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	125014	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA RETIREMENT RESIDENCE	1434 PUNAHOU STREET HONOLULU, HI 96822

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4 000	Initial Comments A re-licensure survey was conducted by the Office of Healthcare Assurance (OHCA) on 01/27/21 to 02/02/21. The facility was found not to be in substantial compliance with Hawaii Administrative Rules, Chapter 11-94. One facility reported incident (ACTS #8061) was investigated and not substantiated. Survey Census: 71 Sample Size: 42	4 000		
4 115	11-94.1-27(4) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on interview with residents, the facility did not ensure residents were treated with respect and dignity by speaking in a non-dominant language of the facility while providing care. Findings include: Resident Council Interview was done on 02/01/21 at 10:35 AM, two residents reported staff	4 115		

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4 115	Continued From page 1 members speaking in the non-dominant language of the facility. One resident reported staff members speak in a non-dominant language while providing care. Another resident reported when staff members don't speak in English she is unable to understand what they are saying.	4 115		
4 120	1-94.1-27(9) 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: (9) The right to names, addresses, and telephone numbers of pertinent resident advocacy groups; This Statute is not met as evidenced by: Based on observation and interview with residents, the facility did not ensure postings which include names, addresses (mail and email) and telephone numbers of the State Long-term Care Ombudsman program and the State Agency to formally complain were provided to the residents. Although postings were found, the residents were not aware of where to find the information. Findings include: Resident Council interview was done on 02/01/21 at 10:35 AM. Inquired whether residents knew where the ombudsman's contact information is posted. The residents were not familiar with the	4 120		

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4 120	Continued From page 2 Ombudsman. The residents were not familiar with the State Agency. On 02/02/21 observed the facility had brochures regarding Ombudsman services on a rack outside of the third floor dining room, the second floor dining room on the Waikiki unit, and across the nurse's station on the second floor Ewa unit. Ombudsman brochures were available; however, placed too high on the rack to be accessible for residents seated in a wheelchair. The contact information for the Ombudsman was not posted. The name and phone number for the State Agency and the name and phone number of the facility's Administrator was affixed to the bottom of the all the racks. However, the signage was blocked by the water cooler on the second floor, Waikiki unit.	4 120		
4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth.	4 136		

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4 136	Continued From page 3 This Statute is not met as evidenced by: Based on observations, record review, and interviews with staff member, the facility failed to implement interventions, including adequate supervision consistent with the resident's needs, goals, and care plan to prevent an avoidable fall for 1 out of 4 residents (Resident (R) 17) that resulted in sustaining a fracture to right arm and significant weight loss. Findings Include: Review of R17's "Investigate Report Following Adverse Event" regarding an incident on 12/18/20, R17 had a witnessed fall and sustained fracture to right acute great tuberosity (prominent area of bone at the top of the humerus and is the attachment for the two large, powerful rotator cuff muscles, injured by landing directly onto the side of the shoulder or landing with arm outstretched) and humeral neck (bone in upper arm, located between the elbow and shoulder), causing right shoulder pain. The report further documented that on 12/18/20, R17 "saw a candy container shaped like Santa's "pants" and it was filled with candy canes. The resident stood up from her chair and walked to the nurse's station using her front wheeled walker. She grabbed a candy cane then turned around and took a few steps to give the candy to her husband without utilizing her front wheeled walker then walked back to the nurse's station. The resident remained standing in front of the nurse's station, but she was not holding on to her walker. The resident started to walk backwards, lost her balance, and fell down on the carpeted floor." R17 is a 91-year-old with diagnoses of Alzheimer's Disease, muscle weakness	4 136		

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4 136	Continued From page 4	4 136		

(generalized), and unsteadiness on feet and with history of falls. Review of R17's Care Plan, documents a fall in her independent living apartment on 07/01/19, and subsequent falls at the facility on 02/05/20, 03/23/20, 04/12/20, 07/29/20, 11/19/20, and 12/18/20.

Review of R17's quarterly Minimum Data Set (MDS) with an assessment reference date of 11/12/20, R17's Brief Interview Mental Status (BIMS) scored her at a 3 (severe cognitive impact). In Section G. Functional Status, under Transfers (how resident moves between surface including to and from bed, chair, wheelchair, standing position), R17 requires limited assistance with one-person physical assist. Walk in Room and Corridor, R17 requires limited assistance with one-person physical assist. Under Balance During Transitions and Walking, R17 scored a 2 (not steady, only able to stabilize with human assistance) for walking (with assistive device if used) and turning around and facing the opposite direction while walking.

Review of R17's physician's encounter note dated on 11/23/20, R17 "...requires very close monitoring and prognosis remains guarded with high risk for adverse events due to advanced age and comorbidities- Due to Muscle weakness, unsteady gait needs close observation due to high risk for falls, traumatic injuries...Safety monitoring for falls prevention with consideration for poor memory and safety awareness"

Review of "Fall Risk Assessment" dated on 11/20/20 scored R17 at 11 and on 12/21/20 scored 12, according to the assessment this puts R17 at High Risk and requires appropriate fall interventions from Protocol II. However, from the 10 listed fall preventions in Protocol II only one

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4 136	Continued From page 5 was instituted, "1...Fall Prevention Protocol 1." The following were included in R17's "Fall Prevention Protocol 1:" Frequently reorient and repetitively reinforce use of call bell and ensure it is within reach, Reassess for a clutter-free, well-lit environment, Reinforce use of assistive devices, if used, Assess for safe footwear, Monitor use of eyeglasses and hearing aid if applicable, Consider Wellness Center for strengthening, if appropriate, and Evaluate the need for adjustment in resident's daily activity schedule. Interview with the Director of Nursing (DON) and Administrator on 02/02/21 at 10:17 AM noted that there were two Registered Nurses (RN) 14, and RN9, behind the Ewa Nurse's Station when the incident happened on 12/18/20. RN14 initially was right by R17 when she grabbed candy for her husband, but RN14 went behind the station before the incident took place. According to DON, R17 "is unpredictable sometimes" and does not use her walker all the time. She further stated that R17 needs general supervision when walking but not stand by assist, "many times when she does ambulate, we see her ambulating, so we can watch her." Concurrent review of the resident's care plan, effective from 11/18/20 to present, was done with the DON. Review of care plan under "Impaired Mobility/Falls" states that R17 "...has balance problems and required 1-man limited to extensive assistance with ambulation and transfers." Interventions for ambulation notes that R17 uses a front wheeled walker (FWW) "...with SBA [stand-by assistance] to contact guard assistance." According to DON stand-by assist means close by and contact guard assistance means "...you are pretty much next to her." Inquired whether the resident's fall could have been prevented if the two nurses had intervened, to ensure R17 safely returned to her chair next to	4 136		

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4 136	Continued From page 6	4 136		

her spouse. The DON did not respond. Further inquired whether the interdisciplinary team (IDT) met to discuss the fall, DON responded they met; however, there is no documentation. The DON reported the root cause was weakness, poor balance, and poor safety awareness. DON explained that if R17 ambulated without the walker staff is expected to redirect her to use her walker. DON confirmed that R17 has a FWW and is supposed to use but also has a purple cane that she will use.

Observed R17 on 01/27/21 at 09:27 AM, 11:53 AM, 12:56 PM, and 01:41 PM, R17 sitting in the hallway in front of Ewa Nurse's station on a chair without FFW. On 01/28/21 at 07:52 AM, sleeping in her room with no FFW in sight and at 11:42 AM in the hallway in front of the Ewa Nurse's station eating lunch seated on a chair with a purple cane on her left side. On 02/01/21 at 08:49 AM, resident in her room by the bathroom ambulating holding on to a wheelchair, yelling for help.

On 02/02/21 at 10:43 AM, concurrent observation with the DON found no FWW in R17's room. Interviewed the Physical Therapist (PT). The PT stated he was looking for the FWW as well, it has been missing for two days in a row, noticed it was missing since Friday (01/29/21).

Review of R17's documented weight on 12/08/20, her weight was 118 pounds (lbs.) and after the fall on 12/18/20 documented R17 weight on 12/21/20 was 111 lbs. R17 had a 6% weight loss within 13 days from 12/08/20 and 12/21/20. Interview with Registered Dietician (RD) on 02/01/21 at 12:59 PM, RD stated that she noticed resident also had a weight loss in July after a fall. RD further stated she thinks R17's refusal to eat is related to pain.

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4 159	Continued From page 7	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, review of the facility's policy and procedures, and interview with staff member, the facility failed to ensure that all foods were procured, stored, prepared, distributed, and served under sanitary conditions. Three observations of a refrigerator found temperatures greater than 41 degrees Fahrenheit (F); stored food items were not covered; and expired dry good was not disposed. Findings Include: During the initial kitchen tour observation with Chef on 01/27/21 at 08:49 AM, the "Tray Setter Holding Fridge 2" inside thermometer measured 45 degrees F. Interview with Chef confirmed the measurement. Second observation on 02/01/21 at 07:45 AM found the inside thermometer measured 45 degrees F and the exterior thermometer measured 45 degrees F. Third observation on 02/02/21 at 12:15 PM, the inside thermometer measured 50 degrees F and the	4 159		

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4 159	Continued From page 8 exterior thermometer measured 33.5 degrees F. During interview with Chef, "Temperature should be no higher than 41 degrees..." F. Observation during initial tour on 01/27/21 at 08:49 AM also found in the "Pantry Reach in Fridge" carrot sticks in a clear plastic container with lid slightly uncovered and tray of sliced and plated Tiramisu cake located in "Pantry Walk in Fridge" on a tray cart uncovered. The plastic that is on top of the tray cart was not completely over the cart. Chef acknowledged it should be covered. Observation on 02/02/21 at 12:15 PM of the dry goods storage, observed Kinoshita flour with written date 11/26/18. Interview with Chef, written dates are the day the goods were delivered, and the products are thrown out one year from delivery date. Chef stated the flour should have been thrown out. Review of facility's dining protocols under "Labeling Protocols" last revised on 04/2020, states "All non-perishable food will be stored in the storeroom and labeled with the date of receipt/delivery of items. Discard date is based on manufacturer recommendations and if none is available, then one year from date of receipt/delivery."	4 159		
4 243	11-94.1-64(a) Engineering and maintenance (a) The facility shall maintain all essential mechanical, electrical, and resident care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations and interview with staff	4 243		

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4 243	Continued From page 9 member, the facility failed to ensure the dishwasher is maintained in safe operating conditions. The facility did not have a system to ensure proper temperatures of the dishwasher was achieved. Observation on 01/27/21 at 08:49 AM, while a dish test tray was going through the dishwasher, observed 2 out of 3 thermometers not reaching appropriate temperature. The thermometer for the wash function measured 140 degrees Fahrenheit (F) but indicated above the thermometer that it needs to reach 150 degrees F minimum. The thermometer for the rinse function measured 155 degrees F but indicated above the thermometer that it needs to reach 160 degrees F. Chef acknowledged "...something was wrong...". Interview with Chef on 02/02/21 at 12:15 PM, stated on 01/27/21 the service company found the two thermometers were not working properly because there was a shortage in the wires. Review of facility's dining protocols under "Sanitation" last revised on 12/07/16, states "Equipment used for...proper dishwashing shall be maintained in good working order."	4 243		