STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125032	A. BUILDING _____ B. WING _____	06/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE HO'OLA HAMAKUA	45-547 PLUMERIA STREET HONOKAA, HI 96727

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 05/25/21 to 06/01/21. The facility was found to not be in compliance with 42 CFR 483 Subpart B The SA also investigated the following Aspen Complaints/Incidents Tracking System (ACTS) #HI00008374 and #HI00008509 which were not substantiated. Survey Dates: 05/25/21 to 06/01/21 Census: 59 residents Sample Size: 16	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		8/6/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/01/2021

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review (RR), the facility failed to protect and promote quality of life for four residents (R)30, R50, R27, and R22, by ensuring that they were treated with respect and dignity. As a result of this deficient practice, these residents have experienced embarrassment, ridicule, sadness, frustration, and defeat, and have been prevented from attaining their highest practicable well-being. This deficient practice has the potential to affect all residents in the facility. Findings include: 1) R30 was a 42-year-old male admitted on 10/20/20 for long-term care with a diagnosis of Amyotrophic Lateral Sclerosis (ALS), a disease	F 550	Corrective Action: This facility will ensure that each resident is treated with respect and dignity and that care is delivered in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. Resident #30 was interviewed regarding reported complaints on 6/1/21. Resident did report that there were staff members that did not know how to use the air tap mattress. Resident #30 did not name specific staff, but stated that it was "the day shift". Training on use of the air-tap mattress and proper positioning was done by the rehab department with the day shift	

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F 550	Continued From page 2	F 550		

affecting nerve cells in the brain and spinal cord, causing progressive loss of voluntary movements and muscle control, and eventually leading to death. Since his admission, R30 had been isolated in a single room in the facility, leaving his room only to attend outside doctor appointments.

On 05/26/21 at 09:41 AM, during an interview and concurrent observation with R30 in his room on the Lehua Unit, R30 described several situations where he felt staff had treated him disrespectfully. R30 reported that many of the Certified Nurse Aides (CNAs) on the morning shift were rude and lazy, grumbling when he asked for help, ignoring him as they "talk[ed] story" over him, sometimes speaking in Filipino and laughing while changing his incontinence brief, and gossiping about other staff and residents as if he was invisible. When he has asked them to stop, he was ignored. R30 stated that sometimes when he asks to be turned, cleaned, or repositioned and pulled up in bed, the CNAs have treated him roughly and carelessly, leaving him uncomfortably positioned on his side longer than necessary, dropping his legs, grabbing his arm to turn him instead of using the draw mattress, or insisting that he is fine positioned the way he is. The thing that bothers him the most is how careless they are with positioning the draw mattress under him. R30 stated that it is always too high, so that when it is inflated, he is hanging off it from the hips down. When he asks the morning CNAs to fix it, they usually either tell him that it does not need to be fixed, or that they will fix it "later". The poor positioning of the draw mattress was confirmed through direct observation. There was noted to be approximately two feet of the deflated draw mattress hanging down off the head of the bed. R30 stated that when positioned correctly, the top

staff that were assigned to this unit on 5/28/21. These staff members were also educated on customer service and positioning on 6/20/21. He also named three staff members that spoke in the Filipino language while caring for him. These staff members have been provided education by the Director of Nursing, which was completed on 6/29/21. Resident was educated on how to report complaints and grievances by the Social Worker on 6/29/21.

Resident #50 was provided with a privacy bag to cover her urinary catheter collection bag on 5/26/21. Resident #50 was interviewed by the Director of Nursing on 6/25/21 regarding reported complaints. The resident named a specific CNA, stating that she was saying "the bushes, the bushes are on fire" while performing care on her. She states that this happened during the week of survey and that she did not report it to the charge nurse because she didn't want to bother her because she was too busy. The resident states that she does not have any problem with the employee but would like her to be educated. Education was provided to this employee regarding customer service and resident rights on 6/30/21. On March 3, 2021, the resident was asked about her shower schedule preference during care plan conference and it is documented that she requested to continue showers two times per week. Resident was again asked about her shower schedule on 6/25/21 and she reported that when she was first admitted

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of the draw mattress should be behind his shoulders. When asked, R30 stated that he had shared some of what had been going on with Restorative Nurse Aide (RNA)2.

On 05/27/21 at 09:45 AM, during a phone interview with RNA2, RNA2 confirmed that R30 had discussed some of the morning CNAs with her. RNA2 stated that R30 had complained to her that some of the CNAs make him feel uncomfortable and that they do not position him properly. RNA2 shared that she had observed times when the draw mattress was not positioned correctly, or R30 had a wet incontinence brief, and she would call the CNAs in to fix it, R30 would ask her to please stay and watch the CNAs to make sure they did it right. RNA2 also stated that once she had observed a CNA grab R30's hand to pull him for turning and she had immediately intervened and instructed the CNA on how to turn him safely using the draw mattress. RNA2 stated she did not document any of this but had reported some of it to the Assistant Administrator.

On 05/27/21 at 12:54 PM, an interview was done with the Assistant Administrator in her office. The Assistant Administrator acknowledged that RNA2 had come to her with some of R30's concerns, but the way it was presented to her, she was unaware that R30 had complaints of specific nursing staff and took the relayed concerns as a need for additional education of all nursing staff. The Assistant Administrator stated that she did speak to R30 twice to assess whether he had any complaints against specific staff, and twice he denied it. As a result, the assessments and denials were not documented anywhere, but additional education pertaining to R30's

she wanted to shower more than three days a week, but is now showering on Tuesdays and Fridays and would like to remain on this shower schedule. She states that she will notify staff if she would like to be showered more often.

Resident #27 was not provided a napkin during his meal per report. Staff assigned to the resident's unit were educated on ensuring that napkins were provided to the resident at meal time on 6/25/21. The plan of care was updated to indicate the resident's preference to keep a napkin on his chest area during meals on 6/25/21.

Resident #22's soiled incontinence brief and wipes were discarded on 5/27/21. Plastic trash bags were provided to staff for use during incontinent care on 6/23/21. Staff that were assigned to his unit were educated on incontinent care and proper disposal of waste on 6/25/21.

All residents have the potential to be affected by this deficiency.

The Director of Nursing and Facility Superintendent or designees will be responsible for ongoing compliance.

Systemic Changes and Monitoring:
Education will be provided for all CNAs regarding customer service, use of air tap mattress and positioning.

Education will be provided for all CNAs regarding preparing residents for meals.

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F 550	Continued From page 4 positioning, pain, and disease management was provided to nursing staff. 2) R50 was a 58-year-old female admitted on 10/06/16 for long-term care with diagnoses including quadriplegia (paralysis of all four limbs), schizophrenia, chronic obstructive pulmonary disease (COPD), and non-insulin dependent diabetes. On 05/25/21 at 01:09 PM, an observation and interview were done of R50 in her room on the LU. R50 was observed with an indwelling catheter with dark yellow urine in the tube, draining into a urinary bag with no privacy cover that was hooked under her bed. R50 stated she spends much of the day in her room, but usually gets out of bed and goes out to the Solarium every morning. On 05/26/21 at 11:30 AM, during an interview of R50 in her room on the LU, R50 tearfully described several situations where staff have treated her disrespectfully. R50 reported that sometimes staff yells at her, and when she asks, "why are you yelling at me?", staff tells her she is the one yelling. Other times staff have treated her roughly when they were changing her incontinence brief, or they have teased her when they turn her onto her back, exposing her privates, and saying "oh look, the bushes, the bushes", pointing and laughing. When R50 has asked staff to stop the disrespectful behavior, staff has denied the events happening. R50 stated that she receives a bed bath three times a week but would like to be bathed more frequently. When she has requested more baths, "they told me I was too heavy." R50 also reported that "sometimes the CNAs [certified nurse aides] don't	F 550	Education will be provided for all CNAs regarding use of privacy bags for residents with urinary catheters, incontinent care and proper disposal of waste, and resident rights. All residents and their responsible party will be educated on how to report complaints and grievances. The Director of Nursing and Facility Superintendent will conduct room rounds, which will include monitoring these issues, Monday - Friday for 90 days to monitor the effectiveness of these changes and ensure that correction is achieve and sustained. The results of these rounds will be reported to the QAPI committee.	

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want to come into the room to help me, sometimes it makes me upset, and I start crying, sometimes I don't know who really to talk to."

On 05/26/21 at 11:49 AM, an observation and concurrent interview was done with licensed practical nurse (LPN)2 at the bedside of R50. R50's urinary collection bag for her indwelling catheter remained uncovered and was positioned flat on the floor under her bed. When pointed out to her, LPN2 agreed that the catheter bag should have a privacy cover and should not be on the floor. LPN2 immediately left the room to grab a privacy cover and a container for the bag to sit in.

On 05/27/21 at 12:25 PM, a RR was done of R50's Quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 04/20/21. It was noted that R50 had yielded a score of 15 (cognitively intact) for her Brief Interview for Mental Status (BIMS).

3) R27 was a 72-year-old male admitted on 07/25/20 for long-term care with diagnoses including Parkinson's Disease, schizophrenia, epilepsy, hypertension (high blood pressure), and asthma. Despite the tremors in both hands related to his diagnoses, R27 could still eat his meals independently with minimal assistance.

On 05/25/21 at 01:17 PM, an observation and interview were done with R27 in his room on the LU as he was eating his lunch. R27 was observed having difficulty cutting his piece of chicken with both hands shaking uncontrollably, inadvertently pushing food off his plate. Milk could be seen dripping down R27's beard and the front of his shirt. When asked if he needed any help, R27 looked embarrassed, wiping his beard

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F 550	Continued From page 6 with his hand saying, "I usually keep my napkin right here [pointing towards his chest], but they didn't give me one today and then they left before I could ask." 4) R22 was a 27-year-old non-verbal male admitted on 09/02/12 for long-term care, with diagnoses including quadriplegia (paralysis of all four limbs), history of traumatic brain injury, and a gastrostomy (a tube surgically inserted into the stomach for nutritional support). R22 was completely dependent on staff for all his activities of daily living (ADLs). On 05/27/21 at 01:21 PM, an observation was done in R22's room on the LU. R22 was lying awake in bed, alone in his room, just after having his incontinence brief changed. At the foot of his bed directly below his feet was a balled up, soiled incontinence brief and two dirty incontinence wipes. On 05/27/21 at 01:47 PM, RNA1 was observed at R22's bedside, working with him using a stand exerciser. The soiled incontinence brief and dirty wipes had been removed from the foot of the bed. RNA1 stated she discarded the items when she saw them and agreed that the CNAs should not have left them there.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.	F 558		8/6/21

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F 558	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review (RR), the facility failed to accommodate the needs of two residents in the sample, as evidenced by not providing resident (R)22 with a call light that he could activate, and not providing R30 with a geriatric chair for mobility and/or a wheelchair for transport. As a result of this deficient practice, R22 was placed at risk of not having his needs identified and met in a timely manner, and R30 was confined to either his bed or a gurney since his admission. This deficient practice has the potential to affect all the residents at the facility. Findings include: 1) R22 was a 27-year-old non-verbal male admitted on 09/02/12 for long-term care, with diagnoses including quadriplegia (paralysis of all four limbs), history of traumatic brain injury, and a gastrostomy (a tube surgically inserted into the stomach for nutritional support). On 05/25/21 at 12:00 PM, an observation was done of R22 in his room on the Lehua Unit (LU). R22 was noted to have contracted elbows, wrists, and fingers and could not move his hands. There was a regular button-style call light placed at R22's right hip. On 05/27/21 at 09:01 AM, an interview was done with LPN2 in the hall outside of room 118. LPN2 stated that R22 communicates with his eyes. To call for help, LPN2 explained that R22 cannot extend his fingers, hands, or elbows, but he could hit the triangular red "sensor" call light by bumping it with his fist or elbow .	F 558	Corrective Action: This facility will ensure that each resident has the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Resident #22's call light was changed to the appropriate touch/sensor call light. This information was entered into the resident's "care needs" area of the electronic medical record to ensure staff are aware of this need. Resident#30: A functional mobility and wheelchair assessment was done previously by PT on 11/21/20, which included a document stating, "based on the functional mobility impairment/deficits as outlined above, the patient in unable/unsafe to operate a lesser functioning power wc device. He requires specific positioning, transfer, and weight shifting allowances and devices to remain pain-free, safe, and to prevent adverse effects and/or skin breakdown. The features recommended above would also allow this patient the maximum ability to safely and independently operate his own mobility device. A lesser functioning device would compromise or eliminate these abilities." Per PT eval documented on 10/24/20, "factors limiting function included poor balance, poor trunk/head control, decreased strength, decreased	

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F 558	Continued From page 8 On 05/27/21 at 09:09 AM, an interview was done with Registered Nurse (RN)2 in R22's room on the LU. RN2 stated that R22 should have a triangular red "sensor" call light that he can activate by hitting it with the lateral surface of his fist, or with his elbow, however she could not locate it in the room. Upon observing the regular button-type call light placed near his right hip, RN2 confirmed that R22 would not be able to activate it. The Nurse Manager (NM)1 was notified that R22 needed a "sensor" call light, and it was installed within two hours. 2) R30 was a 42-year-old male admitted on 10/20/20 for long-term care with a diagnosis of Amyotrophic Lateral Sclerosis (ALS), a disease affecting nerve cells in the brain and spinal cord, causing progressive loss of voluntary movements and muscle control, and eventually leading to death. Since his admission, R30 had been isolated in a single room in the facility, leaving his room only to attend outside doctor appointments. On 05/26/21 at 10:00 AM, an observation and interview were done with R30 in his room on the LU. R30 was observed sitting upright in bed, with the head of the bed up approximately 75 degrees. R30 was wearing a ventilation mask and head gear, his breathing was unlabored, and there were no support pillows or wedges observed under his arms, at his sides, or under his knees or ankles. R30 was on a regular mattress with no devices for off-loading [pressure] observed. R30 stated that he cannot reposition himself independently and requires assistance to move anything below chest level. R30 explained that he spends all his time in bed, except for when he	F 558	endurance and limited range of motion." A new PT eval to determine wheelchair DME needs was done on 6/29/21. Per PT eval, "Resident presents with global weakness though some intact core and UE function, significant extremity edema, reduced trunk control and poor activity tol (causes fatigue and pain). In unsupported static sitting exhibited elevation in BP, elevation in RR, moderate exertion and reported fatigue within first 10 minutes. However, the resident exhibited ability to sit unsupported safely with assistance and would likely be able to sit for brief periods OOB (out of bed) with full back support and LE supported. Recommending geri-lounger for positioning OOB which will fully support resident's back and head in an upright position while also maintaining adequate support for BLEs in an elevated position...Geri-lounger, when compared with other non-custom manual wheelchairs, provides optimal pressure relief and protection of skin integrity, management of edema, and greatest level of support to reduce effort required and support weak musculature. Geri-lounger would not allow for greater independence with mobility related ADL function, thus the power w/c was recommended and remains the preferred option. However, geri-lounger would be the most appropriate alternative option for sitting OOB until the custom w/c can be provided." The facility is actively working on procuring a 30" seat width geri-lounger for the resident's use. All residents have the potential to be	

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F 558	Continued From page 9 leaves the facility for a doctor's appointment, for which he is transferred to a gurney. R30 then stated that the reason he is transported on a gurney is because the facility does not have a wheelchair large enough to fit him. R30 expressed that he does not like, nor does he feel safe being transported on a gurney, especially since the transport service used by the facility does not have a vehicle that the gurney can be safely secured in. He is aware that the facility is working with an ALS organization to obtain a power wheelchair for him but does not understand why there is nothing else he can use to sit in or be transported in for the meantime. Further observations were done of R30 in his room on the LU, on 05/27/21 at 08:30 AM, 01:30 PM, and 03:10 PM and on 05/28/21 at 08:30 AM, 09:20 AM, and 10:00 AM. At each observation, R30 was sitting up in bed with the head of his bed between 75-90 degrees, with no trunk support, head support, or neck support noted. At some times, R30 was observed eating or drinking, and he was noted to feed himself, chew, swallow, and speak without difficulty. On 05/28/21 at 09:00 AM, an interview was done with the Director of Nursing (DON) in her office. The DON confirmed that the facility does not have a manual wheelchair large enough for R30, so he must be transported to outside appointments on a gurney. The DON then stated that the facility was working on obtaining a power wheelchair for R30, which would enable him to be independent with his mobility, but she was unaware of any other mobility or transport devices available that R30 could use while waiting for the power wheelchair.	F 558	affected by this deficiency. Responsible Person: The Director of Nursing, Facility Superintendent, and RAI coordinator or designees will be responsible for ongoing compliance. Systemic Changes and Monitoring: Every resident that need a specialized call light will have that information included in the "care needs" section of the medical record so staff are aware. Specialized call lights have been placed in an area easily accessible to staff. The Director of Nursing and Facility Superintendent will conduct room rounds Monday - Friday for 90 days to monitor the effectiveness of these changes and ensure that correction is achieved and sustained. The results of these rounds will be reported to the QAPI committee. The rehab department will complete a screen for all residents on admission and quarterly and document in the medical record the recommendations for durable medical equipment. The RAI coordinator will review the documentation and update the resident's plan of care accordingly. The RAI coordinator will monitor compliance for 90 days and report findings to the QAPI committee.	

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F 558	Continued From page 10 On 05/28/21 at 10:45 AM, an interview was done with NM1 in the conference room. NM1 stated that due to his "trunk instability", it had been determined that a manual wheelchair would not be appropriate for R30. Documentation of this assessment and specific determination was requested but not received. On 05/28/21 at 11:00 AM, a RR of R30's Physical Therapy Note, dated 11/28/20 "(late entry from 11/25/20)", by Physical Therapist (PT)1 noted the following: " ...[R30] is able to tolerate sitting at edge of bed supported by bilateral UE's [upper extremities] with mina [minimal assistance] for 15 minutes, chair transfers deferred at this time secondary to lack of appropriate chair ...". No documentation found in the Physical Therapy Notes regarding any issues of trunk instability, poor head control, or poor neck control since being discharged from Physical Therapy on 11/25/20.	F 558		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident	F 584		8/6/21

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F 584	Continued From page 11 independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on interviews and observations, the facility failed to ensure the resident's right to a safe, clean, and comfortable environment for everyday living. In various rooms throughout the facility paint was worn and peeling from the walls, an air conditioner was leaking in a room, air conditioner hose laying on the ground, a ceiling tile was cracked/loose, and there were black marks along the interior of the wall. Findings include:	F 584	Corrective Action: This facility will provide a safe, clean, comfortable and homelike environment, including, but not limited to, receiving treatment and supports for daily living safely. Resident #4 has been discharged from the facility and is unavailable for interview. There is documentation per the housekeeping daily checklist that all required cleaning tasks were completed	

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F 584	Continued From page 12 1) On 05/25/21 at 11:51 AM, conducted an interview with Resident (R)4 and quiered the resident regarding the cleanliness of the resident's room. R4 stated for two months housekeeping has not cleaned this resident's side of the room. However, housekeeping has cleaned the R4's roommate's side of the room. On 05/25/21 and 05/26/21 during the day shift, while on the Maile Unit this surveyor did not observe housekeeping staff. An interview was done 05/27/21 at 11:30 AM with Maintenance worker (M)1. M1 stated, "we (the facility) have only three housekeepers, and now we are hiring utility workers." Utility workers are able to work in housekeeping, kitchen (do not handle food), and maintenance departments. 2) On 05/27/21 at 12:00 PM, while on the Maile Unit, an observation was made of a ceiling tile open in the hallway and an air conditioner (AC) leak (which was contained with a dumpster). Upon inquiry of the observation, Licensed Nurse (LN)1 stated there an AC unit was leaking and maintenance was fixing it. LN1 also stated it happens all the time and that is why we have the portable along the hallway. A tour of the facility was done on 05/27/21 at 1:23 PM. This surveyor observed the following: wall paint wear and tear in Rooms 115 A/B, 116A/B, 117A/B, 119, 121A; leaking and stained ceiling panels were noted near Room 210; cracked ceiling tile noted near Room 238; black skid marks on walls in Rooms 236 and 234; ceiling panel loose at area of Room 230; worn down pain and black stain on wall of Room 236; black skid marks on wall of Room 218-220; and a portable AC hose laying on the ground near the wall of	F 584	for this resident's room in the months of April and May of 2021. In addition, a complete wipe down of the resident's room was completed on 5/13/21. Upon his discharge on 6/1/21, room 222 was cleaned and carbolized. The Maintenance supervisor inspected rooms 115A/B, 116A/B, 117A,B, 119, 121A and 236 on 6/22/21 and is working on plans to repaint these rooms. Rooms 218, 220, 234, and 236 were assessed by the Facility Superintendent on 6/25/21 and it was determined that these rooms will also need to be included on the painting schedule. All rooms listed will be repainted by 8/6/21. The portable AC hose near the wall of room 226 and 228 was repaired on 6/22/21. The ceiling tiles in hallway near room 210 and 238 were replaced on 6/29/21. The ceiling tile in room 230 was replaced on 6/29/21. All residents have the potential to be affected by this deficiency. Responsible Person: The Facility superintendent or designee will be responsible for ongoing compliance. Systemic Changes and Monitoring: The housekeeping staff will continue to complete a daily checklist for each room to ensure that all tasks are completed. The inspections of paint and ceiling tiles for all rooms will be added tot he	

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F 584	Continued From page 13 Room 226 and 228. LN1 stated the portable AC hose laying on the ground ".. fell down and is not connected". On 05/27/21 at 02:00 PM, conducted an interview with M2. M2 stated, "We (the facility) are trying to replace units (AC) one at a time. We are looking at our Maile wing to upgrade. I change units all the time and the ceiling tile. We can only do one job at a time. We have been doing this since 1995. Bottom line is that everything costs money."	F 584	maintenance department's monthly checklist. The facility superintendent will monitor both the housekeeping and maintenance checklists for 90 days to ensure compliance and ensure that correction is achieved and sustained. Findings will be reported to the QAPI committee.	
F 585 SS=F	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution	F 585		8/6/21

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of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately

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F 585	Continued From page 15 reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the resident's right to voice grievances to the facility or other agency/entity that hears grievances. Residents were unaware of how to file a grievance/complaint and the contact information of independent entities (pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman	F 585	Corrective Action: This facility will ensure that residents are aware of their right to voice grievances. Residents #16, #5, and #26 were educated by the facility Social Worker on how to file a grievance on 6/29/21. The board of information that was located	

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F 585	Continued From page 16 program or protection and advocacy system) with whom grievances may be filed was not made available to all residents. As a result of this deficiency, residents are at risk for negative psychosocial impacts on their quality of life. Findings include: During an interview with Resident (R)16 on 05/25/21 at 12:56 PM, the resident stated multiple complaints were made to direct care staff (registered nurses (RN) and certified nursing assistants (CNA)) regarding the aspects of the resident's care. Inquired on how the resident would go about filing a grievance with the facility and if the resident was aware of his/her right to contact the State agency. The resident was not aware of how to file a grievance and stated he/she had just been complaining to staff and no one has addressed the resident's verbal complaints. Furthermore, R16 was unaware of the right to contact the State agency, the Office of Health Assurance (OHCA), and did not have access to OHCA's or the Adult Protective Service's contact information. Inquired if the resident attends resident counsel or leaves the room. R16 stated he/she never leaves the room due to the resident's health condition. This surveyor did not observe any posting for information of grievances or any State agency's contact information. On 05/27/21 at 11:15 AM, review of R16's admission Minimum Data Set (MDS) with an assessment reference date of 03/09/21 documented R16's Brief Interview for Mental Status (BIMS) score was 14 indicating the resident is cognitively intact. R16 was admitted to the facility on 03/02/214.	F 585	in an inconspicuous area was relocated to an area that is more easily seen by the residents (in front of the nurses station) on 5/26/21. RN1 was educated on the information provided to the residents in the admission packet on 6/29/21. All residents have the potential to be affected by this deficiency. Responsible Person: Social Worker and the Assistant Administrator or designees will be responsible for ongoing compliance. Systemic Changes and Monitoring: All Residents and staff will be educated on the grievance process. The social worker(or designee) will visit every new admission to ensure that they are aware of their right to file a grievance and what resources are available to them should they choose to file a grievance. There will be written information provided in each room with instructions on how to file a grievance. All new admissions will be audited by the Assistant Administrator or designee for 90 days to ensure compliance and documentation of education on the grievance process to ensure that correction is achieved and sustained. The results will be reported to the QAPI committee.	

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On 05/25/21 at 1:20 PM, requested a list of grievances for the past 6 months from the Administrator. The following day, the Administrator stated that the facility did not have any grievances from the residents.

2) An observation on 05/26/21 at 09:07 AM was made in the Ha'ole Room of the Board of information that includes the Ombudsmen's, grievance information and the States, OHCA contact information. This board was in an inconspicuous area in the dining room of the Ha'ole Room. The board was blocked by a white screen, in the corner next to the bathroom.

Interview on 05/26/21 at 10: 07 AM with the Administrator - there have been no grievances for over a year or longer.

On 05/26/21 at 1:30 and 2:01 PM, respectively interviewed Residents (R)5 and 26. R5 and R26 stated that they do not come out of their rooms, do not know the board in the Ha'ole Room, and do not know how to file a grievance.

An interview with the Social Worker (SW) on 05/27/21 at 10:04 AM. SW stated that the charge nurses go over the admission packet with the residents which includes the grievance procedure process. The SW coordinates the resident council meetings. Review of the resident council minutes dated May 2020, we discussed the Ombudsman as old business. The new business was resident rights. SW showed this surveyor the attendance form which showed 5 residents that attended the meeting in May of 2020, which was the last discussion in resident council regarding ombudsman, grievances and resident

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F 585	Continued From page 18 rights. SW further stated that I do a memory and mood assessment every three months during which the SW asks residents if they have any concerns, any complaints, in care plan conference. On 05/27/21 at 02:02 PM, surveyor interviewed Registered Nurse (RN)1 who is the charge nurse. RN1 was asked to go over the admission packet with this surveyor and duplicate the process when doing an admission to the facility. RN1 referred to the "concern" form in the admission packet and stated "if you have questions in regard to disability or resident rights, you will call that number. Information such as ombudsman, resident centered care, grievances was skipped over. This surveyor went over their paperwork with RN1 named "Got a Concern? Who to call?" The "concern" form includes ten State resource departments that include phone numbers as well. When surveyor asked RN1 if she knew that the states OHCA number and ombudsman's number was on their sheet for regulatory, licensing concerns and grievances, RN1 stated she was not aware of this. RN1 stated that the bulletin in the Maika Rooms has a list of resident rights. There are grievance forms outside of the Maika Room and before you turn to Maile unit. There is also a bulletin board in the Hau'oli room Interview and concurrent observation on 05/27/21 at 03:29 PM with Assistant Administrator (AA) who was shown the board of Information in the Ha'ole Room. The board was covered by a white screen in the back of the room. AA stated "Yes I agree no one can see this board. It needs to be moved."	F 585		
F 656 SS=D	Develop/Implement Comprehensive Care Plan	F 656		8/6/21

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F 656	Continued From page 19 CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 656		

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F 656	Continued From page 20 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review (RR), the facility failed to develop and implement a comprehensive person-centered Care Plan (CP) which met the needs and maintains the resident's highest practicable physical, mental, and psychosocial well-being for two residents ((R)30 and R162) sampled. Staff did not implement R162's comprehensive CP did not include restorative nursing service needs to prevent worsening foot drop and did not receive hot pack treatment for pain as indicated in the CP. An activity CP was not developed for R30's, who was placed in isolation due to the resident's diagnoses, until a few months after the resident's admission. The activity CP which later developed did not address R30's mental and psychosocial needs or risk due to on-going social isolation. As a result of these deficient practices, R30 and R162 were placed at risk for a decline in their quality of life, prevented from attaining their highest practicable well-being, and at risk for psychosocial harm. This deficient practice has the potential to affect all the residents in the facility. Findings include: 1) R162 was admitted to the facility on 05/07/21 with diagnoses which include Parkinson disease, irritable bowel syndrome, effusion of right shoulder, syncope, chronic dislocated shoulder, and anxiety.	F 656	Corrective Action: This facility will ensure that a comprehensive person-centered care plan is developed and implemented for each resident. Resident #162 was placed on the restorative nursing program to address right foot drop as recommended by Physical Therapy. An order was placed for foam boots to prevent pressure to heels and was added to the plan of care. An order was entered for the use of hot packs for pain to the right shoulder and the plan of care was updated. Resident #30's activities plan of care was updated to include interventions that are specific to the resident's needs after being interviewed by the activities director on 6/28/21. All residents have the potential to be affected by this deficiency. Responsible Person: The RAI coordinator or designee will be responsible for on-going compliance. Systemic Changes and Monitoring: Nursing will update care plans in accordance with new physician orders. A list of all new orders for the previous day	

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F 656	Continued From page 21 On 05/25/21 at 11:44 AM, conducted an interview with R162. R162 stated that he/she is supposed to going to physical therapy and receiving services for the resident's foot drop. Inquired with the resident if there are any splints or boots that should be applied to both feet. The resident stated that he/she has boots which the staff need to apply for foot drop, but the staff do not always apply them. On 05/27/21 at 08:52 AM, R162 confirmed foam boots located near the resident's closet were the residents'. On 5/27/21 at 11:51 AM, conducted a RR of R162's electronic medical record (EMR) and concurrent interview with Registered Nurse (RN)15. Review of the R162's CP documented the resident has the potential for a decrease in Activities of Daily Living (ADLs) related to chronic right foot drop. RN15 confirmed that there was no intervention for the application of boots or any intervention related to R162's foot drop in the CP. Further review of the Physician's Orders documented R162 did not have an order for the application of the boots. 2) On 05/25/21 at 11:44 AM, during an interview with R162, the resident stated he/she has chronic pain related to a chronic right shoulder dislocation. The resident stated he/she prefers a hot pack for pain relief instead of medications. Review of the CP documented the resident prefers not to take pain medications due to the resident feeling like it (medication) does not work. Resident stated that despite numerous request, staff do not provide a hot pack and feels like no one is listening. On 05/27/21 at 11:07 AM, conducted an interview and concurrent record review of R162's EMR with	F 656	will be reviewed by nursing for completion and then given to the RAI coordinator to ensure that care plans are complete and accurate in accordance with the physicians orders. RAI coordinator will also monitor to ensure that the comprehensive care plans are completed by Day 21 after admission and quarterly during care plan conference. The RAI coordinator or designee will monitor for 90 days to ensure correction is achieved and sustained and will report results to the QAPI committee.	

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F 656	Continued From page 22	F 656		

RN 15. Review of Physician Orders documented an order for the use of hot packs. Review of a note from a pain clinic appointment documented the use of a hot pack for more than two hours is welcomed. Review of the medication administration record (MAR) documented on 05/18/21, R162 received Tramadol medication for pain. R15 could not provide documentation that a hot pack was offered to the resident before the pain medication was administered. RN15 could not provide documentation that the resident was ever offered a hot pack for pain.

3) R30 was a 42-year-old male admitted on 10/20/20 for long-term care with a diagnosis of Amyotrophic Lateral Sclerosis (ALS), a disease affecting nerve cells in the brain and spinal cord, causing progressive loss of voluntary movements and muscle control, and eventually leading to death. Since his admission, R30 had been isolated in a single room in the facility, leaving his room only to attend outside doctor appointments. Due to medical interventions to manage his ALS symptoms, R30 was placed on droplet plus transmission-based precautions (TBP), requiring all who entered his room to wear gloves, a gown, an N95 respirator and a face shield. R30's only social interactions since his admission were either with the limited staff who entered his room (due to TBP), or through communication he independently initiated on his personal devices.

During an interview with R30 in his room on the Lehua Unit on 05/26/21 at 09:53 AM, R30 stated that he recalled "maybe twice" since admission where someone had come in to offer him a book, magazines, or puzzles to do. R30 continued to state that he spends much of every day alone in his room and has never been offered any

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F 656	Continued From page 23 assistance in setting up a FaceTime call, Zoom Meeting, or window visit with his family. Yesterday was the first time R30 was able to have visitors. R30 stated that prior to the visit, he communicated on his own with his family, without assistance or communication devices offered by the facility. On 05/28/21 at 09:49 AM, a RR of R30's CP was done. It was noted that R30's Activity Care Plan was not initiated until 01/14/21 and included no interventions specific to his unique situation. This was confirmed with the MDS Coordinator (MDS1) during an interview in her office at the same time. MDS1 agreed that R30 had a higher need for person-centered activities due to his isolation, and that his Activity Care Plan should have been developed and implemented sooner. It was also noted that although R30's CP did address his psychosocial well-being soon after admission, it was in the context of short-term isolation and restrictions related to COVID-19, and not the long-term isolation related to his disease management. The interventions included in this part of his CP were no different than any other resident in the sample.	F 656		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and	F 697	Corrective Action:	8/6/21

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F 697	Continued From page 24 record review (RR), the facility failed to ensure pain management was provided to a resident which was consistent with the resident's preference as evidenced by R162 was not provided a hot pack for pain relief related to a chronic dislocated right shoulder as requested by the resident. As a result of this deficient practice, R162 is at risk of increase pain which has the potential to affect the resident's quality of life and prevent the resident from attaining the highest practicable physical well-being. Findings include: R162 was admitted to the facility on 05/07/21 with diagnoses which include Parkinson disease, irritable bowel syndrome, effusion of right shoulder, syncope, chronic dislocated shoulder, anxiety, osteoporosis, and sciatica. On 05/25/21 at 11:44 AM, during an interview with R162, the resident stated he/she has chronic pain related to a chronic right shoulder dislocation. The resident stated he/she prefers a hot pack for pain relief instead of medications. Review of the CP documented the resident prefers not to take pain medications due to the resident feeling like it (medication) does not work. Resident stated that despite numerous request, staff do not provide a hot pack and feels like no one is listening. On 05/27/21 at 11:07 AM, conducted an interview and concurrent record review of R162's electronic medical record (EMR) with RN 15. Review of Physician Orders documented an order for the use of hot packs. Review of a note from a pain clinic appointment on 5/13/21, documented the use of a hot pack for more than two hours is welcomed. Review of the medication	F 697	This facility will ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive, person-centered care plan, and the resident's goals and preferences. Resident #162 was interviewed by the Director of Nursing to determine the resident's preferences for pain management. The resident stated that she wanted to use the same hot pack that was used at Hilo Medical Center, where she was prior to her admission to this facility. She stated that the reason she was refusing the hot packs in the past was because she wanted this same hot pack. Staff verified with Hilo Medical Center that the hot packs that were being used were the same as the ones used there. The resident agreed to use the current hot packs available at the facility after being informed they were the exact same hot packs as Hilo Medical Center used. The order for the hot pack was clarified and entered on 6/24/21 and the plan of care was updated. All Residents have the potential to be affected by this deficiency. Responsible Person: The LTC Nurse Manager or designee will be responsible for ongoing compliance. Systemic Changes and Monitoring: Education will be provided to the nursing staff regarding pain management and	

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F 697	Continued From page 25 administration record (MAR) documented on 05/18/21, R162 received Tramadol 25 mg at 09:25 AM for pain. R15 could not provide documentation that a hot pack was offered to the resident before the pain medication was administered. RN15 reviewed R162's entire EMR and could not provide documentation that the resident was ever offered a hot pack for pain. RN15 verbally confirmed R162 does not receive hot packs for pain management. On 05/27/21 at 11:45 AM, an interview with a certified nursing assistant (CNA) who is familiar with R162, confirmed the resident is not given a hot pack for pain relief.	F 697	non-pharmacological approaches to pain management. A report will be created to list all residents that received a PRN analgesic. The nurse managers will review this report and audit the chart to ensure that each resident's pain is managed in accordance with their preferences for 90 days to ensure corrective action is achieved and sustained. The findings of audits will be reported to the QAPI committee.	
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers'	F 700		8/6/21

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F 700	Continued From page 26 recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, record review (RR), and interview, the facility failed to ensure a safe environment free of accident hazards for one resident ((R)22) in the sample, as evidenced by upper bed rails being inappropriately engaged for R22. As a result of this deficient practice, R22 was placed at risk for avoidable injuries. This deficient practice has the potential to affect all the residents at the facility for whom it was determined that side rails were not recommended. Findings Include: R22 was a 27-year-old male admitted on 09/02/12 for long-term care, with diagnoses including quadriplegia (paralysis of all four limbs), history of traumatic brain injury, and a gastrostomy (a tube surgically inserted into the stomach for nutritional support). On 05/25/21 at 12:00 PM, an observation was done in R22's room on the Lehua Unit. R22 was lying in bed with both arms contracted to his chest and his torso leaning towards the right, floor pads were on the floor on both sides of his bed, and both upper bed rails had been locked in the up position. It was noted that the bed rails could only be disengaged from the outside of the bed. On 05/25/21 at 01:21 PM, an interview was done with the nurse manager (NM)1 of the Lehua Unit as she stood at R22's bedside. Both upper bed rails were still engaged at this time. When asked about the bed rails, NM1 stated that for any	F 700	Corrective Action: This facility will attempt to use appropriate alternatives prior to installing a side or bed rail. Resident #22's side rails were lowered as care-planned on 5/25/21. All residents have the potential to be affected by this deficiency. Responsible Person: The Director of Nursing and Facility Superintendent or designees will be responsible for ongoing compliance. Systemic Changes and Monitoring: Nursing staff will be educated on the proper use of side rails. Instructions on side rail use will be added to the "Care Needs" section of the medical record so that it is easily accessible to the staff. The Director of Nursing and Facility Superintendent will conduct room rounds Monday through Friday for 90 days to monitor the effectiveness of these changes and ensure that correction is achieved and sustained. The results of these rounds will be reported to the QAPI committee.	

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F 700	Continued From page 27 resident that had upper bed rails up, there should be orders in the chart. NM1 stated that she did not think R22 had bed rail orders, but she would double-check. At 01:28 PM, NM1 returned to R22's room and confirmed that all his bed rails should be down, stating that she did not know why they were placed up. On 05/27/21 at 12:00 PM, a RR of R22's Care Plans for Potential for Decrease in ADLs, dated 01/11/19, and Potential/History of falls, dated 10/18/18 noted the following intervention: "I have no functional use of UEs [upper extremities] and it is recommended that all my side rails to be in the down position."	F 700		
F 802 SS=D	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced	F 802		8/6/21

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F 802	Continued From page 28 by: Based on observation, interviews and record reviews, the facility failed to provide sufficient staff during the dining experience who can effectively carry out the food and nutrition service. Findings include: Observation was done on 05/25/21 at 12:15 PM on the Maile Unit. Wagon was delivered in the Hau'ole Room. There were 8 residents, one resident per table. All trays were served from that wagon to residents in the dining area. However, one tray was delivered to Room 226. There were no more trays to deliver. At 12:45 PM, the second wagon had arrived. This cart came down the hall to Maile unit. Trays were delivered to Room 222, 228, 230, 232, 218, 216, 234 and 212 respectively. The time delivery for the last tray was delivered at 12:56 PM. This placed the meal trays provided to the residents outside of the 45 minutes of scheduled time for meals. Interview on 05/25/21 at 12:44 PM with Dietary Manager (DM) was done. DM stated dietary do not have enough staff to deliver the trays. Here, it is the nurses who deliver the trays. We have to wait for nursing staff to come pick up the wagons and transport to the floors. From what happens, they may have to stop for trays to answer call lights. We can start the trayline on time. The first wagon can go out on time but the process of the trayline is lengthly and sometimes it can take 45 minutes, up to one hour. It also has to do with requests, i.e. if we have to make an extra papaya. Sometimes, the utility guys deliver the trays.	F 802	Corrective Action: This facility will employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service. All residents have the potential to be affected by this deficiency. Corrective Action: Four (4) new kitchen helper positions were posted on 6/28/21, which are being offered at a premium pay rate in order to attract more qualified applicants and increase staffing in the Food and Nutrition Services department. At this time, the utility workers will be responsible for delivering the meal carts to the units until the new positions are filled. Once the positions are filled, the kitchen helpers will deliver the meal carts. Responsible Person: The Food Service Manager or designee will be responsible for ongoing compliance. Systemic Changes and Monitoring: Dining Observations will be made to monitor if the resident's meal carts are being delivered in a timely manner. These observations will be made daily for 90 days to ensure that corrections are achieved and sustained, and the findings will be reported to the QAPI committee.	
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)	F 804		8/6/21

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F 804	Continued From page 29 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to ensure residents received food and drink that is palatable, attractive, and appetizing temperature for five residents in the sample (Resident (R)16, 5,47,34, and 26). As a result of this deficient practice, all resident's quality of life are at a potential to be affected. Findings include: On 05/25/21 at 12:56 PM, during dining observation, R16 in the room waiting for lunch to arrive. R16 stated that by the time the resident receives lunch it is usually cold and in general, the food does not always taste or look good. At 1:10 PM, R16 received lunch and was being assisted by staff and commented to this surveyor that it does not taste good and is cold as usual. 2) Interview on 05/25/21 at 10:50 AM with Resident (R) 5 stated "I don't care for the food. It is not flavored and it does not taste good. Interview on 05/25/21 at 12:02 PM with R47 who stated "The food is boring. It's the same thing. I don't get visitors so I can't get any outside food.	F 804	Corrective Action: This facility will ensure that each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor and appearance and is palatable, attractive and at a safe and appetizing temperature. Resident #16, Resident #5, Resident #47, Resident #34 and Resident #26 were interviewed by the Food and Nutrition Services Manager and the Registered Dietitian on 6/25/21 to address concerns. The 5-week cycle house menu was updated on 6/23/21. Two new alternative menus were created on 6/23/21, which will be alternated to ensure variety. All residents have the potential to be affected by this deficiency. Responsible Person: The Food and Nutrition Services Manager or designee will be responsible for ongoing compliance. Systemic Changes and Monitoring:	

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F 804	Continued From page 30 Interview on 05/25/21 at 2:22 PM with R34 who stated "The food is the same, chicken every time. They gave us one time three small sausages. The food is very little, half scoop rice, half broccoli. They give me half portions. Interview on 05/26/21 at 09:46 AM with R26 who stated "I'm very careful of what I eat and what they give. Surveyor asked if she makes special requests and she stated "yes because I notice food is in cycles and sometimes the rice is not cooked." Interview on 05/27/21 at 12:44 PM with Dietary Manager (DM) was done. DM stated that the facility is on a 5 week cycle. Our process is when a resident is admitted within the first two days, the diet aids go over their likes and dislikes. We have their likes, dislike and preferences and we let their nurses know. The dietician goes to talk with them. We are currently in the process of changing the menu. The dietary aides are supposed to go to the rooms and check with the residents about their likes and dislikes and offer any preferences daily. Surveyor shared observation of no dietary aids at bedside seen discussing menu with residents and residents not mentioning any dietary aids coming to the bedside about their meals. DM stated she will have to check with the dietary aids if they are still going to the rooms.	F 804	A "Dietary Concern" form was created in order to document residents' reports of dissatisfaction with food items. The dietary aides will visit the residents daily and will fill out a dietary concern form if there are any issues with food quality. This will be submitted to the Food and Nutrition Services Manager for follow up. Surveys will also be completed with residents on a monthly basis for 90 days and the results will be reported to the QAPI committee.	
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident	F 810		8/6/21

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F 810	Continued From page 31 can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review (RR), the facility failed to protect and maintain the ability to eat independently for Resident (R)27 by ensuring that he was provided with the special eating equipment he needed when consuming his meals. As a result of this deficient practice, R27 had difficulty consuming some of his meals and was placed at risk of a decrease in nutritional status and activities of daily living (ADLs). This deficient practice has the potential to affect all residents in the facility requiring assistive devices to eat. Findings Include: R27 was a 72-year-old male admitted on 07/25/20 for long-term care with diagnoses including Parkinson's Disease, schizophrenia, epilepsy, hypertension (high blood pressure), and asthma. On 05/25/21 at 12:29 PM, during an interview with R27 in his room on the Lehua Unit (LU), R27 stated that he is provided special utensils and a plate guard with his meal trays, due to the tremors in both of his hands related to Parkinson's Disease. On 05/25/21 at 01:17 PM, an observation and interview were done with R27 in his room on the LU during his lunch. A weighted spoon and fork were visible on the lunch tray, with a regular butter knife, and no plate guard. R27 was observed having a difficult time cutting a piece of chicken that was placed on his plate whole, with	F 810	Corrective Action: This facility will provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. Resident #27 had an order for an OT screen on 6/28/21 to determine his needs. "Resident demonstrated ability to use and manipulate butter knife with moderate difficulty. OT simulated weighted knife and resident demonstrated ability to manipulate knife with mild difficulty. Resident reported he would like to use a weighted knife. OT will order weighted knife for resident." Resident seen on 6/29/21 for follow-up with OT to assess ability and willingness to use a plate guard. Resident was explained benefits of plate guard and taught how to use it properly. He opted to trial use of plate guard at this time. Education was provide on 6/29/21 to dietary and nursing staff that were working on 6/25/21 about the importance of ensuring all adaptive equipment/assistive devices be available for resident use. All residents have the potential to be affected by this deficiency. Responsible Person: The Food Services	

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HALE HO'OLA HAMAKUA	45-547 PLUMERIA STREET HONOKAA, HI 96727

(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) COMPLETION DATE
F 810	Continued From page 32 food falling off his plate as he struggled to manipulate the utensils with both of his hands shaking. R27 stated the shaking in his hands was frustrating and wanted to ask the doctor if there was a surgery that could help. On 05/27/21 at 12:30 PM, a RR was done of R27's Care Plan for Nutritional Risk, dated 08/04/20. It was noted that one of the planned interventions was to "Provide me with weighted utensils and a plate guard." On 05/28/21 at 09:45 AM, an interview was done with the MDS Coordinator (MDS)1 in her office regarding the weighted utensils and plate guard in R27's care plan. MDS1 stated that although assistive devices should be placed on the meal tray by the kitchen, it is nursing's responsibility to ensure that care plan interventions are carried out, so the Nurse Aides (NAs) delivering the meal trays should be checking for and following up on assistive devices that may be missing from the tray. On 05/28/21 at 09:51 AM, an interview was done with the Registered Dietician (RD), and Nurse Manager (NM)2 in the hall outside of the RAI office. The RD stated that the only weighted knives the facility had were sharp knives and were not supplied to residents due to safety concerns. The RD confirmed that the facility had not ordered a weighted knife for R27 but that the regular butter knife that was currently being placed on R27's meal trays was there so the nursing staff that delivers the tray could cut his food for him. NM2 stated that R27 did not use the plate guard when it was provided, so it was not added to his meal trays anymore. Both the RD and NM2 acknowledged that R27's care plan	F 810	Manager and the RAI coordinator or designees will be responsible for ongoing compliance. Systemic Changes and Monitoring: The rehab department will assess residents during their admission and quarterly screens for the need for assistive devices for eating. The RAI coordinator will monitor for 90 days to ensure correction is achieved and sustained and will report the results to the QAPI committee. Dining observations will be made for 90 days to ensure assistive devices are on trays as ordered and to ensure correction is achieved and sustained and the results will be reported to the QAPI committee.	

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F 810	Continued From page 33 had not been updated to reflect these changes, and if assistive devices were refused by the resident, a signed refusal should be documented prior to discontinuing them.	F 810		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		8/6/21

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F 880	Continued From page 34 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to ensure appropriate protective and preventive measures for COVID-19 and other communicable diseases and infections. The nasal cannula for a resident receiving oxygen	F 880	Corrective Action: This facility will establish and maintain and infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help	

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F 880	Continued From page 35 therapy was not changed out appropriately. A suction canister was not properly changed out to prevent potential infection control issues. Also, staff did not appropriately store or properly re-use N95 respirators. As a result of these deficient practices, staff and patient infection control safety was compromised. These deficient practices have the potential to affect all residents in the facility, as well as all healthcare personnel at the facility. Findings include: 1) Observations on 05/25/21 at 1:45 PM and 05/26/21 at 10:35 AM, observed Resident (R)16 wearing nasal cannula tubing which was dated 5/17/12 at 6:00 PM for oxygen therapy. On 05/27/21 at 2:00 PM, interviewed the Assistant Administrator (AA) regarding when the nasal cannula tubing used for oxygen therapy should be changed out. AA stated the tubing should be changed out weekly every Monday and verbally confirmed R16's tubing should have been dated 5/24/21. Shared additional observations on 5/25/21 and 5/26/21 of R16's tubing dated as 5/17/21 at 6:00 PM, then a subsequent observation on 5/27/21 of R16's tubing was dated 5/23/21. The AA stated staff should not have back dated the nasal cannula tubing and will follow-up with staff. 2) On 05/25/21 at 12:00 PM, an observation was done in room 115B. A suction canister was observed on the wall behind a resident's head dated "5/10/21". The canister contained 350mLs of light blue fluid and was connected to tubing labeled "5/23/21".	F 880	prevent the development and transmission of communicable diseases and infections. Resident #16's oxygen tubing was changed on 5/27/21. Education was provided to the staff working on this unit on 6/30/21. Resident #22's suction canister was changed on 5/25/21. Education was provided to the staff working on this unit on 6/30/21. Staff working on this unit were re-educated on writing on their paper bags that stored their N95 masks to indicate the number of usages on 6/30/21. Responsible Person: The Infection Control Coordinator or designee will be responsible for ongoing compliance. Systemic Changes and Monitoring: All staff will view training videos "Keep COVID-10 Out!" and "Lessons" as required per the Directed Plan of Correction included in the notice dated 6/22/21. All staff will also receive training on Preventing Respiratory Infection found in QSO 19-10 NH dated 3/11/19 - Module 12A. Training on this module will be done by the Infection Control Coordinator as required by the Directed Plan of Correction in the notice dated 6/22/21. An RCA was conducted with the Director of Nursing, Infection Control Coordinator, Assistant Administrator, Nursing Home Administrator, and a member of the	

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F 880	Continued From page 36 On 05/25/21 at 01:21 PM, an interview was done with the nurse manager (NM1) in room 115B. NM1 stated that suction canisters should be changed out weekly and acknowledged that the suction canister above the bed should have been replaced. NM1 agreed that it was an infection control issue. 3) On 05/26/21 at 09:18 AM, an observation was done outside room 114, which was on transmission-based precautions (TBP). At the entrance to the antechamber of room 114 was a 3-drawer cart. Each of the three drawers were stuffed full of paper bags labeled with different names, and inside the bags were N95 respirators. No dates or other markings were noted on the bags. On 05/26/21 at 09:24 AM, an interview was done with NM1 outside room 114. NM1 stated that the paper bags were used to store the N95 respirators removed by staff as they left the room. NM1 described the facility's extended use policy of N95 respirators as allowing a maximum of five uses per respirator, stating that staff should be marking the outside of the paper bags with a hash mark each time they placed the respirator in it, so they could track how many more uses they had. When asked, NM1 could not locate any paper bags in the cart that were labeled with anything more than a name. NM1 acknowledged that since staff were not marking the paper bags appropriately, there was no way to tell how many times any of the respirators in the cart had been used.	F 880	governing body on 6/25/21 as required by the Directed Plan of Correction in the notice dated 6/22/21. Results of the RCA were used to develop the following plan: Nursing staff will be re-educated on infection control processes such as the timely changing of equipment and supplies as well as how to track the number of usages of their N-95 to ensure that it is used for no more than 5 donnings per CDC recommendations. The Director of Nursing and Facility Superintendent will monitor for compliance during daily room rounds Monday - Friday for 90 days and report findings to Infection Control Coordinator. The Infection Control Coordinator will compile this information and perform random weekly room checks for 90 days for additional monitoring and to ensure that corrections are achieved and sustained, and the findings will be reported to the QAPI committee.	

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E 000	Initial Comments A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 05/25/21 to 06/01/21. The facility was found to be in substantial compliance with Appendix Z, Emergency Preparedness, §42 CFR 483.73 for long term care facilities.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/01/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.