Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING: ______ B. WING ______	06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 000	Initial Comments A state relicensure survey was conducted by the Office of Health Care Assurance on 06/02/21 - 06/04/21. The facility was found not to meet the requirements at Hawaii Administrative Rules, Title 11, Chapter 94.1, Nursing Facilities. The census was 34 residents at the time of entrance.	4 000		
4 095	11-94.1-20(a) In-service education (a) There shall be a staff in-service education program that includes the following: (1) Orientation for all new employees that shall include: (A) Information to acquaint them with the philosophy, organization, program, policies and procedures, practices, and goals of the facility; and (B) Competency evaluation to ensure that staff are able to carry out their respective duties; (2) In-service training for employees who have not achieved the desired level of competence, and continuing in-service education to update and improve the skills and competencies of all employees; (3) In-service training that shall include annually, at minimum, prevention and control of infections, fire prevention and safety, disaster preparedness for all hazards, accident prevention, resident rights including prevention of resident abuse, neglect and financial exploitation, and problems and	4 095		7/19/21

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4 095	Continued From page 1 needs of the aged, ill, and disabled; (4) Competency testing for cardiopulmonary resuscitation to annually certify the nursing staff; (5) Training in oral hygiene and denture care, which shall be given to the nursing staff at least annually; and (6) Appropriate personal hygiene instructions at regular intervals shall be given to all personnel providing direct care and handling food. This Statute is not met as evidenced by: Based on interview, and record review, the facility failed to ensure that an annual competency certification for cardiopulmonary resuscitation (CPR) was maintained for all nursing staff. Findings Include: On 06/04/21 at 08:27 AM, after receiving staff competency and testing documentation from the facility, and noting expired competencies, an interview was done with the Administrator and the Office Manager (OM) in the front office. The OM confirmed that out of five randomly selected staff members (only three of which were nursing staff), for whom competency documentation was requested, there was one Certified Nurse Aide (CNA) that was still working despite having a CPR/First Aid certification that had expired on 05/07/20. The Administrator stated that monitoring staff credentialing, training, and testing was usually done by an Assistant Administrator	4 095	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Office Manager will ensure that CPR/First Aid Certification and TB clearances are up-to-date. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All current and new residents have the potential to be affected by the same deficient practice. What measures will be put into place or	

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4 095	Continued From page 2 (AA)2, who had been working remotely since March of 2020. The Administrator also stated that the facility was aware that they had fallen behind and were trying to improve.	4 095	systemic changes made to ensure that the deficient practice does not recur? The Office Manager will ensure that CPR/First Aid Certification and TB clearances are up-to-date. The Assistant Administrator will review the required certifications and clearances and double check that they are completed prior to the expiration date. How the facility plans to monitor its performance to make sure the solutions are sustained? The Assistant Administrator will review and double check that all required certifications and clearances are completed prior to expiration dates. The Assistant Administrator will conduct random monthly checks of the certifications and clearances.	
4 113	11-94.1-27(2) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (2) The right to be free of interference,	4 113		7/19/21

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4 113	Continued From page 3 coercion, discrimination, and reprisal from the facility that shall include the right to be free of chemical or physical restraints not medically indicated; This Statute is not met as evidenced by: Based on observations, interviews with staff members, record reviews, and review of the facility's policy and procedures, the facility failed to ensure 2 of 2 residents (Resident 25 and 29) sampled for physical restraints and one add-on resident (Resident 15) were free from physical restraints imposed for the purposes of discipline or convenience. The use of physical restraints was employed to restrict residents' movements which had the potential to contribute to a decline in physical functioning and/or affect residents' psychosocial functioning (agitation, shame, depression, dehumanization). This deficient practice has the potential to affect all the residents at the facility. Findings Include: 1) R25 was admitted to the facility on 01/15/20 with diagnoses that include hyperosmolality and hyponatremia, depressive disorder, vascular dementia with behavioral disturbance, and metabolic encephalopathy. Observation on 06/02/21 at 02:10 PM found Resident (R)25 in her room lying in bed. Bilateral upper rails were up, a folded blue floor mat was placed against the rail (extending the length of the upper bed rail) at the head of the bed with a geri chair placed at the foot of the bed, both items were on the left side of the resident's bed. The privacy curtain to the right side was drawn closed. There was a geri chair placed on the outside of	4 113	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? R25 the MDS will be reviewed and the ID Team will reassess the use of a blue pad and upper/top bedrail. The resident□s Broda char will be stored outside of the resident□s room. R29 on June 4, 2021 at 5 PM the DON and Physical Therapy Aide (PTA) discussed the resident□s physical limitations. The DON was updated by the PTA that the resident□s physical strength had improved, her ability to ambulate increased, and the wheelchair was no longer needed as a mode of locomotion. R29 was moved to a regular chair during activities and dining, and the pin alarm was removed. The resident was eventually discharged to home on June 14, 2021. R15 will be offered a regular chair to sit in while awake or during activities to ensure the least restrictive use of restraints or use of the recliner. The resident will be offered meaningful activities to ensure the resident remains free from falls or injuries.	

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4 113	Continued From page 4 the curtain which was placed against the resident's bed. The geri chair blocked the middle portion of the resident's bed. The resident's bed was positioned with her head and legs raised, creating a concave mattress. Second observation on 06/02/21 at 03:50 PM found R25 was out of bed. The folded blue mat and geri chair remained positioned at the head and foot of the bed as observed earlier. Third observation on 06/03/21 at 07:20 AM found the resident was out of bed and the folded blue mat and geri chair remained positioned to the left side of the bed at the head and foot of the bed. Record review done on 06/03/21 at 10:30 AM found an annual Resident Assessment with an assessment reference date of 04/30/21 documenting no use of restraints. A review of the care plan documents interventions for seizure disorder but no interventions to address placing the blue mattress and geri chair along the left side of the resident's bed. The quarterly "Morse Fall Scale" dated 04/15/21 indicates R25 has a history of falls and yielded a score of 55 (resident is a high risk for falling). Interview with the MDS Coordinator (MDSC) and Social Worker Designee (SS) was done on 06/03/21 at 01:54 PM at their desks in the breezeway. The MDSC reported R25 has combative behavior, she will fight staff. Further queried whether R25 ever fell out of bed. The MDSC found an incident on 07/18/20 R25 documenting R25 was awake, restless, and agitated. R25 threw pillows on the floor and slid down but did not fall on the floor. SS reported R25's bed is placed on the lowest position with a floor mattress plus pillows and rolled sheets are placed on the side of the resident as she can	4 113	How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All current and new residents that have a diagnosis of vascular dementia and exhibit restlessness that may require pin alarms or recliners may be potentially affected by the deficient practice. A restraint assessment will be conducted by the ID Team prior to the implementation of pin alarms, bed alarms, and mattresses/pads. A quarterly or as needed assessment will be conducted to ensure a restraint free environment. All RNs will be provided an in-service on the facility□s restraint protocol to ensure all alarms will have a physician□s order. All Certified Nurse Aides and the SWD will be provided an in-service in regards to physical restraints. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? The DON will conduct quarterly, random checks to ensure a restraint free environment. The ID Team will promote a restraint free environment by assessing the appropriateness of physical restraints and the use of the least restrictive measures quarterly.	

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4 113	Continued From page 5 move around in her bed. Record review on 06/04/21 at 08:00 AM of progress note dated 07/18/20 at 06:52 AM (referenced by the MDSC and SS) documents R25 was "awake, restless, combative and agitated, calling out all night...shaking the left side rail...resident's head was right next to the rail while she was shaking." R25 was repositioned away from the rails and pillows were applied to both side, resident continued to grab all pillows. On 06/04/21 at 08:10 AM, interviewed Certified Nurse Aide (CNA)3 in the resident's room (resident was not present). Inquired whether the "Broda" chair belonged to R25, CNA3 responded, the chair belongs to R12 (roommate) and was placed next to the bed as she was feeding R12. CNA3 also stated sometimes staff store the chair there. Upon further query CNA3 reported R25 will move about in bed and sometimes the blue folding mat is opened and placed along both sides of the bed should R25 awaken, to make sure resident doesn't go down. CNA3 could not recall resident falling out of bed; however, recalled R25 bumped her head on the rail. Interviewed the Director of Nursing (DON) on 06/04/21 at 08:29 AM at the nursing station. The DON reported R25 stays up at night and will try to grab staff and move about; however, there is no report of falls. Initially a bed alarm was used and has since been discontinued. The observation of the placement of the folded floor mattress and geri chair along the left side of R25's bed was shared with the DON. The DON acknowledged the placement of these items restricts R25's space and is a physical restraint. A request was made for the facility's policy and procedures on physical restraints.	4 113	How the facility plans to monitor its performance to make sure the solutions are sustained? The DON will conduct a quarterly restraint audit.	

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4 113	Continued From page 6 A copy of the policy and procedures was provided by the DON on 06/04/21 at 10:40 AM. The intent of the policy is for residents to be free from any physical restraints imposed for purposes of discipline or convenience and not required to treat residents' medical symptoms. The procedure includes the following: performing a Restraint Assessment, no less than quarterly; try less restrictive measure such as pillows, bed monitors, anti-slip pads on chairs, wedge cushions, one side rail down, etc; assist resident with appropriate exercise to achieve proper body position, balance and adjustment and to prevent contractures; and consult with other health professionals. 2) R29 was an 88-year-old female admitted on 05/11/21 following a right hip replacement. Other diagnoses include anemia, hypertension (high blood pressure), hyperlipidemia (increased lipids), dementia, and a history of falls. On 06/02/21 at 11:57 AM, an observation was done in the dining room. R29 was noted to have her wheelchair pushed up to a table with the wheels locked, and the footrests positioned at the level of her shins. R29 had just completed her lunch and was trying to stand up. As she struggled to stand, trying to push her chair back and in a crouched position with both shins pushed against the footrests of the wheelchair, R29's "pin" [chair] alarm loudly went off. The noise of the alarm startled R29, and she had an embarrassed look on her face as the Social Worker Designee (SS) rushed over to her and shut off the alarm. The SS then assisted R29 in standing, pushing the footrests out of the way, and walking her to the other side of the table where R29 wiped her table-mates area clean. SS	4 113		

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4 113	Continued From page 7	4 113		

then assisted R29 back to her wheelchair, where the chair alarm was reapplied.

On 06/03/21 at 07:03 PM, during a review of R29's electronic medical record and a copy of her baseline care plan, it was noted that there were no orders for a chair alarm, nor was it a part of her baseline or comprehensive care plans.

On 06/04/21 at 08:48 AM, an interview was done with the Director of Nursing (DON) at the nurse's station. When asked about the chair alarm and restricting the movement of R29, coupled with the wheelchair locks and footrests, the DON agreed that although the intention was not to restrain the resident, those interventions together do restrict the resident from standing. The DON also stated that all residents with bed or chair alarms should have an order for them. When asked to present the order for R29's chair alarm, the DON could not find one.

3) R15 was admitted on 1/25/13 with diagnoses that included vascular dementia with behavioral disturbances, hypertension, heart disease without failure, and anxiety disorder.

Multiple observations (06/02/21 at 08:43, 10:49 AM, 11:58 AM, 3:53 PM; 06/03/21 at 09:48 AM, 10:50 AM, 1:15 PM; and 06/04/21 at 10:15 AM and 12:10 PM) were made of R15 in the main dining room, laying in a recliner chair (the back of the chair lowered to an approximate 165 degree angle and footrest elevated which propped up R15's feet) sleeping and watching television (TV). On 06/02/21 at 11:58 AM, during lunch, observed R15 seated in the recliner with the back of the recliner an upright (approximately 90-degree angle) position. R15 stood up from the recliner and the Activities Director (AD) immediately ran

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4 113	Continued From page 8 over to R15 and told the resident to sit down. R15 sat back down then continued to attempt to stand but was unable to due to the AD standing directly in front of the resident. The AD placed his/her right hand on the front of R15's right shoulder and forcibly pushed R15's upper body towards the back of the recliner. The AD then laid the back of the recliner down, positioning R15 in a supine position on the resident's back. R15 made several unsuccessful attempts to stand from the recliner while in the supine position. After reclining R15, the AD proceeded to assist another resident with lunch. On 06/03/21 at 11:18 AM, conducted a record review (RR) of R15's hard chart and electronic medical record (EMR) at the nursing station. On 04/10/21 at 2:08 PM, an activity note documented R15 is able to walk using a walker to use the toilet and to monitor R15 for safety because R15 will stand up when the recliner is in an up position. R15's Plan of Care note written on 4/09/21 at 2:26 PM documented R15 is a high risk for falls with no regards to safety. On 06/03/21 at 2:45 PM, inquired with the AD regarding observations of R15 in a supine position in the recliner. The AD stated R15 will stand up from the recliner if it upright and attempt to walk, but the resident is a high fall risk and will fall if unassisted. The AD continued to explain R15 is place in a supine position in the recliner because staff is unable to safely monitor and prevent R15 from falling due to the resident's impulsive behavior and lack of safety awareness.	4 113		
4 115	11-94.1-27(4) Resident rights and facility practices	4 115		7/19/21

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4 115	Continued From page 9 Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on observation, and interview, the facility did not assure residents were treated with the respect and dignity during meals to promote enhancement of their lives, and in recognition of their individuality. This was evidenced by one resident (R)29 had a cloth clothing protector placed around her neck prior to each meal, and this was not her choice. As a result of this deficient practice, having been placed at risk of a decline in psychosocial functioning (embarrassment, shame, depression, dehumanization), this resident was prevented from attaining her highest practicable well-being. This deficient practice has the potential to affect all residents in the facility. Findings Include: 1) R29 was an 88-year-old female admitted on 05/11/21 following a right hip replacement. Other diagnoses include anemia, hypertension (high blood pressure), hyperlipidemia (increased lipids), dementia, and a history of falls.	4 115	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The DON will provide in-service training for all nursing staff, activity staff, and the SWD in regards to Dining Room Practices. This will include utilizing trays to deliver food and identifying which residents prefer using a tray while eating. The residents preferences will be identified and updated as needed through their care plans. Large clothing protectors will be discarded and the facility will provide cloth napkins to enhance the dining experience. Food serving will be modified to ensure that staff will be available to provide assistance for residents that require assistance during meals.	

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4 115	Continued From page 10 On 06/02/21 at 11:25 AM, an observation and interview were done with R29 in the dining room. R29 was observed having her lunch, which was served on a large plastic tray, with a large cloth clothing protector placed around her neck covering her chest and entire front torso. R29 was observed to be fully independent with feeding herself. R29 slowly and carefully cut the stuffed cabbage on her plate into bite-sized pieces without difficulty, then she began to feed herself lunch, with nothing falling off her fork, and not dropping anything. Once she had finished eating, R29 stood up to wipe her table-mate's area clean, as her area was already spotless. When asked if she wanted or had requested to wear a clothing protector, R29 answered, "no, they just put it on me." On 06/03/21 at 11:15 AM, an observation was done in the dining room of R29 sitting and waiting for lunch. The Activities Director was observed setting R29 up for lunch, placing a large cloth clothing protector around her neck. R29's permission was neither asked for nor given prior to the clothing protector being placed around her neck.	4 115	How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All current and new residents have the potential to be affected by the same deficient practice. Each resident□s cognitive functioning and physical functioning will be identified through the MDS assessment. Residents identified as needing assistance with meals will be provided with activities until a staff member is available to assist them. The staff member will then bring the resident to the dining room to assist them with their meal. The facility will continue to recruit and train staff to assist residents with meals as identified by the Facility Assessment. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? An annual Dining Room Practices in-service will be provided for all nursing staff, activity staff, and the SWD. How the facility plans to monitor its performance to make sure the solutions are sustained? The SWD will conduct a quarterly audit of	

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4 115	Continued From page 11	4 115	dining room experiences. The DON will conduct random checks of dining room practices quarterly. The DON will review and revise the dining room practices and protocol annually or as needed.	
4 118	11-94.1-27(7) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (7) The right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive; □ This Statute is not met as evidenced by: Based on interview and record review (RR), the facility failed to ensure an Advance Directive and/or discussions regarding Advance Directives was documented in one resident's medical record. As a result of this deficient practice, resident (R)29 was placed at risk of not having her wishes honored for future health care decisions, should she become incapacitated. This deficient practice has the potential to affect all the residents at the facility.	4 118	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Licensed Social Worker (LSW) was notified about the deficient practice and updated the Social Services Initial Assessment Form to include Advanced Health Care Directive information.	7/19/21

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HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

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4 118	Continued From page 12	4 118		

4 118 — Summary statement of deficiencies:

Findings Include:

On 06/02/21 at 03:09 PM, a RR of R29's hard chart and electronic medical record (EMR) noted a POLST (Provider Orders for Life-Sustaining Treatment), and a selection of a surrogate, but no Advance Directive. Further review noted no social services documentation that it had been discussed with R29 or her surrogate.

Advance Directive documentation was requested from the Director of Nursing (DON) on 06/04/21 at 08:48 AM.

On 06/04/21 at 11:42 AM, a brief interview was done with the DON in the Conference Room where she confirmed that R29 had no Advance Directive and it had not been discussed.

4 118 — Provider's plan of correction:

The SWD will be educated on the revised form and AHCD questionnaire.

R29 was discharged on June 14, 2021, with the son stating he will continue as the surrogate since R29 has short term memory loss and has been residing with him due to her condition.

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

All new and current residents without an AHCD will potentially be affected by the deficient practice.

The SWD will utilize the AHCD questionnaire when meeting with the resident or family member upon admission.

The SWD will review the code status quarterly, including if an AHCD is present.

The Administrator will be given a list of residents and the type of Medical Directives that are available in the EHR.

What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur?

The LSW will conduct a quarterly review of residents AHCD, with reports and recommendations forwarded to the Administrator.

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4 118	Continued From page 13	4 118	How the facility plans to monitor its performance to make sure the solutions are sustained? The LSW will conduct quarterly audits of the AHCDs.	
4 126	11-94.1-27(15) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (15) The right to translation or interpretation services or other communication assistance as necessary. This Statute is not met as evidenced by: Based on observations, record review, and interview with staff members, the facility did not ensure that the development and implementation of comprehensive person-centered care plans were done for one resident (R)31 in the sample. Specifically, care plan interventions were not developed to address communication needs for R31 once it was identified that she did not speak English. As a result of this deficient practice, R31 was placed at risk for a decline in her quality of life, and was prevented from attaining her highest practicable physical, mental, and psychosocial well-being. This deficient practice has the	4 126	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? R31 the MDSC will revise and update the plan of care to reflect the need of a Japanese interpreter. In the absence of an interpreter, staff will utilize translation applications to communicate with the resident.	7/19/21

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4 126	Continued From page 14 potential to affect all the residents at the facility. Findings Include: Resident (R)31 was an 89-year-old female admitted on 05/08/21 with diagnoses of Alzheimer's with Dementia, and a history of frequent falls. During an observation and attempted interview with R31 on 06/02/21 at 11:45 AM in the dining room, R31 was noted to be sleepy with a flat affect and was not responsive to any greetings or questions. On 06/02/21 at 02:11 PM, a phone interview was done with R31's family representative (FR2). FR2 confirmed that R31 does not respond to questions or greetings in English any longer, stating that R31 has reverted to only speaking in and responding to communications given in Japanese. FR2 stated she and other family members had noticed that even with them, R31 is much more directable and agreeable if she is spoken to in Japanese. R31 also stated that she informed the facility of this upon admission and was assured that there were Japanese-speaking staff available. On 06/02/21 at 08:08 PM, a review of R31's initial Resident Assessment with an assessment reference date (ARD) of 05/21/21 noted question A1100 A. "Does the resident need or want an interpreter to communicate with a doctor or health care staff?" To which it is documented that the resident answered "yes." The same assessment also documented that the resident's preferred language is Japanese. On 06/03/21 at 05:30 PM, a record review of	4 126	How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All current and new residents have the potential to be affected by the same deficient practice. The DON will monitor all completed assessments and comprehensive care plans for new admissions. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? All new admission assessments will be reviewed by the DON and the ID Team will review comprehensive care plans for all new admissions. After the ID Team reviews the plan of care, the MDSC will meet with all Certified Nurse Aides to review interventions. All preventative interventions will be placed in the PCC tasks (EHR) for daily monitoring. How the facility plans to monitor its performance to make sure the solutions are sustained? A comprehensive care plan audit tool will be utilized for a quarterly review by the DON.	

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4 126	Continued From page 15 R31's comprehensive care plan, initiated on 05/20/21, was done. It was noted that the comprehensive care plan included no Communication Plan or any interventions for interpreter services. It was also noted that despite having potential behavioral problems such as aggression, restlessness, and agitation identified and addressed, the comprehensive care plan contained no interventions that included addressing R31 in her preferred language. On 06/04/21 at 08:48 AM, an interview was done with the Director of Nursing at the nurse's station. When asked about interpreter services for R31, the DON stated that the facility had a certified nurse aide (CNA) that worked full-time on the evening shift, and a physical therapist working full-time that could both speak Japanese. Other than that, the DON stated the facility did not have access to interpreter services. When discussing R31's comprehensive care plan, the DON agreed that communicating with R31 in her preferred language should be a part of any plan addressing behavior.	4 126		
4 153	11-94.1-40(a) Dietary services (a) The food and nutritional needs of the residents shall be met through a nourishing, well-balanced diet in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, and shall be adjusted for age, sex, activity, and disability. (1) At least three meals shall be served daily at regular times with not more than a fourteen hour span between a substantial evening meal and breakfast on the following day;	4 153		7/19/21

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4 153	Continued From page 16 (2) Between meals nourishment that is consistent with the resident's needs shall be offered routinely and shall include a regular schedule of hydration to meet each resident's needs; (3) Appropriate substitution of foods shall be promptly offered to all residents as necessary; (4) Food shall be served in a form consistent with the needs of the resident and the resident's ability to consume it; (5) Food shall be served with appropriate utensils; (6) Residents needing special equipment, implements, or utensils to assist them when eating shall have the items provided by the facility; and (7) There shall be a sufficient number of competent personnel to fulfill the food and nutrition needs of residents. Paid feeding attendants shall be trained as per the facility's state-approved training protocol. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to assure there was sufficient staff to fulfill the food and nutrition needs of the residents in a timely manner. Residents that required assistance or dependent on staff members with their meals were observed to wait for staff members to assist them. The residents who dined in their room were also observed to wait for assistance with their meals. Also, observed staff members interrupting residents' meals when they	4 153	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All Certified Nurse Aides will be trained using the Hand in Hand Training that covers training for patients with dementia. The facility will modify kitchen serving	

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4 153	Continued From page 17 were called away to assist other residents. Findings Include: 1) Observation on 06/03/21 at lunch meal from 11:00 AM in the dining room found 15 residents seated in the dining room. The first tray was served at 11:21 AM. The last tray was served at 12:09 PM to Resident (R)25. Observed there were five residents that required assistance or were dependent on staff to assist in their meals, including R25 who was served 48 minutes after the first tray. R24 was seated in a geri chair, her lunch tray was provided at 11:29 AM, staff member sat with R24 at 11:36 AM to assist her with lunch. The staff member left at 11:42 AM to assist R1 leaving R24 with her lunch tray sitting in front of her. At 12:03 PM, the Activity Director (AD) went to assist the resident. A review of the admission Resident Assessment with assessment reference date (ARD) of 05/11/21 found R24 is dependent on staff for eating with one-person physical assist. R15 was seated in a geri chair in front of the television. R15's tray was provided at 11:31 AM, placed on an over bed tray. R15 received assistance from Registered Nurse (RN)2 with her lunch at 12:10 PM (39 minutes after resident was provided with her lunch tray). A review of the quarterly Resident Assessment with an ARD of 04/06/21 notes R15 required limited assist with one-person physical assist for eating. R25 was observed in the dining room at 11:00 AM. R25 was seated in a geri chair in the middle of the dining room (not at a table or over bed tray provided). At 12:09 PM, staff member was observed to provide a lunch tray to R25 and	4 153	times into 3 groups to provide sufficient dietary assistance for residents during mealtimes. Residents will be assessed and divided into groups for meals depending upon the level of assistance required during meals. The facility will implement a resident satisfaction survey, which will include questions on dietary staffing levels, staff approaches, and the dining experience. The Administrator is recruiting and training staff to assist with mealtimes. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All new and current residents who require assistance with meals may be affected by the deficient practice. The ID Team will continuously assess residents abilities and current needs to determine the level of assistance required during meals, and that there is sufficient staff assistance. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? The DON will monitor the efficacy of the modified meal times during periodic observations.	

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4 153	Continued From page 18 assisted her with her meal. A review of the annual Resident Assessment with ARD of 04/30/21 found R25 requires extensive assistance with one-person physical assist for eating. R10 was observed in the dining room at 11:00 AM. After waiting 42 minutes, RN2 assisted R10 with her lunch meal. A review of a significant change MDS with ARD of 03/22/21 noted R10 required limited assistance with one-person physical assist for eating. 2) Dining observation on 06/02/21 at 11:39 AM in the dining/activities room, observed Resident (R)32 was seated in a geri chair in front of the television with two residents positioned on each side. R32 did not have her lunch tray; however, the residents seated to her side both had their meals and were eating. Second observation at 11:53 AM found R32 still didn't have her lunch tray. At 06/02/21 at 12:09 PM interviewed the AD in the dining room and asked her whether R32 eats food. AD replied she will get R32's meal tray now. On the way to the kitchen, AD was called away to assist another resident. At 06/02/21 at 12:19 PM, RN2 was observed to assist R32 with her meal. R32 waited 40 minutes in the dining room while other residents were eating to begin her lunch. 3) On 06/02/21 at 12:01 PM in the dining room, R25 was observed receiving assistance with her lunch. R25's food is pureed. At 12:02 PM, AD was called to assist a resident that stood up (alarm went off). At 12:04 PM, AD returned to continue assisting R25 with her meal. AD was called away again. At 12:12 PM observed another staff member assisting the resident with her lunch. At 12:13 PM, this staff member was	4 153	The SWD will conduct resident satisfaction surveys monthly. Annual in-services for CNAs will include dementia specific training, utilizing the Hand in Hand Nursing Home training series. How the facility plans to monitor its performance to make sure the solutions are sustained? A quarterly resident satisfaction audit tool will be conducted by the SS.	

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4 153	Continued From page 19	4 153		

called away to help another resident. At 12:15 PM, R25 was observed to continually yell, "hey, hey, hey." No staff responded to her calling out. AD returned at 12:18 PM to continue feeding R25. R25's meal was interrupted three times within 17 minutes, disrupting her meal.

4) During lunch dining observation on 06/03/21 at 11:07 AM, observed kitchen staff prepare the first meal tray, resident (R)32's meal, and dining staff put R32's lunch tray in a brown tray cart. At 11:12 AM observed the last meal tray for residents' rooms 7 through 11 put into the brown tray cart and taken to the rooms' corridor. There are a total of six residents who need extensive assistance with their meals from this corridor and two Certified Nursing Aides (CNA) assigned to provide assistance, CNA10 and CNA1. From 11:12 AM to 12:00 PM, CNA10 was observed to provide set up assistance to residents who need less support, pick up and put away finished meals, and provide meal assistance with the residents who need extensive support.

At 11:20 AM, observed CNA1 provide assistance to R6 for lunch and was observed to finish lunch at 11:52 AM. At 11:56 AM, CNA1 proceeded to provide R30 assistance with lunch. R30 waited 44 minutes to eat lunch, from 11:12 AM to 11:56 AM. Interview with CNA1 at 11:53 AM in room 11, CNA1 stated she provides assistance with meals for three residents, but one of the three residents, R24, is in the facility dining room today.

From 11:24 AM to 11:39 AM, observed CNA10 provide assistance to R16 for lunch. From 11:43 AM to 11:57 AM, observed CNA10 provide assistance to R32 for lunch. R32 was the first meal tray prepared by kitchen staff at 11:07 AM and did not receive her lunch until 11:43 AM.

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4 153	Continued From page 20 Interview with CNA10 at 11:57 AM in front of room 8, CNA10 stated she provides assistance with meals for three residents. CNA10 was observed to provide assistance to R20 at 12:00 PM. R20 waited 48 minutes to eat lunch, from 11:12 AM to 12:00 PM.	4 153		
4 155	11-94.1-40(c) Dietary services (c) A nutritional assessment and care plan shall be recorded in each resident's medical record and integrated into the overall comprehensive assessment and overall plan of care coordinated/integrated with all disciplines. The nutritional assessment and care plan shall be reviewed on a regular basis and adjusted as needed. This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide care and services to prevent significant weight loss or to identify the need for dietary evaluation and intervention for one resident (R)31, as evidenced by an unrecognized weight loss of 6% in less than 30 days. As a result of this deficient practice, the facility placed this resident at risk for avoidable declines and injuries. This deficient practice has the potential to affect all residents at the facility. Findings Include: Resident (R)31 was an 89-year-old female admitted on 05/08/21 with diagnoses of Alzheimer's with Dementia, and a history of frequent falls. On 06/02/21 at 11:34 AM, R31 was observed sitting at a table in the dining room fast asleep,	4 155	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On June 4, 2021, the DON notified the resident□s attending physician and the RD about the resident□s poor PO intake and weight loss of 6% in less than a month. The DON received an order for Ensure 4 oz 6x/day. The RD recommended to monitor intake and provide high calorie snacks. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	7/19/21

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4 155	Continued From page 21 with her lunch sitting on a tray in front of her. Staff made multiple attempts to wake her and get her to eat, but R31 pushed her lunch tray away and refused, returning to sleeping in an upright position. On 06/03/21 at 05:30 PM, a record review was done of R31's electronic health record (EHR). It was noted that R31 was weighed only once since admission with a documented weight of 113 lbs. (pounds) on 05/10/21. A review of R31's meal intake noted documentation that R31 had refused all three meals on 05/30/21, had refused two meals and eaten 0-25% of a third meal on 05/31/21, had eaten 0-25% of all three meals on 06/01/21, and had refused one meal and eaten 0-25% of two meals on both 06/02/21 and 06/03/21. Further review of R31's comprehensive care plan, initiated on 05/20/21, noted the facility was aware of her poor nutritional intake, and was to "monitor/document/report... [R31] refusing to eat." On 06/04/21 at 08:48 AM, an interview was done with the Director of Nursing (DON) at the nurse's station regarding R31's poor intake and potential weight loss. The DON stated the facility protocol for all residents is that nursing should be monitoring resident intake. If there is poor intake documented for three days, then the resident should be weighed at that point, and the Registered Dietician (RD) and Physician should be notified. When informed of R31's poor intake for the past five days, the DON checked the EHR and confirmed that there was no documentation that the poor intake had been recognized, reported or acted upon. The DON agreed that R31's weight should have been checked and notification should have been done and stated that she would follow-up on it.	4 155	All new residents may potentially be affected by the deficient practice. The DON will review and update the policy and procedure for weight loss. The night shift RN will review the intake records and notify the day shift RN of residents who have had poor PO intake over the previous 3 days. The day shift RN will then make a referral or notify the family, RD, and attending physician. All nursing staff (RN and Certified Nurse Aides) will be provided in-service training with the revised weight loss protocol. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? The DON will review and update the policy and protocol regarding the procedure for weight loss. The night shift RN will review the intake records and notify the day shift RN of residents who have had poor PO intake over the previous 3 days. The day shift nursing staff will weigh the resident and notify the attending physician and RD for any new orders or recommendations. How the facility plans to monitor its performance to make sure the solutions are sustained? The DON will monitor residents� weights	

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4 155	Continued From page 22 On 06/04/21 at 12:50 PM, the DON entered the conference room and stated that R31 had been weighed, and her current weight was 106 lbs., reflecting a 6% weight loss in less than a month. The DON further stated that the RD and Physician had been notified.	4 155	monthly and ensure that any significant weight gain/loss is communicated to the RD and attending physician.	
4 174	11-94.1-43(b) Interdisciplinary care process (b) An individualized, interdisciplinary overall plan of care shall be developed to address prioritized resident needs including nursing care, social work services, medical services, rehabilitative services, restorative care, preventative care, dietary or nutritional requirements, and resident/family education. This Statute is not met as evidenced by: Based on observations, record review, and interview with staff members, the facility did not ensure that the development of comprehensive person-centered care plans were done for 4 (Residents 27, 16, 30, and 5) of 13 residents in the sample. Specifically, care plans were not developed for positioning of residents during meals with the potential to result in aspiration. Residents experiencing weight loss did not have care plan interventions to address the problem which may affect residents' nutritional status. Activity care plans were not developed to include person-centered interventions that would engage the resident in meaningful activities. As a result of this deficient practice, these residents were placed at risk for a decline in their quality of life, and were prevented from attaining their highest practicable physical, mental, and psychosocial well-being. This deficient practice has the	4 174	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? R27 on June 22, 2021, the DON notified the MD about the deficient practice and received an order for PT evaluation and treatment as indicated for safe positioning. In addition, the DON discussed the risks and benefits with the resident and their guardian. The MDSC updated the resident□s plan of care to address the risk of aspiration. R16 the MDSC will revise and update the plan of care related to unexplained weight loss as recommended by the RD.	7/19/21

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4 174	Continued From page 23 potential to affect all the residents at the facility. Findings Include: 1) Resident (R)27 was admitted to the facility on 05/03/21. Diagnoses include: history of cerebrovascular accident with right sided weakness, kyphosis, and Vitamin D deficiency. On 06/02/21 at 11:50 AM observed R27 in her room eating lunch (entrée was minced). R27 was flat on her bed with her head raised by a pillow. R27's head was drooped to the right, her head touching her shoulder. R27's plate was placed on her stomach as she fed herself. R27 was asked whether she was comfortable and ate this way at home. R27 responded that this was the way she ate at home and denied coughing or choking while eating. Second observation in the resident's room on 06/03/21 at 11:05 AM, found Certified Nurse Aide (CNA)10 reposition R27 with the head of the bed raised (approximately 25 degree angle) and placed a kidney shaped pillow around the resident's neck. At 11:24 AM, R27 was eating her meal, the lunch tray was placed on the over bed tray. R27's head was hanging to the front and drooping to the right side. Record review was done on 06/03/21 at 01:44 PM. A review of the admission Resident Assessment with an assessment reference date of 05/16/21 notes R27 yielded a score of 11 (moderately impaired) when the Brief Interview for Mental Status was administered. R27 was noted to require supervision (oversight, encouragement, cueing) with only setup help. In Section K. Swallowing/Nutritional Status, R27 was coded with no signs/symptoms of possible	4 174	R5 The ID Team will proceed to modify the MDS dated 12/10/2020 and the CAA for activities will be corrected to address a comprehensive person-centered care plan to enhance the quality of life. In addition, Section B of the MDS assessment will corrected to reflect the resident□s cognition. The AD will update and revise the resident□s preferences and interests on the activity flow sheet. The DON will collaborate with Bristol Hospice to engage residents in meaningful activities. R30 the MDSC will update the plan of care to address the risk of aspiration, as well as an intervention of seating the resident in her gerichair due to improved intake and decreased risk of aspiration due to positioning. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents with poor posture and increased aspiration risk, poor PO intake, and those who prefer to remain in their rooms may be affected by the deficient practice. The AD will identify all resident□s activity levels and engage residents in an activity of their choice and preference. The activities staff will develop a daily assignment list to offer and provide activities for residents who prefer to stay in their room to ensure all residents have an activity of their preference.	

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4 174	Continued From page 24 swallowing disorder. Further review found no care plan to address R27's positioning during meals that places her at risk for aspiration. Interview was conducted with the Director of Nursing (DON) on 06/04/21 at 10:52 AM in the breezeway. Inquired why does R27 have difficulty holding her head in midline. The DON reported that R27 has kyphosis and reportedly had a fall which resulted in injury to her neck. The DON also reported R27 has pain related to her neck and can't tolerate sitting up for too long. However, R27 will tolerate sitting for approximately 20 minutes when she has visitors. Inquired about R27's positioning while eating, DON responded R27 will tell staff how much to raise her head during meals and will not tolerate 90 degrees positioning as it hurts her back and neck. DON stated the facility is following her wishes. Further queried whether risks vs. benefits was discussed with the resident or her family representative. The DON agreed to follow-up for documentation that risks vs. benefits were discussed with the interdisciplinary team and resident/family representative. Prior to the survey team exit, documentation was not provided regarding the risks vs. benefits. 2) Resident (R) 16 was admitted to the facility on 03/29/2016 with diagnoses of unspecified dementia with behavioral disturbance, age related osteoporosis without current pathological fracture, bilateral primary osteoarthritis of knee, hypertension, and unspecified hyperlipidemia. On 06/03/21 at 02:06 PM, reviewed R16's quarterly Resident Assessment with an assessment reference date of 04/13/21, in Section G. Functional Status, under Eating (how resident eats and drinks, regardless of skill.), R16	4 174	A weekly plan of care updates review will be conducted by the MDSC. Interventions will be monitored by the charge nurse. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? The DON will conduct a random plan of care review on a quarterly basis to ensure that preventative measures are implemented. A monthly meeting with the AD and Assistant Administrator will be held to ensure adequate staffing for the activities department and to prepare necessary materials. An annual in-service for all activities and nursing staff will be conducted that will cover the Hand-in-Hand Dementia Care for All. How the facility plans to monitor its performance to make sure the solutions are sustained? A quarterly plan of care audit will be conducted by the DON. A quarterly activity audit will be conducted by the AD to ensure that the deficient practice will not recur.	

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4 174	Continued From page 25 requires total dependence-full staff performance every time with one person physical assist. Under Section K. Swallowing/Nutritional Status K.0300.Weight Loss, R16 had a loss of 5% or more in the last month or loss of 10% or more in the last 6 months and is not on a physician-prescribed weight-loss regimen. On 06/04/21 at 01:03 PM, reviewed R16's monthly weight chart from 08/10/20 to 05/04/21, R16 was 164 pounds (lbs.) on 08/10/20 and gradually decreased to 138 lbs. on 05/04/21. In one year, R16 lost 26 lbs. Interview with the Dietician (D1) on 06/04/21 at 08:03 AM, on the phone, stated R16 had unexplained weight loss. D1 was unable to further elaborate due to not having the resident's record in front of her, but stated she believes R16 is taking a supplement. Inquired whether there should be a care plan for R16's weight loss, D1 stated it should be in the care plan. On 06/04/21 at 09:06 AM, reviewed D1's most recent progress note entry dated 05/01/21, " ...April 2021 wt [weight] review for resident w [with]/significant, unexplained ...wt loss within the past 6 months ...Aspiration risk r/t [related to] hx [history of] difficulty swallowing and coughing during meals d/t [due to] advanced dementia: required a mechanically altered diet textured of minced solids. Remains on regular (thin) liquids. No noted problems on present diet, however requires total dependence w/meals d/t advanced dementia." Goals include maintaining R16's weight to prevent further unintended weight loss, no aspirations, maintain adequate hydration, no complains of constipation, and for R16 to consume 50% to 100% of food and fluids. In R16's dietary progress not, D1 recommended to	4 174		

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add 4 ounces (oz) of Ensure Plus two times a day with lunch and dinner to prevent further weight loss. "Encourage adequate hydration throughout the day to a goal of 1500ml/day. Continue to provide assistance w/meals to promote improved PO [by mouth] intake. Continue to monitor wt, intakes, diet consistency tolerance, labs as ordered."

Concurrent review of R16's care plan with Director of Nursing (DON) on 06/04/21 at 10:06 AM, at the nurses' station, D1's recommendations were not included in R16's care plan. R16 did not have a care plan for her unexplained weight loss.

3) R30 was admitted to the facility on 05/07/21 with diagnoses of unspecified epilepsy, intractable with status epilepticus, age-related osteoporosis without current pathological fracture, unspecified hyperlipidemia, and age-related physical debility.

During lunch observation on 06/02/21 at 12:18 PM, observed CNA10 assist R30 with her meals. CNA10 stated CNA1 usually assists R30 with her meals but is helping today. R30's bed was positioned at approximately 25 degree angle and R30's head was positioned forward, chin pointing at her chest. CNA10 used her hand to position R30's head straight prior to feeding R30. CNA10 then released her hand from R30's head without ensuring R30 swallowed and R30's head dropped to a forward position, chin pointing at her chest. Inquired about R30's bed position while eating, CNA10 quickly positioned R30 at a 45 degree angle and stated R30 will sometimes slide down from her bed.

On 06/03/21 at 02:10 PM, reviewed R30's admission Resident Assessment with an

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assessment reference date of 05/20/21, in Section G. Functional Status, under Bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed), R30 requires total dependence-full staff performance every time with one person physical assist. Under Eating (how resident eats and drinks, regardless of skill.), R30 requires total dependence-full staff performance every time with one person physical assist. In Section K. Swallowing/Nutritional Status, R30 was coded with no signs/symptoms of possible swallowing disorder.

Interview with CNA1 on 06/03/21 at 11:20 AM, CNA1 stated due to R30's head positioned forward, chin pointing at her chest, CNA1 positions R30's head straight with her hand, prior to feeding R30. CNA1 further stated she waits until R30 swallows her food to prevent aspiration and releases R30's head back to the forward position, chin facing her chest.

Interview with the Director of Nursing (DON) on 06/04/21 at 10:12 AM, DON stated while providing R30 assistance with meals, her bed should not be lower than a 45 degree angle. DON also acknowledged that staff should wait until R30 swallows prior to releasing her head back to the forward position, chin facing her chest, to prevent aspiration. Concurrent review of R30's care plan, R30 was not care planned to address R30's bed and head positioning, as well as, person-centered staff practice while providing assistance during meals.

4) Resident (R)5 was admitted to the facility on 11/27/20. Diagnoses include cognitive, social or emotional deficit; osteoporosis; and Type II diabetes mellitus.

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4 174	Continued From page 28 Observation on 06/02/21 at 09:01 AM, R5 was lying in her bed awake, asked the resident if she was okay and whether she had eaten her breakfast already. R5 replied she was okay but not sure if she had her breakfast. Subsequent observations on 06/02/21 at 09:28 AM, 11:08 AM, 02:12 PM (asleep), and 03:53 PM found R5 lying in her bed with the privacy curtain drawn across the foot of the bed, not engaged in any activity. R5 was observed eating her lunch at 11:44 AM. On 06/02/21 at 03:57 PM the television placed at the back wall (to the resident's right side) was on, Travel station. On 06/03/21 at 07:20 AM, R5 was lying in bed awake with no activity. Subsequent observation at 10:10 AM, R5 was lying asleep in bed with an empty cup on her bedside tray. R5 was not observed in dining/activity area and there were no activity materials (books, newspapers) left in her room to engage in an activity of choice. Record review was done on 06/03/21 at 10:15 AM. R5's admission/comprehensive Resident Assessment with assessment reference date of 12/10/20 indicates R5 has a severe cognitive impairment. A review of Section F. Preferences for Customary Routine and Activities, the following items were marked as the resident's preferences: receive shower, bed bath, sponge bath, receiving snacks, family involvement, reading books, newspaper, or magazine, and listening to music. Activities was triggered on the Care Area Assessment (CAA); however, it was noted the interdisciplinary team decided not to develop an individualized care plan for activities. The care plan provided by the facility on 06/03/21 at 02:44 PM notes a care plan for activities with the goal for the resident to attend activities three to five times weekly. Interventions includes: all staff to converse with resident while providing	4 174		

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4 174	Continued From page 29 care; invite the resident to scheduled activities; thank resident for attendance at activity function; resident needs assistance with ADLs as required during activity; resident needs 1:1 bedside/in-room visits and activities if unable to attend out of room events; and the resident needs assistance, escort to activity functions. Further review was done on 06/04/21 at 07:40 AM. A review of the "Activity Assessment Form" signed 12/10/20 lists R5's leisure interest as "spectator: watch TV/Movies/Sports; Music listening/plays instruments; and reading/writing/cognitive." There is a space to list specific preferences; however, it is blank. Also noted, resident is under hospice care and upon admission was on 14 day quarantine protocol; she has her own television to watch (likes to watch Korean drama); and newspaper to read or magazines will be offered. Interview was done with the Activity Director (AD) on 06/04/21 at 08:18 AM in the activity/dining room. AD reported R5 comes out for activities two to three times a week and is able to do memory match cards and puzzles. AD also reported the television in R5's room belongs to R12. Inquired what activities are provided during 1:1. AD responded, they usually visit R5 in the morning and will do orientation (name and day). They also invite R5 to watch television in the activity/dining room; however, AD is not sure of what R5's response is ("not sure what she is saying"). Further queried AD regarding documentation of R5's participation in activities or activities that were provided. AD reported staff will document in the tablet everyday what activities were provided. Requested a copy of R5's activity participation. Documentation/report of R5's participation in activities (day and type of	4 174		

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4 174	Continued From page 30 activity) was not provided prior to the survey team's exit on 06/04/21. On 06/04/21 at 08:28 AM a brief interview was conducted with R5 in her room. R5 was asked what she was going to do today, she did not respond. Asked if she would be going out to activities or prefers to stay in her room. R5 responded it's her preference to stay in the room. Further asked R5 whether she is provided with puzzles, books, or newspapers, she replied, "no."	4 174		
4 176	1-94.1-43(d) Interdisciplinary care process (d) Implementation of the overall plan of care shall be documented in each resident's medical record. This Statute is not met as evidenced by: Based on observations, record review, and interview with staff members, the facility did not ensure that the implementation of comprehensive person-centered care plans were done for two Residents (R)11, and 25. Care plans were not implemented to protect a resident with fragile skin from bruising or skin tears and for a resident with behaviors that include picking at her skin causing skin tears. Care plan interventions (hand roll towel) were not implemented for a resident with hemiplegia to prevent hand contractures or the worsening of contractures. As a result of this deficient practice, these residents were placed at risk for a decline in their quality of life, and were prevented from attaining their highest practicable physical, mental, and psychosocial well-being. This deficient practice has the potential to affect all the residents at the facility.	4 176	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? R25 the MDSC will revise and update the plan of care to include interventions to prevent bruising and skin tear. Resident bathing will be modified to prevent injury. All Certified Nurse Aides will be educated on the use of padding on the resident□s gerichair and applying protective sleeves on upper and lower extremities. R11 the MDSC will update and revise the plan of care and provide an in-service for all Certified Nurse Aides and nursing staff about interventions to prevent further contractures.	7/19/21

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4 176	Continued From page 31 Findings Include: 1) R25 was admitted to the facility on 01/15/20 with diagnoses that include hypersomality and hyponatremia, depressive disorder, vascular dementia with behavioral disturbance, and metabolic encephalopathy. Resident representative (RR) interview was conducted on 06/02/21 at 09:45 AM. RR reported that he has been notified of his parent having bruises. He further stated R25 has behavior where she thinks that someone is trying to hurt her, staff try to calm her down, however, she becomes combative. Observations on the following days found R25 did not have any bruises or skin tears and did not have geri sleeves applied: 06/02/21 at 11:50 AM seated in a geri chair in the dining room; 06/02/21 at 02:10 PM lying in bed in her room; 06/02/21 at 03:50 PM seated in a geri chair in the dining room; 06/03/21 at 07:20 AM seated in a geri chair in the dining room; and 06/03/21 from 10:44 AM through 12:27 PM seated in a geri chair in the dining room. Record review done on 06/03/21 at 10:30 AM found skin assessments from 03/19/21 to 04/16/21 noting ecchymosis to bilateral upper and lower extremities. Subsequent assessment note of 04/23/21 documents a bruise to the right side of the chin. The assessment of 05/07/21 notes the bruise to the right chin fading. Interview was done with the MDS Coordinator (MDSC) and Social Worker Designee (SS) at their desks in the breezeway. The MDSC reported R25 has combative behavior, usually dangling her legs from the recliner resulting in	4 176	How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents with poor posture and residents that exhibit restlessness with fragile skin are affected by the deficient practice. A weekly plan of care updates review will be conducted by the MDSC. Interventions will be monitored by the charge nurse. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? The DON will conduct a random plan of care review on a quarterly basis to ensure that preventative measures are implemented. All preventative interventions will be placed in the PCC tasks (EHR) for daily monitoring. How the facility plans to monitor its performance to make sure the solutions are sustained? A quarterly plan of care audit will be conducted by the DON.	

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bruises on her shins. MDSC also noted R25 becomes restless and hits her legs against the recliner. The SS reported the resident always has discoloration of the skin.

The Director of Nursing (DON) was interviewed on 06/04/21 at 08:29 AM at the nursing station. The DON reported that R25 is difficult to bathe, requiring two person assist and will flail her arms during the shower. The bilateral ecchymosis to upper and lower extremities were discovered after a bath. R25 reportedly grabs staff and tries to scratch them so another staff member has to assist to hold the resident in the chair to prevent her from falling. The DON further reported R25 displays the same behavior when provided bed bath and during perineal care.

Further queried whether the facility has developed a care plan to address R25's skin. The DON found a care plan for the resident to be free from skin tears through the review date (08/04/21) which includes intervention for "protective sleeves for the arms daily as indicated." The DON reported the sleeves should be applied daily and could not recall whether R25 refuses the sleeves. Informed the DON, R25 was not observed with protective sleeves during the survey. The DON also identified bathing R25 continues to be a problem as the resident becomes combative and the facility has not found a solution to bathing resident without a struggle.

2) R11 was admitted to the facility on 06/17/19 with diagnoses including dementia with behavioral disturbances, hemiparesis and hemiplegia following other cerebrovascular disease affecting the left dominant side, bradycardia, muscle weakness, atherosclerotic heart disease, and hyponatremia and

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4 176	Continued From page 33 hypo-osmolality. On 06/02/21 at 11:39 AM and 06/03/21 at 09:54 AM and 11:44 AM, observed R11 did not have a hand roll towel or any other type of equipment placed in the resident's hands to prevent contractures. On 06/02/21 at 11:50 AM, conducted a record review of R11's electronic health record (EHR). Review of the resident's care plan documented hand roll towels should be placed in R11's hands as an intervention for the prevention of contractures which was implemented on 06/17/19. On 06/03/21 at 10:00 AM, conducted a simultaneous record review of R11's EHR and interview with the DON. The DON navigated R11's EHR and confirmed R11's care plan includes interventions to place hand roll towels in the resident's hands to prevent contractures. Shared observations made of R11 with no hand roll towels on 06/02/21 and 06/03/21. The DON confirmed hand roll towels should have been implemented for the prevention or worsening of contractures.	4 176		
4 195	11-94.1-46(l) Pharmaceutical services (l) All drugs, including drugs that are stored in a refrigerator, shall be kept under lock and key, except when authorized personnel are in attendance. The facility shall be in compliance with all security requirements of federal and state laws as they relate to storerooms and pharmacies.	4 195		7/19/21

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4 195	Continued From page 34 This Statute is not met as evidenced by: Based on observation and interview with staff member, the facility failed to ensure drugs were securely stored. The medication cart was left unlocked for 36 minutes with the potential for residents to access medication or staff members for drug diversion. Findings Include: Observed an unlocked medication cart in the dining room on 06/02/21 at 11:32 AM through 12:08 PM (36 minutes). The cart was parked against the wall in the dining room next to the double doors leading to the corridor for rooms 12 and 13. The cart was unattended and staff were not administering medication. At this time, 15 residents were eating their lunches in the dining room. Concurrent observation of the medication cart was done with the Director of Nursing (DON) on 06/02/21 at 12:08 PM. The DON confirmed the cart was not locked and stated the medication cart should be locked. The DON was walking away from the cart and was stopped and instructed to lock the cart.	4 195	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The DON secured the cart. On the following shift, the DON notified all RNs about the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All current and new RNs may potentially perform the same deficient practice. All RNs will be reminded about locking the medication cart when unattended. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? The DON will perform an in-service on proper medication administration protocols with all RNs. The DON will conduct monthly random medication administration checks for all RNs. The pharmacy consultant will conduct medication administration checks on a monthly basis.	

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4 195	Continued From page 35	4 195	How the facility plans to monitor its performance to make sure the solutions are sustained? The DON will conduct a monthly medication administration audit.	
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, and staff interviews, the facility failed to implement appropriate protective and preventive measures for COVID-19 and other communicable diseases, infections, and foodborne illnesses. The facility did not conduct thorough or consistent screening of visitors entering the facility for signs and symptoms of COVID-19, staff did not perform hand hygiene between residents or tasks during dining services, and the facility did not have a system to ensure that proper sanitation temperature of the dishwasher was achieved. As a result of this deficiency, all residents are at an increased risk of developing and transmitting communicable diseases and infections. Findings Include: 1) On 06/02/21 at 07:57 AM, four (4) surveyors entered the facility. The Office Manager (OM)	4 203	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The health screening questionnaire was reviewed and updated to reflect current recommendations and restrictions related to COVID-19. Designated staff were re-trained on the sign-in process for all staff and visitors who enter the facility. The training includes how to properly use the thermometer and how to identify if it is working properly, and the use of the health screening questionnaire. How will the facility identify other residents	7/19/21

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4 203	Continued From page 36	4 203		

greeted the surveyors and proceeded to screen all surveyors which included answering a screening form and temperature screening. The screening form documented:

-Full legal name
-Purpose of visit
-Have you/anyone close to you worked at, visited, or resided at any other facility in the last 14 days? IF YES, please provide details:
-In the last 14 days, have you traveled to Oahu or spent any amount of time with someone who has traveler to Oahu? Yes No IF YES, DO NOT ENTER FACILITY
-In the last 10 days, have you/anyone close to you been tested for COVID-19? (include routine testing). If yes, please provide details- Yes No
-Do not enter id you answer yes to any of the following questions to the right->
- Been exposed to individuals with cold or flu-like symptoms
- Tested positive for COVID-19
- Had any of the following symptoms
- Sore throat (Yes No)
- Fever >or equal to 100F (Yes No)
- New or worsening cough (Yes No)
- Shortness of breath (Yes No)
- Chills/Fatigue (Yes No)

This surveyor answered yes to Have you/anyone close to you worked at, visited, or resided at any other facility in the last 14 days? IF YES, please provide details. This surveyor and another surveyor traveled to Hawaii Island on 5/25/21 and returned to Oahu on 5/28/21. The OM then attempted to take the surveyors' temperatures, but the thermometer was not properly working and the OM went and got the Social Worker Designee (SS) to help with the thermometer. The completed screening forms were collected by the SS, who then quickly scanned the forms and

having the potential to be affected by the same deficient practice and what corrective action will be taken?

All new and current residents may be affected by the deficient practices.

What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur?

The health screening questionnaire will be reviewed and updated each time the policy & procedures related to COVID-19 are updated.

Designated staff will be re-trained on the protocol to sign-in all staff and visitors who enter the facility. Training will also include health screening questions, proper thermometer usage, and when to restrict persons from entering the facility.

Annual in-services will include infection control practices, including hand hygiene.

The IP or a designated RN will conduct random monthly hand hygiene audits of all staff and provide feedback or retraining to staff as needed.

How the facility plans to monitor its performance to make sure the solutions are sustained?

Hand hygiene audits will be reviewed during the QAA/QAPI meetings.

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4 203	Continued From page 37 placed the forms in a plastic storage container drawer above the screen table with other completed screening forms. The surveyors were not questioned about recent travel or asked to provide details regarding questionable answers to the screening questions. On 06/03/21 only 2 of 4 surveyors were required to fill out the screening form. On 06/04/21, 2 of 4 surveyors were required to fill out the screening form and one surveyor took their own temperature and logged the reading in the facility book. On 06/04/21, 1 of 4 surveyors received a sticker which indicated the surveyor was screened and approved to enter the facility. All surveyors were not aware of or provided stickers post screening on the first and second days of entering the facility. On 06/04/21 at 10:19 AM, conducted an interview with the Infection Preventionist (IP) regarding visitor screening. The IP was informed of the inconsistent screening of the surveyors throughout the survey. The IP confirmed staff did not receive training on how to properly use the thermometer or how to identify if the thermometer is properly working. Inquired what happens to the visitor screening form once it is placed into the plastic storage container drawer above the screening table. The IP stated the drawer is emptied and placed in another container in the office. Inquired if the screening forms are reviewed by the IP or other staff. The IP confirmed the visitor screening forms are not reviewed to ensure the screening was completed thoroughly or correctly. 2) During a dining observation on 06/02/21 at 11:18 AM in the facility dining room, observed Certified Nursing Aide (CNA)5 adjust resident (R) 25's geriatric (geri) chair to an upright position and proceeded to help another staff member	4 203	The health screening questionnaire will be reviewed and updated each time the policy & procedures related to COVID-19 are updated. The IP will review the updates with the DON and Administrator for approval.	

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4 203	Continued From page 38	4 203		

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adjust R15's geri chair to an upright position by pushing the footrest down without handwashing or using alcohol-based hand rub (ABHR) between residents. After using ABHR, at 11:21 AM, CNA5 then went back to R25 and turned R25's geri chair to the dining table and proceeded to walk to R4 sitting across R25 and rub R4's shoulder to arouse her to wake up for lunch, without performing handwashing or using ABHR between residents.

At 11:29 AM observed Social Worker Designee (SS) touch R4 on the shoulder to arouse her to wake up for lunch, walk to an unidentified resident sitting in a geri chair and adjusted this resident's eyeglasses on her head. SS then walked to R29 and adjusted the puzzle on R29's dining table then walked to R14, announced to R14 it is lunch time and put the Japanese books R14 was reading to the side of her table, then walked to R3 and grabbed a newspaper on R3's dining table. SS did not perform handwashing or use ABHR between residents and tasks.

At 11:31 AM observed CNA5 bring R22's lunch tray to R22, set-up R22's beverages by putting straws in her cups, grabbed the lid covering R22's meal and proceeded to walk to an unidentified resident, touch this resident on the shoulder, grabbed her spoon, encouraged her to eat, then took this resident's knife and cut the stuffed cabbage into pieces without performing handwashing or using ABHR between residents/tasks.

3) During the initial tour of the kitchen with Kitchen Supervisor (KS) on 06/02/21 at 08:05 AM, KS stated the facility's sanitation method for dishes is by heat at 180 degrees Fahrenheit (F). KS demonstrated by turning on the dishwasher,

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4 203	Continued From page 39 three out of three times during the demonstration the dishwasher did not reach 180 degrees F. The following temperatures were concurrently observed with KS, 177 degrees F, 177 degrees F, and 174 degrees F. Observed written on the dishwasher, "Rinse temperature 180 F ...MIN." Inquired how the facility ensures the dishwasher is operating properly, KS stated a contracted agency comes once a month to maintain the dishwasher and ensure it is operating properly. Review of the facility's policy and procedure regarding "Use of Dishwasher" received on 06/04/21 at 10:37 AM, states "Check rinse cycle at 180 degree F or higher."	4 203		
4 209	11-94.1-53(b)(6)(7) Infection control (b) The facility shall have provisions for isolating residents with infectious diseases until appropriate transfers can be made. (6) There shall be a documented record that every employee and resident has an initial and an annual tuberculosis (TB) clearance. Facilities shall be in compliance with the most current and updated guidelines as set forth in chapter 11-164, Exhibit A; and (7) When a known negative tuberculin skin test on an employee or resident converts to a positive test, it shall be considered a new case of tuberculosis infection and shall be reported to the department. This Statute is not met as evidenced by: Based on interview, and record review, the facility	4 209	What corrective action(s) will be	7/19/21

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4 209	Continued From page 40 failed to ensure that an annual tuberculosis (TB) clearance was maintained for every employee. Findings Include: On 06/04/21 at 08:27 AM, after receiving staff competency and testing documentation from the facility, and noting expired TB clearances, an interview was done with the Administrator and the Office Manager in the front office. The OM confirmed that out of five randomly selected staff members for whom clearances were requested, one dietary personnel had not had a TB test since 04/04/18, and one Assistant Administrator (AA)1 had not had a TB test since 04/17/20. The Administrator stated that monitoring staff credentialing, training, and testing was usually done by AA2, who had been working remotely since March of 2020. The Administrator also stated that the facility was aware that they had fallen behind and were trying to improve.	4 209	accomplished for those residents found to have been affected by the deficient practice? The Office Manager will ensure that CPR/First Aid Certification and TB clearances are up-to-date. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All current and new residents have the potential to be affected by the same deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? The Office Manager will ensure that CPR/First Aid Certification and TB clearances are up-to-date. The Assistant Administrator will review the required certifications and clearances and double check that they are completed prior to the expiration date. How the facility plans to monitor its performance to make sure the solutions are sustained? The Assistant Administrator will review and double check that all required certifications and clearances are	

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4 209	Continued From page 41	4 209	completed prior to expiration dates. The Assistant Administrator will conduct random monthly checks of the certifications and clearances.	
4 220	11-94.1-55(g) Housekeeping (g) All combustible, potentially hazardous, or poisonous agents used for the cleaning of the facility shall be stored in a secured and locked area. This Statute is not met as evidenced by: Based on observation and interview with staff members, the facility failed to safely dispose of a cleaning chemical to ensure a safe environment for 1 out of 7 residents who had access to a shared bathroom. Findings Include: On 06/03/21 at 09:41 AM, observed in a shared bathroom between rooms 10 and 11 a non-acid disinfectant bathroom cleaner in the bathroom trash bin. At 10:02 AM, concurrent observation with Housekeeping (HK)6 of the bathroom cleaner in the trash bin, HK6 stated he left the bathroom cleaner in the trash and planned to take out the trash after lunch. HK6 further stated there is 1 resident between room 10 and 11 who can ambulate and has access to the bathroom. Interview with Housekeeping Supervisor (HS) on 06/04/21 at 08:13 AM, explained if there is an empty cleaning chemical bottle, staff are to dispose empty chemical bottles in the trash bin outside of the facility building. HS further stated that staff should only dispose of empty cleaning	4 220	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Housekeeping Supervisor (HS) will conduct an in-service to review proper disposal of empty chemical bottles. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The deficient practice affects all new and current residents who are ambulatory. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur? The HS will periodically respect resident trash bins to ensure housekeeping staff	7/19/21

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4 220	Continued From page 42 chemicals bottles in resident access trash bins if staff plan to throw away the trash right for resident safety. Interview with Certified Nursing Aide (CNA)1 on 05/04/21 at 08:19 AM, stated there are 3 residents who can use the bathroom on their own when taken. 1 out of the 3 residents can go into the bathroom with just staff stand-by assistance, staff positioned outside of the bathroom door.	4 220	are following proper disposal procedures for chemical substances. How the facility plans to monitor its performance to make sure the solutions are sustained? The HS will provide training for all new and current housekeeping staff. The HS will periodically inspect resident trash bins to ensure chemical bottles are disposed of properly.	