usable space, excluding closets, bathroom, alcoves and entryways for each resident in one of six rooms on a unit. Findings include: Room HH3 on the Hale Ho'olu unit houses multiple residents and does not meet the requirement of eighty square feet per bed of usable space for each resident occupying this room. Documentation provided by the facility notes this room presently has a waiver.	4 278	The facility has a current waiver for this room.	