STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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4 000	Initial Comments A Relicensing survey was conducted by the Office of Health Care Assurance in conjunction with Healthcare Management Solutions, LLC who conducted the recertification survey. The federal tags were crossed over to Chapter 11-94, Skilled Nursing/Intermediate Care Facilities for the state. The facility was found not to be in substantial compliance with Chapter 11-94, Skilled Nursing/Intermediate Care Facilities. Survey Dates: 02/17/21 through 02/19/21 Survey Census: 69	4 000		
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 interview, record review, review of the facility's policy, and review of the facility's investigation report, the facility failed to develop abuse policies that included current required time frames for reporting abuse. In addition, the facility failed to assure that its policies provided procedures regarding conducting thorough investigations when abuse was alleged. The failure to have current, comprehensive abuse policies affected one of 18 sampled residents (Resident (R) 12) whose allegation of abuse was	4 131		

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4 131	Continued From page 1 not reported to the State Agency (SA), and was not thoroughly investigated. Findings include: 1. Review of an "Investigation Report," dated 12/08/20 revealed R12 reported an allegation of sexual and verbal abuse. (Please refer to F609.) Review of the "Investigative Report" revealed no evidence that the facility reported this allegation to the SA. Review of the facility's policy titled, "Policy on Abuse, Neglect, and Exploitation," reviewed 11/2019, revealed: " Reporting: 2. In the event that any individuals suspects an abuse or incidents of abuse, he or she must report the incident to the nurse supervisor or charge nurse who will then report the incident to the Director of Nursing, or the Director of Social Service, or the Administrator. 3. If the incident occurred or discovered after hours or during the weekend, the above personnel must be called at home and informed of such incident not later than 2 hours after forming the suspicion of abuse. 4. Any suspected abuse that results to serious bodily injury must be reported to OHCA [Office of Health Care Assurance] and Administrator (or designated representative) within 2 hours of the incident ...6. The Director of Nursing and the Director of Social Services will do an investigation and file a follow-up report. When there is an alleged or suspected case of mistreatment, neglect, injuries of unknown origin, or abuse, the Director of Social Services will notify the appropriate agencies immediately or within 24 hours." Review of the facility policy revealed that it did not meet the current requirements of 42 CFR 483.12	4 131		

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4 131	Continued From page 2 which requires that all allegations of abuse, not just ones that result in serious bodily injury, be reported to the SA (OHCA) within two hours. 2. Review of the "Investigation Report," dated 12/08/20 regarding R12's allegation of sexual and verbal abuse revealed a thorough investigation was not conducted. (Please refer to F610.) There was no evidence that the facility interviewed any residents besides the alleged victim while investigating R12's allegation of abuse. Review of the facility's policy titled, "Policy on Abuse, Neglect, and Exploitation," reviewed 11/2019, revealed that it did not include procedures to assure that a thorough investigation was conducted whenever abuse was alleged. The policy failed to address the need for observations, as well as the need to interview other staff and residents who might have been a witness to the alleged abuse. The policy did not address the need to interview other residents who had received care from the same alleged perpetrator to help identify possible patterns of behavior. Interview on 02/19/21 at 3:56 PM with the Social Work Director (SWD) revealed that the Director of Nursing (DON) and Administrator served as the facility's Abuse Coordinators. Interview on 02/19/21 at 4:06 PM with the Administrator confirmed that R12's allegation of abuse had not been reported to the SA. The Administrator was unaware that the facility's policies did not meet current requirements, as he stated he did not know the regulation that abuse	4 131		

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4 131	Continued From page 3 had to be reported to the SA within two hours.	4 131		
4 133	11-94.1-29(d) Resident abuse, neglect, and misappropriation (d) The facility shall maintain a record that all alleged violations were thoroughly investigated, and shall take all reasonable steps to prevent further abuse while the investigation is in progress. This Statute is not met as evidenced by: Based on interview, record review, and review of the facility's policy, the facility failed to ensure an allegation of abuse was reported to the State Agency (SA) within two hours for one of 18 sampled residents (Resident (R) 12). On 12/08/20, R12 reported an allegation of sexual and verbal abuse to the facility; however, the facility did not report the allegation to the SA. In addition, the facility failed to report the findings of its investigation to the SA within five working days as required by regulation. Findings include: Review of the facility's policy titled, "Policy on Abuse, Neglect, and Exploitation," reviewed 11/2019, revealed " ...2. In the event that any individual suspects an abuse or incidents of abuse, he or she must report the incident to the nurse supervisor or charge nurse who will then report the incident to the Director of Nursing, or the Director of Social Service, or the Administrator. 3. If the incident occurred or discovered after hours or during the weekend, the above personnel must be called at home and	4 133		

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4 133	Continued From page 4 informed of such incident not later than 2 hours after forming the suspicion of abuse. 4. Any suspected abuse that results to serious bodily injury must be reported to OHCA [Office of Health Care Assurance] and Administrator (or designated representative) within 2 hours of the incident ...When there is an alleged or suspected case of mistreatment, neglect, injuries of unknown origin, or abuse, the Director of Social Services will notify the appropriate agencies immediately or within 24 hours ..." Continued review of the facility's policy revealed the facility's policy did not require that all allegations of abuse must be reported to the SA within two hours. (Please refer to F607.) Review of the facility's abuse "Investigation Report," dated 12/08/20 revealed an allegation that R12 was abused. Per this "Investigation Report, the date of the incident was 12/08/20. The "Investigation Report" documented that "Resident [R12's initials] reported to the LPN [Licensed Practical Nurse] ...LPN [name] called the social worker [Social Work Director (SWD)] to report the incident. Social Worker made a virtual interview with the resident and the statement of the resident are as follows: CNA [Certified Nursing Assistant] Grab and hold my crotch. Yells at met-get in the shower [;] get there to the bed. That during shower rubbing my private. CNA also used his arm around my back. Rubbed hand on crotch while showering. Berating me." Further review of the 12/08/20 "Investigation Report" revealed no evidence that the initial allegation of sexual and verbal abuse was ever reported to the SA. In addition, there was no evidence that the facility reported the findings of their investigation to the SA within five days.	4 133		

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4 133	Continued From page 5 Interview on 02/19/21 at 3:56 PM with the Social Work Director (SWD) revealed she would not be the person who reported abuse to the SA. The SWD identified the Director of Nursing (DON) and Administrator as the Abuse Coordinators for the facility. Interview on 02/19/21 at 4:06 PM with the Administrator revealed he was not aware that all allegations of abuse had to be reported to the SA within two hours. Per the Administrator, the facility had waited for the former DON to complete the investigation prior to reporting the allegation to the SA. He continued that, once the former DON determined that abuse was not substantiated, neither the initial allegation of sexual and verbal abuse, nor the required five-day report with the investigation's conclusion was ever reported to the SA.	4 133		
4 140	11-94.1-36(d) Admission, transfer, and discharge (d) The facility shall provide supportive counseling and preparation to the resident to ensure safe and orderly transfer or discharge from the facility to mitigate possible relocation stress. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide access to persons and services inside and outside the facility. Resident (R)269 was not seen by a social worker from admission on 02/03/21 through the current day of 02/19/21 regarding discharge. Findings include:	4 140		

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4 140	Continued From page 6 On 02/19/21 at 09:36 AM, with (Resident (R) 269) who stated that "no social worker has seen me." There is a place that I can go in Ewa Beach. It's a short term and I must call this realty. Surveyor asked R269 if she was sure that no social worker had talked with her? R269 stated no one except the surveyor has been talking with her. R269 is a 67-year-old female who was in the yellow zone, which is the area that is considered the 14-day quarantine unit for contact/droplet precautions, for new admissions. The yellow zone was zoned off from the remainder of the facility with plastic barrier walls. Surveyor interviewed R269 in the yellow zone. Record review on 02/19/21 revealed that R269 had a history of metabolic encephalopathy on admission. Although her (Brief Interview for Mental status (BIMs) was 13, R269 was able to state her full name, the current date and describe her current situation regarding discharge back into the community during an interview. Interview on 02/19/21 at 09:50 AM with (social worker (SW) who stated "no, I have not talked with her." I have been trying to talk to her son whom I asked about her assets and financial status, but I am not sure he is reliable. Because she is not reliable mentally, I am not sure that I can rely on talking with her. Surveyor stated to SW that the resident seemed to be cognizant enough and was sure she had not seen a SW. SW stated, "I was told that once I go in the back, I cannot come back into the facility." (Assistant director of nursing (ADON) who was sitting at the nurse's station during interview with SW emphasized that "we don't have an outbreak" and you can come back in, but you must don and doff. Surveyor inquired with ADON who is updating and	4 140		

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4 140	Continued From page 7 teaching their ancillary staff. ADON stated that their educator left last Friday. Review on 02/19/21 Social Services progress notes revealed an in-person meeting with R269 on 02/19/2021 at 10:47 AM. Record also confirmed that resident was admitted on 02/03/2021 and had not been seen by social services until the sixteenth day in the facility.	4 140		
4 141	11-94.1-36(e) Admission, transfer, and discharge (e) At the time of transfer for hospitalization or therapeutic leave, the facility shall provide written information to the resident concerning the facility's bedhold policy. This Statute is not met as evidenced by: Based on interviews, record reviews, and review of the facility's admission paperwork, it was determined the facility failed to ensure all residents were provided a written notice which specified the duration of the bed-hold policy at the time of transfer to the hospital for one (Resident (R) 64) of 18 sampled residents. On 01/24/21, R64 was transferred to the hospital after a change of condition; however, she was not given the written notice that addressed holding the resident's bed during her absence. The systemic failure to offer and provide notice of the facility's practices regarding bed holds had the potential to affect any residents who could require transfer to another health care facility. Findings include: Review of the facility's admission packet titled "Resident Handbook," revised 08/2019, revealed	4 141		

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4 141	Continued From page 8 " ...Resident & Guest Information ...Bed Hold. Once discharged from [facility name], beds are not held for residents, unless requested by the resident or resident representative. Request to hold a bed must be made within 24 hours of discharge at the per diem rate. Otherwise, a discharged resident can be re-admitted if a bed becomes available and if we [facility] are able to meet the resident's medical needs. For Medicaid eligible residents, a bed will be held for 3 days, should a resident be transferred for hospitalization or therapeutic leave and should the absence exceed the 33-day requirement, the resident may return to the facility in the first available bed ..." Review of R64's undated "Resident Face Sheet," located in the resident's Electronic Medical Record (EMR) under the face sheet tab, revealed the resident was admitted to the facility on 12/31/20 and readmitted on 01/29/21 with diagnoses which included sepsis. Review of R64's "Nursing Progress Notes," dated 01/24/21 revealed " ...Obtained order to transfer resident to acute facility via 911 ambulance ...paramedics came in at around 9:15 PM [sic] ..." Review of R64's EMR revealed no documented evidence a bed hold notice was given to the resident upon her transfer to the hospital on 01/24/21. Interview on 02/19/21 at 1:33 PM with the Social Work Director (SWD) revealed the facility did not have an official bed hold policy. The SWD stated the facility's admission paperwork stated the facility did not offer bed holds. Interview on 02/19/21 at 4:17 PM with the	4 141		

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4 141	Continued From page 9 Administrator revealed it was his expectation a bed hold would have been given upon R64's transfer to the hospital. Interview on 02/19/21 at 4:51 PM with the Director of Nursing (DON) revealed he was not aware that bed holds were to be offered to residents.	4 141		
4 152	11-94.1-39(e) Nursing services (e) There shall be a policies and procedures manual that is kept current and consistent with current nursing and medical practices and approved by the medical advisor or director and the person responsible for nursing procedures. The policies and procedures shall include but not be limited to: (1) Written procedures for personnel to follow in an emergency including: (A) Care of the resident; (B) Notification of the attending physician and other persons responsible for the resident; and (C) Arrangements for transportation, hospitalization, or other appropriate services; (2) All treatment and care provided relative to the resident's needs and requirements for documentation; and (3) Medication or drug administration procedures that clearly define drug administration process, documentation, and authorized	4 152		

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4 152	Continued From page 10 This Statute is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure that an interdisciplinary team had determined that it was appropriate for a resident to self-administer medications for one of 18 sampled residents (Resident (R) 14). On 02/17/21, R14 was provided medications to self-administer without an assessment or physician's order. Findings include: Review of the facility's policy titled, "Administration of Medications," reviewed 02/02/19, revealed " ...General Rules for Medication Administration: ...4. The Interdisciplinary Team has determined in the interest of all residents' safety, that no self-administration of medication will be allowed, except for the following and only after visual inspection by the Director of Nursing. 1. Vitamins. 2. Herbs. 3. Eye Drops. 4. Non-steroid topical creams/ointments. 5. Inhalers. Interdisciplinary Team must justify that resident [sic] is capable of self-administering his/her medications and an order from the Attending Physician must be obtained prior to allowing self-administration of these medications and for allowing them to be kept at the resident's bedside ...7. Pre-poured medication shall not be left at the resident's bedside ...unless so ordered by the MD [Medical Doctor] for self-administration ...14. Licensed nurse will remain with the resident and face him/her until the medication is swallowed." Review of R14's undated "Resident Face Sheet," located in the resident's electronic medical record	4 152		

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4 152	Continued From page 11	4 152		

(EMR) under the face sheet tab, revealed the resident was a long-term resident with diagnoses which included Parkinson's disease, major depressive disorder, essential hypertension, dementia, hyperlipidemia, gastro-esophageal reflux disease, and osteoporosis.

Review of R14's physician "Orders," dated from 02/01/21-02/28/21 revealed the resident was ordered by her physician to receive the following medications: Zoloft (medication used to treat depression) oral tablet 150 mg (milligram) every AM (before noon) for recurrent depression; cetirizine (an antihistamine) HCL oral tablet 10 mg twice daily for itching; Losartan Potassium (medication used to treat hypertension) oral tablet 100 mg daily for hypertension; raloxifene (used to treat osteoporosis) HCL oral tablet 60 mg daily; Norvasc (used to treat blood pressure) oral tablet 10 mg daily, Rasagiline Mesylate (used to treat Parkinson's Disease) oral tablet 1 mg daily; Vascepa (used to treat cholesterol) oral capsule 2 mg twice a day; and Potassium Chloride ER (supplement) oral capsule 10 mg daily.

Observation on 02/17/21 at 11:20 AM revealed R14 was sitting on the edge of her bed conversing with her roommate. Continued observation revealed a small medication cup containing multiple medications, was on top of the resident's bedside table.

Interview on 02/17/21 at 11:27 AM with Registered Nurse (RN) 4 revealed that when she brought R14 the medications earlier that morning, the resident told her she would take them in a few minutes. RN4 stated she usually goes back and checks to make sure the resident takes them; however, she did not this morning. RN4 also stated R14 did not have a physician's order to

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4 152	Continued From page 12 self-administer medications. The RN confirmed the following medications were at the resident's bedside: Zoloft tablet, cetirizine tablet, Losartan Potassium tablet, raloxifene tablet, Norvasc tablet, Rasagiline Mesylate tablet, Vascepa capsule, and Potassium Chloride capsule. Interview on 02/19/21 at 4:14 PM with the Administrator revealed it was his expectation the RN would have ensured the medications were administered to the resident and the resident did not self-administer medications unless ordered and assessed to do so. Interview on 02/19/21 at 4:55 PM with the Director of Nursing (DON) revealed it was his expectation that, unless a resident had an order from a physician to self-administer, medications should not be left at a resident's bedside.	4 152		
4 160	11-94.1-41(b) Storage and handling of food (b) Effective procedures to promptly and consistently clean all equipment and work areas shall be enforced. This Statute is not met as evidenced by: Based on observation, interviews, review of dishwasher temperature logs, and dishwashing machine specifications, the facility failed to assure that the dishwashing machine used sufficiently hot water temperatures in accordance with the manufacturer's instructions. The failure to correctly clean and sanitize dishware had the potential to affect 64 of 69 residents who consumed an oral diet that was prepared in and/or served on this dishware.	4 160		

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4 160	Continued From page 13 Findings include: Review of the dishwasher specifications for the facility's low temperature, sanitizing dishwasher revealed the temperature should be maintained at 120 degrees Fahrenheit when coupled with the use of sanitizer. Review of the facility dishwasher temperature log on 02/18/21 at 8:55 AM revealed each day for the month of February 2021 indicated that the dishwasher temperature was 120 degrees Fahrenheit (F). Observations on 02/18/21 at 8:55 AM revealed the dishwashing gauge recorded hot water temperatures of 88 degrees, F, 90 degrees F, 90 degrees F, and 98 degrees F while running to clean successive loads of breakfast dishes. These dishes were processed and stacked for re-use as clean/sanitized. Interview with the Dietary Manager (DM) at 9:00 AM revealed the gauge on the dishwashing machine was working. She continued to process additional loads, with the gauge next showing water temperatures of 106 degrees F, 108 degrees F, and 110 degrees F. The DM stated, "We will call the maintenance man to increase the hot water tank temperature." Hot water in the dishwasher was recorded at 118 degrees F at 9:45 AM. Interview with the Maintenance Director on 02/19/21 at 11:00 AM revealed that the temperature for the hot water tank had previously been set at 110 degrees F and was turned up to 130 degrees F on 02/18/20 after surveyor intervention.	4 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125041	A. BUILDING: _____ B. WING _____	02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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4 203	Continued From page 14	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 observation, interviews, review of screening and personnel records, and facility policies, the facility failed to ensure that two of 32 staff were screened for COVID-19 prior to beginning work on first shift on 02/19/21. The failure to screen all staff had the potential to affect all 69 residents. Findings include: 1. Observation on 02/19/21 at 7:00 AM revealed Receptionist 1, who was responsible for screening staff and ensuring all processes were followed, did not screen herself. At this time, Receptionist 1 was observed walking into the building through the main entrance, assisting staff with screening and going behind the desk to take staff temperatures. However, the receptionist, herself, was not screened prior to entering into the building. Review of the facility screening records and time clock records confirmed that as of 2:30 PM on 02/19/21, Receptionist 1, who came into contact with all staff that entered the building for the 7:00 AM to 3:00 PM shift, had still not been screened for the day.	4 203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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4 203	Continued From page 15 During an interview with Receptionist 1 on 02/19/21 at 2:35 PM, she stated "I forgot to sign in." 2. Further review of the screening records on 02/19/21 at 2:30 PM revealed that Dietary Aide (DA) 2 was not screened at the start of her shift. The COVID-19 screening process did not record her as entering the facility. However, review of time clock records revealed that DA 2 worked her entire shift. Interview with DA 2 at 2:40 PM on 02/19/21 revealed that she did not remember if she signed in or not. When informed there was no record of her signing in or being screened, she stated "I don't know." Review of the facility's "COVID-19 Policies and Procedures" dated 09/01/20, revealed all staff entering on their shift will be asked to use alcohol-based hand rub, sign in and check their body temperature prior to starting their shift.	4 203		