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 A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	125038		08/12/2021

NAME OF PROVIDER OR SUPPLIER
ALOHA NURSING & REHAB CENTRE

STREET ADDRESS, CITY, STATE, ZIP CODE
45-545 KAMEHAMEHA HIGHWAY
KANEOHE, HI 96744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 000	Initial Comments A relicensing survey was conducted by the Office of Healthcare Assurance (OHCA). The facility was found not to be in substantial compliance with Hawaii Administrative Rules, Title 11, Chapter 94.1 Nursing facilities. Survey dates: August 09 to August 12 2021. Survey Census: 103 Sample size: 23	4 000		
4 114	11-94.1-27(3) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (3) The right to be fully informed, both orally and in writing in a language understood by the resident, or in a manner that allows for the resident's understanding, of the resident's rights and all rules and regulations governing resident conduct and responsibilities; This Statute is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide R18 education about resident rights (RR). This deficient practice failed to give R18 the capability to protect his rights in the facility and has the potential to affect most of the residents.	4 114	4114 Resident Rights and Facility Practices F572 Notice of Rights and Rules Preparation and/or execution of this Plan	9/30/21

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/21/21

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4 114	Continued From page 1 Findings include: R18's EMR was reviewed on 08/09/21 at 1:14 PM. R18 is a 65-year-old male admitted to the facility on 02/03/17 for the inability to move his legs and lower body. On MDS with ARD of 07/22/21, he scored "15" for his Brief Interview for Mental Status (BIMS), out of a maximum of 15, meaning he is cognitively intact. An interview was conducted with R18 at the front entrance of the facility on 08/10/21 at 10:19 AM. He was reviewing a paper that contained communication about him to the outpatient physical therapy. While concurrently reading his medical diagnoses, he stated, "What are all these diagnoses?! I don't have these!" R18 was upset. He was queried whether he knew that he had the right to review his medical record at the facility. He stated that he didn't know that he could do so. The resident council (RC) meeting agenda for 07/21/21 was reviewed on 08/10/21 at 3:00 PM. Entry noted, "Resident rights: Handout available (See [TRM])." A follow up interview was done with R18 on 08/12/21 at 08:10 AM in his room. He stated that he doesn't like to attend the RC meetings and staff had not spoken to him about RR. He also stated that he had not seen any other information about RR in the facility. An interview was done with the Quality and Compliance Manager (QCM) in the conference room on 08/12/21 at 10:49 AM. She stated that RR are discussed in the RC meeting and a handout is given. She was queried of the facility's process for providing this information to residents	4 114	of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility□s credible allegation of compliance. 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. - On 9/17/21, Resident R18 was provided with education of the Resident Rights, and a handout was provided to Resident R18. The Licensed Social Worker explained to Resident R18 that he has the right to ask the facility for a copy of his medical records. - On 9/17/21, associates of the Therapeutic Recreation Department provided copies of the Residents Rights to each resident. Reasonable accommodations to address language barriers, hearing, and visual difficulties were offered; verbal translation of Resident Rights, printed copy of Residents Rights in various languages, and larger print of the Residents Rights. - On 9/26/21, the activities staff were in-serviced regarding educating the residents on their rights each month	

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4 114	Continued From page 2 who do not want to or are unable to attend the RC meetings. She stated that the TR department is responsible for providing information about resident rights (RR) to all residents in the facility.	4 114	during Resident Council Meeting with review of the Residents Rights. - To protect residents in similar situations, the facility staff were educated regarding providing the residents with notice of rights and services to the resident prior to or upon admission and during the resident□s stay. - A copy of the Residents Rights document is provided to the resident and/or resident□s representative prior to or upon admission to the facility. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice. - The alleged practice has the potential to affect facility residents. - To identify other residents having the potential to be affected by the identified deficient practice, the Aloha Nursing & Rehab Centre (ANRC) Resident Focus Round was created. - The DON or designee is to monitor and manage compliance by performing random assessments of compliance during weekly completion of the Aloha Nursing & Rehab Centre (ANRC) Resident Focus Round auditing tool. - Completed forms are to be kept in a binder in the Nursing Home Administrator□s (NHA□s) office or designee.	

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4 114	Continued From page 3	4 114	3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? - To ensure quality assurance and effectiveness, and to protect residents in similar situations, the facility staff were educated regarding Resident Rights including, but not limited to, providing the residents with notice of rights and services to the resident prior to or upon admission and during the resident□s stay. - In-services will be ongoing as needed, and will also be conducted with licensed and non-licensed staff at new hire orientation and, at least, annually by an activities staff or designee. - A designated location in the common area was selected to post Resident Rights information to ensure easy access and visibility to residents and their responsible parties when in the facility. - The facility will continue to provide a copy of Resident Rights and review its contents with the resident and/or responsible party upon admission. - A copy of Resident Rights will be distributed during monthly Resident Council Meetings. - Residents Rights will be reviewed and acknowledged with residents and/or their responsible parties during care plan	

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4 114	Continued From page 4	4 114	meetings. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. - To ensure that correction was achieved, all of the residents currently residing in the facility were given a copy their rights and an overview of their rights was completed by an associate of the activities department. - Facility staff were in-serviced on providing Residents' Rights to the resident and their responsible party upon admission and during their stay. - To ensure quality assurance and effectiveness of promoting the wellbeing of our residents, and upholding the residents□ rights for systemic changes, ongoing monitoring and random evaluation with application of the Aloha Nursing & Rehab Centre (ANRC) Resident Focus Round auditing form will be completed. - Completion of this tool is to occur weekly x 1 month, bimonthly x 1 month and monthly x 1 month by the DON or designee for a minimum of 12 weeks to ensure compliance. - Corrective action is to be taken	

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4 114	Continued From page 5	4 114	immediately and staff education is to be provided as deemed necessary. - Additionally, the facility□s Therapeutic Manager will review and audit Resident Council Minutes to ensure that the Residents Rights are covered at every Resident Council Meeting. Corrective measures and education to be taken with any deficient findings. - To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved. - If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met. - Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate. Included dates when corrective action will be completed: - Corrective action completion date by Nursing Home Administrator and/or designee.	
4 115	11-94.1-27(4) Resident rights and facility practices	4 115		9/30/21

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4 115	Continued From page 6 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 observations, interview and record review, the facility failed to treat Resident (R)13 and R80 with respect and dignity by not providing care in a manner that promotes maintenance of their quality of life. R13 was not provided appropriate and timely personal care that should have included daily grooming. R80 enjoyed crafting and creating decorative objects, which is part of his individuality. The deficient practice robs R13 and R80 of their self-worth and has the potential to affect all residents in the facility. Findings include: 1) Surveyor made observations on 08/09/21 at 08:16 AM and R13 was noted to be in his bed lying on his back, facing the right side. Christmas decoration was on his bedside table with a few other items dusty and in disarray. He was wearing a hospital type gown that was bunched up in a wad on his chest. His hair looked unclean and uncombed. His knees were tightly bent up under him and facing to the right side. His left leg was outside of the sheet, excoriations were	4 115	4115 Resident Rights and Facility Practices F550 Resident Rights/ Exercise of Rights Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility□s credible allegation of compliance. 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.	

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4 115	Continued From page 7 observed on his lower leg. A second observation was made at 10:53 AM. R13 was in the same position. Surveyor made additional observations on 08/10/21 to 08/12/21 throughout the day shift and into the evening shift. Noted that R13 was in his bed in his hospital gown and appeared with the same disheveled hair. On 08/12/21 at 10:06 AM, surveyor interviewed two staff (S)45 and S34 who requested to remain anonymous. Surveyor asked S45 how often are the showers and personal care being done for R13? S45 responded that today we have three certified nurse aides (CNA) assigned to this side and one who floats between the two sides. We try to do personal care when we make our rounds, baths are usually given two to three times a week. This is the heaviest floor; we really need at least four CNA's because the residents are heavier and more dependent. Sometimes we just can't get to everything, and they don't get all the personal care. S34 stated that she would like to have more time to provide more personalized care to the residents like grooming and cleaning nails. We are often short staffed, there's just no time for those things. 2) An initial observation of R80 was made on 08/09/21 at 10:48 AM. R80 was sitting upright in bed, sleeping with his television set on the channel and program guide. A hand made sign made with wire and numerous other wire craft objects were in his room. His partially eaten breakfast remained on a tray located on his bedside table at the side of his bed.	4 115	- On 9/10/21 Resident R13 was assessed for appropriate personal care of grooming and appearance by the Director of Nursing (DON). The resident was observed to have had a bed bath, he was neatly groomed with clean gown on, his bedside table was tidied, and the Christmas decoration was removed and stored. Residents comprehensive care plan reflects the resident□s preference to wear gown. - On 9/14/21 The Therapeutic Recreation (TR) manager assisted Resident R80 with a crafting activity of the resident□s choice. - On 9/15/21 Resident R80 was interviewed by the TR designee regarding the resident□s activity preferences and crafting activity schedule. - A personalized activities schedule was created for Resident R80 (refer to attached document); this schedule is subject to change according the resident□s preference & identified reasonableness - Staff has been educated on the Resident Rights of a dignified existence, self-determination, and the right to exercise his or her rights as a resident of the facility - Staff is to provide residents with care in a manner that promotes maintenance of their quality of life to promote their self-worth. 2) Address how the facility will identify other residents having the potential to be	

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4 115	Continued From page 8 R80 was interviewed on 08/10/21 at 12:00 PM in his room. R80 stated that he created the wire decorative objects in his room by hand with wire hangers. He stated that he had the tools to create his crafts but had been unable to use them. His tools were locked up at the facility because they were considered dangerous and could only be used when he was supervised. He stated that he could use them previously and staff would supervise him but thinks that he was now unable to because "they don't have enough staff." An interview was done with the Therapeutics Recreations Manager (TRM) on 08/12/21 at 09:12 AM in the training room. She stated that the facility had R80's soldering iron, pure alcohol and glue. The therapeutics recreation (TR) staff or social services (SS) would help to supervise R80 while he was utilizing these items to create his craft projects. She further stated, "He takes so long to get ready. We try to allocate the time for him." R80's "TR Routine Roster" report for the dates of 06/12/21 to 08/12/21 was reviewed on 08/12/21 at 11:00 AM. There were no activities documented for the month of August. In a follow-up interview with the TRM at 11:17 AM in the conference room, she stated that activities with the residents are documented when the TR staff does or upon completion of the activity with the resident.	4 115	affected by the same deficient practice. - The alleged practice has the potential to affect facility residents. - To identify other residents having the potential to be affected by the identified deficient practice, the F-550 Dignity Personal Care Tracking Tool (Grooming, Bedside Table, Activities Participation) has been created (refer to attached document). Comprehensive care plans will be updated as needed to incorporate resident preferences according to the findings. - Furthermore, managers of the interdisciplinary team are to monitor and manage compliance by performing random assessments of compliance during completion of weekly auditing with use of the referenced tool. - Completed forms are to be kept in a binder in the Nursing Home Administrator□s (NHA□s) office or designee. 3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? - To ensure quality assurance and effectiveness, staff were in-serviced regarding Residents Rights to a dignified existence, self-determination and care preferences to promoting quality of life. Comprehensive care plans will be updated	

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4 115	Continued From page 9	4 115	to incorporate resident preferences. - In-services will be ongoing as needed. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. - Unit Manager will review Resident R13□s personal care activity for four weeks to ensure that the facility is meeting the daily personal care activities and care needs of the resident. Findings will be reviewed with members of the interdisciplinary team (IDT) team, and staff is to be educated as needed. - TR Manager will audit Resident R80□s weekly therapeutic activity attendance for four weeks to ensure that the facility is supporting the resident□s right to meaningful activities. - To ensure quality assurance and effectiveness of promoting dignity and upholding the residents□ rights for systemic changes, ongoing monitoring and random evaluation with application of the Dignity Personal Care Tracking Tool (Grooming, Bedside Table, Activities Participation) will be completed. - Completion of this tool is to occur weekly	

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4 115	Continued From page 10	4 115	x 1 month, bimonthly x 1 month and monthly x 1 month for a minimum of 12 weeks to ensure compliance. - Corrective action is to be taken immediately and staff education is to be provided as deemed necessary. - To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved. - If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met. - Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate. Included dates when corrective action will be completed: - Corrective action completion date by Nursing Home Administrator and/or designee. F574 Required Notices and Contact Information Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider	

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4 115	Continued From page 11	4 115	that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility□s credible allegation of compliance. 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. - On 9/16/21, Resident R86 and Resident R63 were informed by facility staff that Amy Lee is the new Administrator. Both residents were also informed that all issues and concerns may be addressed with the facility Administrator, Social Services Department, or any supervisor or department manager. These residents were also informed that complaints about the facility could also be filed with a state agency. - On 9/26/21, to protect residents in similar situations, facility staff were in-serviced on the facility□s responsibility to provide residents with State Agency, Ombudsman, and Adult Protective Services information to submit and file a complaint as needed or as deemed necessary. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	

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4 115	Continued From page 12	4 115	- The alleged practice has the potential to affect facility residents. - To identify other residents having the potential to be affected by the identified deficient practice, the Aloha Nursing & Rehab Centre (ANRC) Resident Focus Round was created to assess for knowledge deficit of filing complaints with state agencies: Hawaii Dept. of Health Office of Health Care Assurance, Hawaii State Ombudsman, and Adult Protective Services (APS). - The DON or designee is to monitor and manage compliance by performing random assessments of compliance during weekly completion of the Aloha Nursing & Rehab Centre (ANRC) Resident Focus Round auditing tool. - Completed forms are to be kept in a binder in the Nursing Home Administrator□s (NHA□s) office or designee. 3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? - An informational wall, a designated location in the common area, has been created to allow residents to see and obtain pertinent contact information at wheelchair level to promote resident visibility. The information posted has also been posted in a larger, easy to read, font.	

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STREET ADDRESS, CITY, STATE, ZIP CODE
45-545 KAMEHAMEHA HIGHWAY
KANEOHE, HI 96744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 115	Continued From page 13	4 115	- Residents Rights, state regulatory, informational and advocacy agencies contact numbers will be reviewed with residents during resident council meetings and care plan conferences. If the resident is unable to understand the information, the information will be provided to the resident s responsible party. - Resident Focus Rounds was created to reflect resident interview query regarding their ability to contact the State Agency: Hawaii Department of Health Office of Health Care Assurance - Register of Complaint Confidential Information, Hawaii State Ombudsman, and APS. Contact information to file a complaint as needed of the referenced state agencies is included on the ANRC Resident Focus Rounds document. - To ensure quality assurance and effectiveness, and to protect residents in similar situations, the facility staff were educated regarding the aforementioned Residents Right. - In-services will be ongoing as needed, and will also be conducted with licensed and non-licensed staff at new hire orientation and, at least, annually by an activities staff or designee. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action	

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	125038		08/12/2021

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4 115	Continued From page 14	4 115	evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. - The Therapeutic Manager (TM) will randomly audit 10 resident records monthly to ensure that residents were notified of Residents Rights and advocacy contacts. Audit findings will be reviewed and discussed during the monthly Quality Assurance Performance Improvement (QAPI) meetings. - To ensure that correction was achieved, all of the residents currently residing in the facility were informed of their rights to file a complaint with the facility Administrator, Social Services Department, or any supervisor or department manager. The residents were also informed that complaints about the facility could also be filed with a state agency. - On 9/26/21, to protect residents in similar situations, facility staff were in-serviced on the facility□s responsibility to provide residents with State Agency, Ombudsman, and Adult Protective Services information to submit and file a complaint as needed or as deemed necessary. - To ensure quality assurance and effectiveness of promoting the wellbeing of our residents, and upholding the residents□ rights for systemic changes, ongoing monitoring and random evaluation with application of the Aloha Nursing & Rehab Centre (ANRC) Resident Focus Round auditing form will be completed.	

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4 115	Continued From page 15	4 115		

- Completion of this tool is to occur weekly x 1 month, bimonthly x 1 month and monthly x 1 month by the DON or designee for a minimum of 12 weeks to ensure compliance.

- Corrective action is to be taken immediately and staff education is to be provided as deemed necessary.

- To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved.

- If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met.

- Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate.

Included dates when corrective action will be completed:

- Corrective action completion date by Nursing Home Administrator and/or designee.

F572 Notice of Rights and Rules

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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4 115	Continued From page 16	4 115	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility□s credible allegation of compliance. 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. - On 9/17/21, Resident R18 was provided with education of the Resident Rights, and a handout was provided to Resident R18. The Licensed Social Worker explained to Resident R18 that he has the right to ask the facility for a copy of his medical records. - On 9/17/21, associates of the Therapeutic Recreation Department provided copies of the Residents Rights to each resident. Reasonable accommodations to address language barriers, hearing, and visual difficulties were offered; verbal translation of Resident Rights, printed copy of Residents Rights in various languages, and larger print of the Residents Rights. - On 9/26/21, the activities staff were in-serviced regarding educating the residents on their rights each month	

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4 115	Continued From page 17	4 115	during Resident Council Meeting with review of the Residents Rights. - To protect residents in similar situations, the facility staff were educated regarding providing the residents with notice of rights and services to the resident prior to or upon admission and during the resident□s stay. - A copy of the Residents Rights document is provided to the resident and/or resident□s representative prior to or upon admission to the facility. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice. - The alleged practice has the potential to affect facility residents. - To identify other residents having the potential to be affected by the identified deficient practice, the Aloha Nursing & Rehab Centre (ANRC) Resident Focus Round was created. - The DON or designee is to monitor and manage compliance by performing random assessments of compliance during weekly completion of the Aloha Nursing & Rehab Centre (ANRC) Resident Focus Round auditing tool. - Completed forms are to be kept in a binder in the Nursing Home Administrator□s (NHA□s) office or designee.	

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4 115	Continued From page 18	4 115	3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? - To ensure quality assurance and effectiveness, and to protect residents in similar situations, the facility staff were educated regarding Resident Rights including, but not limited to, providing the residents with notice of rights and services to the resident prior to or upon admission and during the resident□s stay. - In-services will be ongoing as needed, and will also be conducted with licensed and non-licensed staff at new hire orientation and, at least, annually by an activities staff or designee. - A designated location in the common area was selected to post Resident Rights information to ensure easy access and visibility to residents and their responsible parties when in the facility. - The facility will continue to provide a copy of Resident Rights and review its contents with the resident and/or responsible party upon admission. - A copy of Resident Rights will be distributed during monthly Resident Council Meetings. - Residents Rights will be reviewed and acknowledged with residents and/or their responsible parties during care plan	

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4 115	Continued From page 19	4 115	meetings. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. - To ensure that correction was achieved, all of the residents currently residing in the facility were given a copy their rights and an overview of their rights was completed by an associate of the activities department. - Facility staff were in-serviced on providing Residents' Rights to the resident and their responsible party upon admission and during their stay. - To ensure quality assurance and effectiveness of promoting the wellbeing of our residents, and upholding the residents□ rights for systemic changes, ongoing monitoring and random evaluation with application of the Aloha Nursing & Rehab Centre (ANRC) Resident Focus Round auditing form will be completed. - Completion of this tool is to occur weekly x 1 month, bimonthly x 1 month and monthly x 1 month by the DON or designee for a minimum of 12 weeks to ensure compliance. - Corrective action is to be taken	

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4 115	Continued From page 20	4 115	immediately and staff education is to be provided as deemed necessary. - Additionally, the facility□s Therapeutic Manager will review and audit Resident Council Minutes to ensure that the Residents Rights are covered at every Resident Council Meeting. Corrective measures and education to be taken with any deficient findings. - To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved. - If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met. - Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate. Included dates when corrective action will be completed: - Corrective action completion date by Nursing Home Administrator and/or designee.	
4 120	1-94.1-27(9) Resident rights and facility practices	4 120		9/30/21

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4 120	Continued From page 21 Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (9) The right to names, addresses, and telephone numbers of pertinent resident advocacy groups; This Statute is not met as evidenced by: Based on observations and interviews, the facility failed to provide contact information of pertinent State agencies that were visible to the residents. The deficient practice rendered the residents incapable of contacting advocacy groups for assistance if the facility failed to protect their rights. Finding includes: On initial observations of the facility on 08/09/21 at 09:30 AM, surveyor was unable to locate posted contact information of the State Survey agency, Long Term Care (LTC) Ombudsman and Adult Protective Services (APS). After continued observations of the facility on 08/09/21, 08/10/21 and 08/11/21, contact information was revealed for the previously mentioned agencies printed on an 8 ½ inch by 11-inch document in the horizontal format. It was posted on the wall next to the elevator approximately five feet and five inches up from the floor. An RC meeting took place on 08/10/21 at 10:00	4 120	4120 Resident Rights and Facility Practices F574 Required Notices and Contact Information Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility□s credible allegation of compliance. 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. - On 9/16/21, Resident R86 and Resident R63 were informed by facility staff that	

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4 120	Continued From page 22 AM in the second-floor activities room. R86 and R63 did not know who they could voice their complaints to because their Administrator recently left. They were asked if they knew that complaints about the facility could also be filed with a state agency and they both stated that they didn't know that. R86 stated, "We have a form that we fill out or go to (the former Administrator), but we do not know who to go to now because (the former Administrator) left. R63 stated, "I don't know who to talk to." A review of "COVID 19 Resident Council Satisfaction Survey" from March 3, 2021, to June 30, 2021 was done on 08/10/21 at 3:00 PM. The TRM stated that the facility did these satisfaction surveys in the place of RC meetings because of the COVID-19 pandemic and the inability to do group activities. Question number eight queried the resident, "Are you aware that the ombudsman's contact information is posted? Yes, No." Out of the 36 surveys reviewed, nine circled "Yes," 23 circled "No" and four surveys were not answered, or "N/A" was written. On 08/12/21 at 08:45 AM, an interview was done with RN25 at the unit's nursing station. Surveyor showed RN25 the posted contact information of pertinent State agencies for residents on the wall by the elevator and inquired if residents can read it. RN25 stated that the print was too small, needed to be in bold, was placed too high and that residents would have a hard time seeing the document. RN25 further stated that she previously worked in another nursing home and that the information was provided on a big poster visible to residents.	4 120	Amy Lee is the new Administrator. Both residents were also informed that all issues and concerns may be addressed with the facility Administrator, Social Services Department, or any supervisor or department manager. These residents were also informed that complaints about the facility could also be filed with a state agency. - On 9/26/21, to protect residents in similar situations, facility staff were in-serviced on the facility□s responsibility to provide residents with State Agency, Ombudsman, and Adult Protective Services information to submit and file a complaint as needed or as deemed necessary. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice. - The alleged practice has the potential to affect facility residents. - To identify other residents having the potential to be affected by the identified deficient practice, the Aloha Nursing & Rehab Centre (ANRC) Resident Focus Round was created to assess for knowledge deficit of filing complaints with state agencies: Hawaii Dept. of Health Office of Health Care Assurance, Hawaii State Ombudsman, and Adult Protective Services (APS). - The DON or designee is to monitor and manage compliance by performing random assessments of compliance	

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4 120	Continued From page 23	4 120	during weekly completion of the Aloha Nursing & Rehab Centre (ANRC) Resident Focus Round auditing tool. - Completed forms are to be kept in a binder in the Nursing Home Administrator□s (NHA□s) office or designee. 3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? - An informational wall, a designated location in the common area, has been created to allow residents to see and obtain pertinent contact information at wheelchair level to promote resident visibility. The information posted has also been posted in a larger, easy to read, font. - Residents Rights, state regulatory, informational and advocacy agencies□ contact numbers will be reviewed with residents during resident council meetings and care plan conferences. If the resident is unable to understand the information, the information will be provided to the resident□s responsible party. - Resident Focus Rounds was created to reflect resident interview query regarding their ability to contact the State Agency: Hawaii Department of Health Office of Health Care Assurance - Register of Complaint Confidential Information, Hawaii State Ombudsman, and APS. Contact information to file a complaint as needed	

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4 120	Continued From page 24	4 120	of the referenced state agencies is included on the ANRC Resident Focus Rounds document. - To ensure quality assurance and effectiveness, and to protect residents in similar situations, the facility staff were educated regarding the aforementioned Residents Right. - In-services will be ongoing as needed, and will also be conducted with licensed and non-licensed staff at new hire orientation and, at least, annually by an activities staff or designee. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. - The Therapeutic Manager (TM) will randomly audit 10 resident records monthly to ensure that residents were notified of Residents Rights and advocacy contacts. Audit findings will be reviewed and discussed during the monthly Quality Assurance Performance Improvement (QAPI) meetings. - To ensure that correction was achieved, all of the residents currently residing in the facility were informed of their rights to file a complaint with the facility Administrator,	

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4 120	Continued From page 25	4 120	Social Services Department, or any supervisor or department manager. The residents were also informed that complaints about the facility could also be filed with a state agency. - On 9/26/21, to protect residents in similar situations, facility staff were in-serviced on the facility□s responsibility to provide residents with State Agency, Ombudsman, and Adult Protective Services information to submit and file a complaint as needed or as deemed necessary. - To ensure quality assurance and effectiveness of promoting the wellbeing of our residents, and upholding the residents□ rights for systemic changes, ongoing monitoring and random evaluation with application of the Aloha Nursing & Rehab Centre (ANRC) Resident Focus Round auditing form will be completed. - Completion of this tool is to occur weekly x 1 month, bimonthly x 1 month and monthly x 1 month by the DON or designee for a minimum of 12 weeks to ensure compliance. - Corrective action is to be taken immediately and staff education is to be provided as deemed necessary. - To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved.	

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4 120	Continued From page 26	4 120	- If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met. - Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate. Included dates when corrective action will be completed: - Corrective action completion date by Nursing Home Administrator and/or designee.	
4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth.	4 136		9/30/21

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4 136	Continued From page 27 This Statute is not met as evidenced by: Based on family member interview and record review, the facility failed to ensure that one resident, R162, who had a stage four pressure ulcer to the sacral/coccyx received necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent infection. The deficient practice resulted in R162 acquiring a methicillin resistant staphylococus aureus infection (MRSA) of the sacral wound requiring intravenous antibiotics and a decline in health status. Findings include: 1) Surveyor received telephone call from R162's family member (FM) on 02/19/21 at 05:17 PM at the office of health care assurance (OHCA). FM stated that he had concerns regarding R162 care at the facility. FM stated, I didn't see R162 for several months due to the COVID pandemic and the facility was on lock down, before that I went all the time to visit. In late November 2020 I met her at the hospital when she went for a blood transfusion. I saw that her nails were overgrown and were cutting into her hands. There were sores with puss. I looked at her and almost cried. It was the week before she went to the emergency department (ED), the last week of November. FM stated that R162 went to the ED by ambulance on December 1, 2020 after she stopped breathing at the facility. FM said he talked to the physical therapist and occupational therapist weekly, and they said she was supposed to be getting up in her wheelchair every day. I called once to ask and was told she didn't get up all day, it was already the evening shift. I feel bad for the residents there, they can't speak for themselves. Sometimes when I called	4 136	4136 Resident Care F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility□s credible allegation of compliance. 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. - Resident R162 was discharged from the facility - On 9/26/21, to protect residents in similar situations, facility staff were in-serviced on promoting skin integrity and resident care that is consistent with professional standards of practice, to promote healing, prevention of infection, and prevent new ulcers from developing. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	

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	125038		08/12/2021

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45-545 KAMEHAMEHA HIGHWAY
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4 136	Continued From page 28 to ask the head nurse to ask if she can get R162 up in the wheelchair, they just said we don't have the staff. (Refer to F725). On 08/11/21 at 02:14 PM, surveyor reviewed R162's discharged record from the EMR. Diagnosis: Pneumonitis due to inhalation of food and vomit 11/16/20. Stage four pressure ulcer of sacral region. Osteomyelitis (bone infection), type two diabetes. Progress note 11/17/20 01:57 AM. R162 readmitted to facility. has large decubitus to sacrum, wound bed granulated tissue. Undermining around the entire wound with 3-6 o'clock the worst, light to moderate yellowish drainage during dressing change. On 08/11/21 at 03:55 PM surveyor reviewed the MDS from 01/19/20 through 11/11/20. The review revealed that R162 had stage four pressure ulcer present on the sacral area during the entire time. R162 was also coded as an extensive assistance in her functional abilities and totally dependent in eating. R162's cognitive skills were coded as severely impaired-never/rarely made decisions. Other diagnosis included multidrug resistant organism (MDRO), wound infection, and osteomyelitis. MD orders reviewed: 11/16/20. Sacral wound, cleanse with normal saline, pat dry, pack with calcium alginate and cover with bordered foam. Change every day and as needed. Care plan reviewed. Problem: R162 has stage four noted to coccyx, 3 centimeters (cm) x 4cm x 1.5cm. She is being treated with antibiotics. 01/28/20. Residents area will decrease in size by 50%. Reposition resident every 2 hours and as needed. Resident needs two people to assist	4 136	- The alleged practice has the potential to affect facility residents. 3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? - Facility staff were in-serviced to ensure that residents receive treatment and care in accordance with professional standards of practice to promote healing, prevention of infection, and prevent new ulcers from developing. - Facility staff were educated on the facility□s turning and positioning policy and turning wheel. Turning wheel sticker is applied to all direct care providers name tag for ease of reference. - The facility□s Unit Manager (UM), or designee, will conduct daily walking rounds, and monitor through observation, to ensure turning and repositioning of residents are being conducted with application of the turning wheel and other daily care treatments according to the residents□ person-centered plan of care. - To promote continuity of care, facility staff will be provided with education, as aforementioned, at new hire orientation and at least annually, by the Director of Nursing Services (DON) or designee. - The Aloha Nursing & Rehab Centre	

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4 136	Continued From page 29 with repositioning to avoid skin friction/shearing if needed.	4 136	Resident Focus Rounds was created to promote respect, dignity, and care for each resident in a manner and environment that promotes maintenance or enhancement of each resident□s quality of life. This auditing tool is for monitoring through resident interview query and observation. - The Aloha Nursing & Rehab Centre - Weekly Wound Care Report was created for ongoing wound assessment, treatment, and monitoring. - In-services will be ongoing as needed 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. - To protect residents in similar situations, facility staff were in-serviced on ensuring that residents receive treatment and care in accordance with professional standards of practice, and on application of the turning and repositioning wheel. - To ensure quality assurance and effectiveness of promoting the wellbeing of our residents, and upholding the residents□ rights for systemic changes, ongoing monitoring and random	

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4 136	Continued From page 30	4 136	evaluation with application of the Aloha Nursing & Rehab Centre (ANRC) Resident Focus Round auditing form will be completed. - Completion of this tool is to occur weekly x 1 month, bimonthly x 1 month and monthly x 1 month by the DON or designee for a minimum of 12 weeks to ensure compliance. - To ensure quality assurance and effectiveness of promoting the wellbeing of our residents, and upholding the residents□ rights for systemic changes, ongoing monitoring and random evaluation with application of the Aloha Nursing & Rehab Centre - Weekly Wound Report. - Completion of this tool is to occur weekly by the Wound Treatment Nurse or designee for a minimum of 12 weeks to ensure compliance. * Corrective action is to be taken immediately and staff education is to be provided as deemed necessary. - To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved. - If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met.	

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4 136	Continued From page 31	4 136		
			- Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate. Included dates when corrective action will be completed: - Corrective action completion date by Nursing Home Administrator and/or designee.	
4 145	11-94.1-38(a) Activities (a) The facility must provide for an ongoing program of age-appropriate activities designed to meet the interests, physical, mental, and psychosocial well-being of each resident. This Statute is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide activities that meet the interests of two residents, R80 and R314. This deficient practice does not support the physical, mental, and psychosocial well-being of these residents and could render psychosocial harm. This has the potential to affect most residents in the facility. Findings include: 1) An initial observation of R80 was made on 08/09/21 at 10:48 AM. R80 was sitting upright in bed, sleeping with his television set on the channel and program guide. A hand made sign made with wire and numerous other wire craft	4 145	4145 Activities F679 Activities Meet Interest/Needs of Each Resident Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility□s credible allegation of	9/30/21

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4 145	Continued From page 32 objects were in his room. His partially eaten breakfast remained on a tray located on his bedside table at the side of his bed. R80 was interviewed on 08/10/21 at 12:00 PM in his room. R80 stated that he created the wire decorative objects in his room by hand with wire hangers. He stated that he had the tools to create his crafts but had been unable to use them. His tools were locked up at the facility because they were considered dangerous and could only be used when he was supervised. He stated that he could use them previously and staff would supervise him but thinks that he was now unable to because "they don't have enough staff." R80's EMR was reviewed on 08/10/21 at 3:00 PM. He is a 74-year-old male admitted to the facility with Parkinson's disease (a progressive nervous system disorder that affects movement). His care plan updated on 06/30/21 stated for activities,"...preferences include...working on/creating new art." An interview was done with the TRM on 08/12/21 at 09:12 AM in the training room. She stated that the facility had R80's soldering iron, pure alcohol and glue. The TR staff or SS would help to supervise R80 while he was utilizing these items to create his craft projects. She further stated, "He takes so long to get ready. We try to allocate the time for him." R80's "TR Routine Roster" report for the dates of 06/12/21 to 08/12/21 was reviewed on 08/12/21 at 11:00 AM. There were no activities documented for the month of August. In a follow-up interview with the TRM at 11:17 AM in the conference room, she stated that activities	4 145	compliance. 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. - On 9/14/21, the Therapeutic Recreation Manager (TRM) assisted Resident R80 with a crafting activity of the resident□s choice. - On 9/16/21, the TRM ensured that Resident R314□s television station was set to Resident□s R134□s favorite news station. A sign was also posted on Resident R134□s communication board to remind the care team to turn the television (TV) on to the news station of the resident□s preference. -Since admission R134 cognitive status has improved, R134 is now capable of self- manipulating television, to the station of his choice. R134 is also able to independently utilize iPad due to increase cognitive abilities. - The resident□s care plan reflects Resident R314□s aforementioned TV preference. - Facility staff were educated on the providing residents with activities that are designed to meet their interests and support the physical, mental, and psychosocial well-being of each resident. - Facility staff were educated on	

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4 145	Continued From page 33 with the residents are documented when the TR staff does or upon completion of the activity with the resident. 2) An initial observation was made of R314 on 08/09/21 at 10:40 AM in his room. R314 was wearing a hospital gown, lying in bed with his head of bed (HOB) raised. His eyes remained closed, and he was slow to respond to the surveyor's salutation. R314 was observed at 12:13 PM the same day still lying in bed. His television was off. His roommate had a staff member helping him do range of motion (ROM) exercises of his legs. On 08/10/21 at 09:51 AM, R314 was alone in his room. He was wearing a hospital gown lying in bed tilted to the right side. His television was not on. At 10:46 AM of the same day, RN22 was wearing personal protective equipment (PPE) in R314's room. His television was off. R314's EMR was reviewed on 08/10/21 at 2:50 PM. R314 is a 73-year-old male admitted to the facility on 07/21/21 for an infection. His activity care plan dated 07/26/21 stated, "...preferences include having his family involved in discussions about his care, receiving pet visits, and participating in religious services/practices..." Another entry for his activity care plan stated, "It is very important to (R314) to (sic) with the news via television..." In an interview with the TRM on 08/12/21 at 09:26 AM in the training room, she stated that activities have not been done with R314 because he was sleeping or in therapy.	4 145	implementation of residents□ activity plan and proper documentation of participation / refusal to participate. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice. - The alleged practice has the potential to affect facility residents. 3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? - The TRM, or designee, will provide annual in-service training and new hire training of the importance of providing residents with activities that are designed to meet the residents□ interests and support the physical, mental, and psychosocial well-being of each resident. - The resident□s preference interview will be conducted upon admission and reviewed and updated quarterly and annually during the care plan meeting. - The TRM will review, through observation, activity attendance, and, on a weekly basis, audit resident participation records for all residents; this audit will identify trends regarding activities provided to meet the interests and needs of our residents.	

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4 145	Continued From page 34 R314's "TR Summary Roster" report for 06/12/20 to 08/12/21 was reviewed on 08/12/21 at 10:00 AM. There was only a 20 minute one to one visit documented on 07/31/21.	4 145	- Deficient findings will be followed up upon as deemed necessary; these findings and follow up measures will be reported at the monthly Quality Assurance Performance Improvement (QAPI) meetings. - The Aloha Nursing & Rehab Centre Resident Focus Rounds auditing tool was created to promote respect, dignity, and care for each resident in a manner and environment that promotes maintenance or enhancement of each resident□s quality of life. This auditing tool is for monitoring through resident interview query and observation. - In-services will be ongoing as needed 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. - To protect residents in similar situations, facility staff were in-serviced on providing residents with activities that are designed to meet their interests and support the physical, mental, and psychosocial well-being of each resident. - Facility staff were also educated on implementation of residents□ activity plan	

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4 145	Continued From page 35	4 145	and proper documentation of participation / refusal to participate. - To ensure quality assurance and effectiveness of promoting the wellbeing of our residents, and upholding the residents□ rights for systemic changes, ongoing monitoring and random evaluation with application of the Aloha Nursing & Rehab Centre (ANRC) Resident Focus Round auditing form will be completed. - Completion of this tool is to occur weekly x 1 month, bimonthly x 1 month and monthly x 1 month by the DON or designee for a minimum of 12 weeks to ensure compliance. - Corrective action is to be taken immediately and staff education is to be provided as deemed necessary. - Weekly auditing of facility residents□ activity attendance by the TRM will is to be reported at the monthly Quality Assurance Performance Improvement (QAPI) meetings. - To ensure compliance, audit results completed by the TRM, and auditing with application of the Aloha Nursing & Rehab Centre (ANRC) Resident Focus Round auditing form, will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved. - If further corrective action is needed, the	

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4 145	Continued From page 36	4 145	auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met. - Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate. Included dates when corrective action will be completed: - Corrective action completion date by Nursing Home Administrator and/or designee. F550 Resident Rights/Exercise of Rights Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility□s credible allegation of compliance. 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. - On 9/10/21 Resident R13 was assessed	

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4 145	Continued From page 37	4 145	for appropriate personal care of grooming and appearance by the Director of Nursing (DON). The resident was observed to have had a bed bath, he was neatly groomed with clean gown on, his bedside table was tidied, and the Christmas decoration was removed and stored. Residents comprehensive care plan reflects the resident□s preference to wear gown. - On 9/14/21 The Therapeutic Recreation (TR) manager assisted Resident R80 with a crafting activity of the resident□s choice. - On 9/15/21 Resident R80 was interviewed by the TR designee regarding the resident□s activity preferences and crafting activity schedule. - A personalized activities schedule was created for Resident R80 (refer to attached document); this schedule is subject to change according the resident□s preference & identified reasonableness - Staff has been educated on the Resident Rights of a dignified existence, self-determination, and the right to exercise his or her rights as a resident of the facility - Staff is to provide residents with care in a manner that promotes maintenance of their quality of life to promote their self-worth. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	

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4 145	Continued From page 38	4 145	- The alleged practice has the potential to affect facility residents. - To identify other residents having the potential to be affected by the identified deficient practice, the F-550 Dignity Personal Care Tracking Tool (Grooming, Bedside Table, Activities Participation) has been created (refer to attached document). Comprehensive care plans will be updated as needed to incorporate resident preferences according to the findings. - Furthermore, managers of the interdisciplinary team are to monitor and manage compliance by performing random assessments of compliance during completion of weekly auditing with use of the referenced tool - Completed forms are to be kept in a binder in the Nursing Home Administrator□s (NHA□s) office or designee. 3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? - To ensure quality assurance and effectiveness, staff were in-serviced regarding Residents Rights to a dignified existence, self-determination and care preferences to promoting quality of life. Comprehensive care plans will be updated to incorporate resident preferences.	

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4 145	Continued From page 39	4 145	- In-services will be ongoing as needed. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. - Unit Manager will review Resident R13□s personal care activity for four weeks to ensure that the facility is meeting the daily personal care activities and care needs of the resident. Findings will be reviewed with members of the interdisciplinary team (IDT) team, and staff is to be educated as needed. - TR Manager will audit Resident R80□s weekly therapeutic activity attendance for four weeks to ensure that the facility is supporting the resident□s right to meaningful activities. - To ensure quality assurance and effectiveness of promoting dignity and upholding the residents□ rights for systemic changes, ongoing monitoring and random evaluation with application of the Dignity Personal Care Tracking Tool (Grooming, Bedside Table, Activities Participation) will be completed. - Completion of this tool is to occur weekly x 1 month, bimonthly x 1 month and monthly x 1 month for a minimum of 12	

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NAME OF PROVIDER OR SUPPLIER
ALOHA NURSING & REHAB CENTRE

STREET ADDRESS, CITY, STATE, ZIP CODE
45-545 KAMEHAMEHA HIGHWAY
KANEOHE, HI 96744

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4 145	Continued From page 40	4 145	weeks to ensure compliance. - Corrective action is to be taken immediately and staff education is to be provided as deemed necessary. - To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved. - If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met. - Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate. Included dates when corrective action will be completed: - Corrective action completion date by Nursing Home Administrator and/or designee.	
4 148	11-94.1-39(a) Nursing services (a) Each facility shall have nursing staff sufficient in number and qualifications to meet the nursing needs of the residents. There shall be at least one registered nurse at work full-time on the day shift, for eight consecutive hours, seven days a week, and at least one licensed nurse at	4 148		9/30/21

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4 148	Continued From page 41 work on the evening and night shifts, unless otherwise determined by the department. This Statute is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by the resident assessments, individual plans of care considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment. Findings include: 1) On 08/09/21 at 08:35 AM, conducted an interview with R103 in the resident's room. R103 stated at home, he/she would wake up, get cleaned up (i.e., brush teeth, comb hair, wash face, and change clothes) then eat breakfast. The resident further explained that after waking up with morning breath, the food does not taste good, so R103 has requested to "clean up and brush my teeth, but I need the staff's help and they aren't able to help me at times." R103 pointed out the breakfast on the resident's bedside table and that the resident had not been helped with brushing his/her teeth despite asking staff for help. The resident also stated when she was first admitted she needed help with eating meals and had to wait 35-45 minutes before receiving assistance with meals. On 08/11/21 at 09:00 AM, conducted an interview with RN19. RN19 confirmed, R103 can make needs known and staff try to assist the resident	4 148	4148 Nursing Services F725 Sufficient Staffing Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility□s credible allegation of compliance. 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. - To ensure and promote the highest practicable physical, mental, and psychosocial well-being of the residents found to have been affected by the deficient practice, the following actions were taken: - On 8/13/21, to address concerns regarding Resident R78, nursing staff were in-serviced on the importance to assess and monitor residents returning from dialysis.	

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4 148	Continued From page 42 with all requests made. However, there is only one RN and one CNA assisting residents and although staff try, staff are not always able to assist residents as needed. Conducted a concurrent interview with the DON and review of R103's EMR on 08/11/21 at 12:13 PM. An admission MDS with an ARD of 07/29/21 documented in Section G. Functional Status, R103 required extensive assistance of 2+ person for transferring and extensive assistance with 1-person physical assistance for dressing and eating. Section 04.000 Functional Limitation in Range of Motion documented R103 has impairment on both sides of the upper and lower extremities. Review of R103's care plan documented the resident is autonomous in his/her daily routine which the DON explained indicated the resident is able to control what he/she does from day to day. Shared R103's interview with the DON who confirmed R103 is unable to perform activities of daily living (ADL) independently and if the resident is requesting help with ADLs prior to breakfast, staff should honor the resident's request. 2) R78 was admitted to the facility on 6/26/21 and receives dialysis treatments three (3) times a week on Monday, Wednesday, and Friday. On 08/09/21 at 12:43 PM, conducted an interview with R78. The resident stated that she had returned from her hemodialysis appointment at approximately 11:30 AM. During the time the resident returned from dialysis treatment, unit staff were delivering lunch and assisting other residents with meals. Inquired with R78 regarding how staff monitor her access site. The resident stated, "staff usually look at the access site and check my blood pressure, but staff has	4 148	- Resident R103 was discharged on 9/07/21. - On 9/10/21 Resident R13 was assessed for appropriate personal care of grooming and appearance by the Director of Nursing (DON). The resident was observed to have had a bed bath, he was neatly groomed with clean gown on, his bedside table was tidied, and the Christmas decoration was removed and stored. Residents comprehensive care plan reflects the resident□s preference to wear gown. - On 9/17/21, Resident R13 was assessed for grooming and appearance. Resident was neatly groomed, with clean gown, and bed linen changed. - On 9/18/21, the Director of Nursing (DON) conducted a record review; findings reveal Resident R78 was assessed by licensed nurse. - Resident R78 endured no harm from the cited deficiency and care was provided for the resident by facility staff. - To provide nursing and related services to assure resident safety and to attain or maintain the highest practical physical, mental, and psychosocial wellbeing of each resident, Human Resource Specialist (HRS) has applied the following measures and promoted advertising for hiring with application of the following	

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4 148	Continued From page 43 not been in to check me since I got back from my dialysis appointment." On 08/11/21 at 11:13 AM, conducted a concurrent interview and record review of R78's EMR. R78's admission MDS documented the resident scored a 14 on the BIMS, indicating the resident is cognitively intact. The DON stated staff should assess R78's access site, a change in condition, and obtain at least a blood pressure reading within 30 minutes of returning to the facility. The DON confirmed the time during which R78 returns to the facility, staffing numbers are stretched thin due to coinciding with lunch, nursing staff is usually busy with administering lunch time medications, and staff assisting during lunch is not necessarily qualified to assess R78 after returning from dialysis. On 08/12/21 at 11:07 AM, conducted an interview with the DON regarding sufficient nurse staffing. Reviewed the 2021 Facility Assessment and the staffing schedule for 08/09/21 with the DON. The staff schedule provided by the facility documented on 08/09/21, the Day shift (6-2:30) six (6) registered nurses and ten (10) certified nurse aides; Evening shift five (5) registered nurses, one (1) licensed practical nurse, and nine (9) certified nurse aides; and the Night shift there were four (4) registered nurses, and six (6) certified nurse aides were scheduled as working. The DON stated during lunch, non-direct care staff assist the direct care staff by delivering lunch trays to the residents. According to the 2021 facility assessment, 35.7% (high frequency relative to benchmark) require one-person assistance with eating. Although more staff are available to deliver trays the number of staff trained and able to assist residents with meals remain unchanged if not less when considering	4 148	platforms: " Aloha Nursing & Rehab Centre website " Indeed " Realjobshawaii " Careermd " Active recruitment through our partnered schools: Healthcare Training and Career Consultants, Windward Community College, and the University of Hawaii Nursing Department - Human Resource Specialist, or a designated facility staff member, continue to guest speak at their monthly Certified Nurses Aides (CNA) graduation ceremony " Physical posting of a We□re Hiring banner has been posted by the facility sign at the front of the facility property " The facility has also secured contracted agency workers to promote sufficient nursing staff - As a result of efforts put forth by the Nursing Home Administrator (NHA), HRS, and apposite staff, the following positions have been filled with newly hired associates: " Altres - Agency Hires " Registered Nurses " Registered Nurses - Per Diem " Nursing Assistants - To support nursing staff " Certified Nurses Aides " Infection Control Preventionist / Wound Care Specialist " Interns - To provide non-direct care to support nursing staff *New hires are put through an orientation process to promote the delivery of safe	

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4 148	Continued From page 44 all nurses were observed administering medications as opposed to assisting residents with meals. Queried the DON regarding how the number and acuity of the residents are factored into scheduling of staff. The DON stated the facility staffs according to area, for example on the first floor 3 nurses are scheduled: one on the Plumeria unit, one nurse on the Gardenia unit, and one nurse that has residents on both the Plumeria and Gardenia units and the same model of staffing is applied to the second floor. Inquired if the staff model changes according to the number and/or acuity of the residents. The DON confirmed the number and/or acuity of the residents is not factored in to how the facility staffs the units. 3) Surveyor received telephone call from R162's FM on 02/19/21 at 05:17 PM at OHCA. FM stated that he had concerns regarding R162 care at the facility. FM stated, I didn't see R162 for several months due to the COVID pandemic and the facility was on lock down before that I went all the time to visit. In late November 2020 I met her at the hospital when she went for a blood transfusion. I saw that her nails were overgrown and were cutting into her hands. There were sores with puss. I looked at her and almost cried. It was the week before she went to the ED, the last week of November. FM stated that R162 went to the ED by ambulance on December 1, 2020, after she stopped breathing at the facility. 4) Surveyor made observations on 08/09/21 at 8:16 AM, R13 was noted in his bed laying on his back, facing the right side. Noted a Christmas decoration on his bedside table with a few other items with dust and in disarray. He was wearing a hospital type gown that was bunched up in a wad on his chest. His hair looked unclean and	4 148	resident care - Aloha Nursing & Rehab Centre is committed to operate our facility with superior quality to meet the needs of our residents; our residents are our highest priority, and our associates are our most valuable resource. For this reason, and to promote a collaborative effort amongst members of our facility□s health care team, facility staff were educated on the facility□s attendance policy, and on the importance of regular work attendance to the work flow, productivity, teamwork, and outcomes for all stakeholders. - The DON, Nurse Managers, and apposite staff were educated on staffing to acuity and resident needs. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice. - The alleged practice has the potential to affect facility residents. 3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? - Ongoing measures set forth to promote systemic changes to ensure sufficient nursing staffing and to support our current staff includes: " Advertising for new hires " Offering of union approved incentives	

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4 148	Continued From page 45 uncombed. His knees were tightly bent up under him and facing to the right side. His left leg was outside of the sheet, noted excoriations on his lower leg. A second observation was made at 10:53 AM. R13 was in the same position. Surveyor made additional observations on 08/10/21 to 08/12/21 throughout the day shift and into the evening shift. Noted that R13 was in his bed in his hospital gown and appeared with the same disheveled hair. On 08/12/21 at 10:06 AM surveyor interviewed two staff, S45 and S34, who requested to remain anonymous. Surveyor asked S45 how often are the showers and personal care being done for R13? S45 responded that today we have three CNAs assigned to this side and one who floats between the two sides. We try to do personal care when we make our rounds, baths are usually given two to three times a week. This is the heaviest floor; we really need at least four CNA's because the residents are heavier and more dependent. Sometimes we just can't get to everything, and they don't get all the personal care. S34 stated that she would like to have more time to provide more personalized care to the residents like grooming and cleaning nails. We are often short staffed, there's just no time for those things.	4 148	to CNAs and licensed nurses - For all shifts; including evening and noc shift to ensure adequate assistance with delivery of meals, resident care needs, and grooming " Staff appreciation and recognition with food, games, and door prizes " Tracking of staff attendance " Providing staff with appropriate support and counseling as deemed necessary - To promote continuity of care, and to prevent deficient practice regarding insufficient nursing staffing, facility staff were educated on facility□s the attendance policy, and on the importance of regular work attendance to the work flow, productivity, teamwork, and outcomes for all stakeholders. - As aforementioned, facility staff will be provided with education on the facility□s attendance policy to promote positive outcomes for all stakeholders, at new hire orientation, and at least annually, by the Nursing Home Administrator, Director of Nursing Service (DON), or designee. - Daily nursing staffing and facility census is discussed and reviewed at the daily morning Stand Up meeting. - A staffing chart was created to determine and identify ideal vs. critical staffing levels; staffing levels are reviewed daily by the DON or designee, and auditing of these levels are conducted biweekly by the DON or designee.	

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4 148	Continued From page 46	4 148	-The DON, or designee, will utilize the Facility Assessment and facility census to determine resident acuity and nursing staff needs. - When staffing level falls below ideal for all shifts (including evening and noc shifts), based on the DON□s assessment, contingency measures will be put in place to ensure resident care are being met: " The nursing leadership team, including nurse managers, assist with direct care tasks to ensure that all resident care needs are met " The facility non-nursing managerial team help to provide non-direct support, similar to that of interns, such as answering call lights, emptying trash bins, etc. " Reliant Rehabilitation staff provides assistance in accordance with their skill set 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. - The DON, or designee, will conduct daily random care rounds to promote sufficient nursing staff compliance with residents□ acuity and daily care needs. - To promote sufficient nursing staffing, collaborative action is to taken as	

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4 148	Continued From page 47	4 148	aforementioned, and staff education concerning attendance is ongoing and to be provided as deemed necessary. - The DON, or designee, is to complete weekly x 1 month, bimonthly x 1 month and monthly x1 month audit of the care rounds and staff schedule findings for a minimum of 12 weeks to ensure compliance. - To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved. - If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met. - Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate. Included dates when corrective action will be completed: - Corrective action completion date by Nursing Home Administrator and/or designee. F550 Resident Rights/Exercise Rights	

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4 148	Continued From page 48	4 148	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility□s credible allegation of compliance. 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. - On 9/10/21 Resident R13 was assessed for appropriate personal care of grooming and appearance by the Director of Nursing (DON). The resident was observed to have had a bed bath, he was neatly groomed with clean gown on, his bedside table was tidied, and the Christmas decoration was removed and stored. Residents comprehensive care plan reflects the resident□s preference to wear gown. - On 9/14/21 The Therapeutic Recreation (TR) manager assisted Resident R80 with a crafting activity of the resident□s choice. - On 9/15/21 Resident R80 was interviewed by the TR designee regarding the resident□s activity preferences and crafting activity schedule. - A personalized activities schedule was	

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4 148	Continued From page 49	4 148	created for Resident R80 (refer to attached document); this schedule is subject to change according the resident□s preference & identified reasonableness - Staff has been educated on the Resident Rights of a dignified existence, self-determination, and the right to exercise his or her rights as a resident of the facility - Staff is to provide residents with care in a manner that promotes maintenance of their quality of life to promote their self-worth. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice. - The alleged practice has the potential to affect facility residents. - To identify other residents having the potential to be affected by the identified deficient practice, the F-550 Dignity Personal Care Tracking Tool (Grooming, Bedside Table, Activities Participation) has been created (refer to attached document). Comprehensive care plans will be updated as needed to incorporate resident preferences according to the findings. - Furthermore, managers of the interdisciplinary team are to monitor and manage compliance by performing random assessments of compliance during completion of weekly auditing with use of the referenced tool - Completed forms are to be kept in a	

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4 148	Continued From page 50	4 148	binder in the Nursing Home Administrator□s (NHA□s) office or designee. 3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? - To ensure quality assurance and effectiveness, staff were in-serviced regarding Residents Rights to a dignified existence, self-determination and care preferences to promoting quality of life. Comprehensive care plans will be updated to incorporate resident preferences. - In-services will be ongoing as needed. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. - Unit Manager will review Resident R13□s personal care activity for four weeks to ensure that the facility is meeting the daily personal care activities and care needs of the resident. Findings will be reviewed with members of the interdisciplinary team (IDT) team, and staff is to be educated as needed.	

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4 148	Continued From page 51	4 148	- TR Manager will audit Resident R80□s weekly therapeutic activity attendance for four weeks to ensure that the facility is supporting the resident□s right to meaningful activities. - To ensure quality assurance and effectiveness of promoting dignity and upholding the residents□ rights for systemic changes, ongoing monitoring and random evaluation with application of the Dignity Personal Care Tracking Tool (Grooming, Bedside Table, Activities Participation) will be completed. - Completion of this tool is to occur weekly x 1 month, bimonthly x 1 month and monthly x 1 month for a minimum of 12 weeks to ensure compliance. - Corrective action is to be taken immediately and staff education is to be provided as deemed necessary. - To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved. - If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met. - Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed	

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4 148	Continued From page 52	4 148	as deemed appropriate. Included dates when corrective action will be completed: - Corrective action completion date by Nursing Home Administrator and/or designee. F561 Self Determination Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility□s credible allegation of compliance. 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. -R103 discharged on 9/7/21 prior to receipt of 2567; therefore, the facility was unable to interview the resident and update care preferences and schedule. - To protect residents in similar situations, the facility staff were educated regarding Resident Rights including, but not limited to, the right to a dignified existence, self-determination, and communication	

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	125038		08/12/2021

NAME OF PROVIDER OR SUPPLIER
ALOHA NURSING & REHAB CENTRE

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4 148	Continued From page 53	4 148	with and access to persons and services inside and outside the facility, which included the residents' right to choice of activities, schedule, health care services and providers. The facilities obligation to support, protect and promote the rights of each resident. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice. - The alleged practice has the potential to affect facility residents. - To identify other residents having the potential to be affected by the identified deficient practice, the Aloha Nursing & Rehab Centre (ANRC) Resident Focus Round was created. - The DON or designee is to monitor and manage compliance by performing random assessments of compliance during weekly completion of the Aloha Nursing & Rehab Centre (ANRC) Resident Focus Round auditing tool. - Completed forms are to be kept in a binder in the Nursing Home Administrator□s (NHA□s) office or designee. 3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? - To ensure quality assurance and effectiveness, and to protect residents in	

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4 148	Continued From page 54	4 148	similar situations, the facility staff were educated regarding Resident Rights including, but not limited to, the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, which included the residents' right to choice of activities, schedule, health care services and providers. The facilities obligation to support, protect and promote the rights of each resident. - The identified care and schedule preferences will be incorporated into the resident□s comprehensive care plan. - To promote individualized care and residents□ choices, upon admission and during the initial care plan meeting, the residents and/or responsible party will be interviewed in regards to care and schedule preferences. The identified care and schedule preferences will be incorporated into resident comprehensive care plan. - In-services will be conducted with licensed and non-licensed staff at new hire orientation and, at least, annually by the Director of Nursing (DON) or designee to include supporting the residents□ right to a dignified existence, self-determination, and schedule preferences. - In-services will be ongoing as needed 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction	

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4 148	Continued From page 55	4 148	is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. - To ensure quality assurance and effectiveness of promoting the wellbeing of our residents, and upholding the residents□ rights for systemic changes, ongoing monitoring and random evaluation with application of the Aloha Nursing & Rehab Centre (ANRC) Resident Focus Round auditing form will be completed. - Completion of this tool is to occur weekly x 1 month, bimonthly for 1 month and monthly by the DON or designee for a minimum of 12 weeks to ensure compliance. - Corrective action is to be taken immediately and staff education is to be provided as deemed necessary. - To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved. - If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met. - Results of the monthly QAPI meeting will	

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4 148	Continued From page 56	4 148	be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate. Included dates when corrective action will be completed: - Corrective action completion date by Nursing Home Administrator and/or designee. F698 Dialysis Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility□s credible allegation of compliance. 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. - On 8/13/21, to promote corrective action for the cited deficiency, and to ensure that the deficient practice does not occur, nursing staff were in-serviced on the importance to assess and monitor residents returning from dialysis	

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4 148	Continued From page 57	4 148	- On 9/18/21 Director of Nursing (DON) conducted a record review, findings reveal Resident R78 was assessed by licensed nurse. - Resident R78 endured no harm from the cited deficiency and care was provided for the resident by facility staff. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice. - The alleged practice has the potential to affect facility residents who receive dialysis care and treatment. 3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? - Licensed staff were in-serviced on the following information to ensure that residents who require dialysis receive such care and services, consistent with professional standards of practice: " Proper monitoring of all dialysis residents prior to and upon return to facility from dialysis " The purpose of the dialysis communication form, and the importance of completing the form accurately and completely prior to dialysis " When the form needs to be completed " Protocol for pre and post dialysis assessment, and timely documentation " Nurse competency assessment	

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4 148	Continued From page 58	4 148	- To promote continuity of care, and to prevent deficient practice regarding proper protocol/practices for safe care of residents receiving dialysis, licensed staff will be provided with education, as aforementioned, at new hire orientation, and at least annually, by the Director of Nursing Service (DON) or designee. - Licensed staff will be trained and retrained ongoing as deemed necessary 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. - To protect residents in similar situations, and to reduce the risk of complications, facility staff were in-serviced on ensuring that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents□ goals and preferences. - The Aloha Nursing & Rehab Centre - Dialysis Auditing Tool was created to aid in monitoring that residents receiving dialysis receive care and services, consistent with professional standards of practice.	

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4 148	Continued From page 59	4 148	- Weekly x 1 month, bimonthly x 1 month and monthly x 1 month the Director of Nursing (DON), or designee, will utilize the Aloha Nursing & Rehab Centre - Dialysis Auditing Tool to randomly audit dialysis communication forms, progress notes, vital signs, and nursing post dialysis notes. All findings of concern will be immediately addressed, and corrective action, and resident assessment, as deemed necessary, is to be taken immediately and staff education is to be provided as deemed necessary. - To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved. - If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met. - Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate. Included dates when corrective action will be completed: - Corrective action completion date by Nursing Home Administrator and/or designee.	

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4 148	Continued From page 60	4 148	F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility□s credible allegation of compliance. 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. - Resident R162 was discharged from the facility - On 9/26/21, to protect residents in similar situations, facility staff were in-serviced on promoting skin integrity and resident care that is consistent with professional standards of practice, to promote healing, prevention of infection, and prevent new ulcers from developing. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice. - The alleged practice has the potential to	

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4 148	Continued From page 61	4 148	affect facility residents. 3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? - Facility staff were in-serviced to ensure that residents receive treatment and care in accordance with professional standards of practice to promote healing, prevention of infection, and prevent new ulcers from developing. - Facility staff were educated on the facility□s turning and positioning policy and turning wheel. Turning wheel sticker is applied to all direct care providers name tag for ease of reference. - The facility□s Unit Manager (UM), or designee, will conduct daily walking rounds, and monitor through observation, to ensure turning and repositioning of residents are being conducted with application of the turning wheel and other daily care treatments according to the residents□ person-centered plan of care. - To promote continuity of care, facility staff will be provided with education, as aforementioned, at new hire orientation and at least annually, by the Director of Nursing Services (DON) or designee. - The Aloha Nursing & Rehab Centre Resident Focus Rounds was created to promote respect, dignity, and care for	

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4 148	Continued From page 62	4 148	each resident in a manner and environment that promotes maintenance or enhancement of each resident□s quality of life. This auditing tool is for monitoring through resident interview query and observation. - The Aloha Nursing & Rehab Centre - Weekly Wound Care Report was created for ongoing wound assessment, treatment, and monitoring. - In-services will be ongoing as needed 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. - To protect residents in similar situations, facility staff were in-serviced on ensuring that residents receive treatment and care in accordance with professional standards of practice, and on application of the turning and repositioning wheel. - To ensure quality assurance and effectiveness of promoting the wellbeing of our residents, and upholding the residents□ rights for systemic changes, ongoing monitoring and random evaluation with application of the Aloha Nursing & Rehab Centre (ANRC) Resident	

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4 148	Continued From page 63	4 148	Focus Round auditing form will be completed. - Completion of this tool is to occur weekly x 1 month, bimonthly x 1 month and monthly x 1 month by the DON or designee for a minimum of 12 weeks to ensure compliance. - To ensure quality assurance and effectiveness of promoting the wellbeing of our residents, and upholding the residents□ rights for systemic changes, ongoing monitoring and random evaluation with application of the Aloha Nursing & Rehab Centre - Weekly Wound Report. - Completion of this tool is to occur weekly by the Wound Treatment Nurse or designee for a minimum of 12 weeks to ensure compliance. * Corrective action is to be taken immediately and staff education is to be provided as deemed necessary. - To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved. - If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met. - Results of the monthly QAPI meeting will	

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4 148	Continued From page 64	4 148	be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate. Included dates when corrective action will be completed: - Corrective action completion date by Nursing Home Administrator and/or designee.	
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty- first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided.	4 149		9/30/21

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4 149	Continued From page 65 This Statute is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a comprehensive person-centered care plan was developed and implemented for each resident to meet resident's medical, nursing, and psychosocial needs for two residents, R60 and R56. This deficient practice enables the potential for these residents to receive sub-optimal care and could affect all residents in the facility. Findings include: 1) R60 is a 100 years old and was admitted on 06/14/21 with diagnoses including a urinary tract infection (UTI). On 08/10/21 at 11:34 AM, conducted a review of R60's EMR. R60's admission MDS documented in Section N, Medications, was receiving antibiotic treatment and Section V. Care Area Assessment (CAA) Summary documented Urinary Incontinence and Indwelling Catheter care area was triggered and a decision to care plan this area. Review of R60's care plan did not include a care plan for urinary incontinence or the use of a straight catheter. Progress notes documented a straight catheter was used to obtain a urinary specimen on 08/06/21. On 06/11/21 at 12:15 AM, conducted a concurrent interview with the DON and record review of R60's EMR. Reviewed the resident's care plan. The DON confirmed urinary incontinence/indwelling catheter was identified on the CAA and marked as care planned but a care plan was not developed. 2) Observations made on 08/10/21 (01:29 PM),	4 149	4149 Nursing Services F656 Comprehensive Care Plans Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility□s credible allegation of compliance. 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. - On 8/16/21, Resident R60□s comprehensive care plan was reviewed and updated to include a urinary incontinence care plan or the use of a straight catheter. - On 8/16/21, Resident R56□ comprehensive care plan was reviewed and updates to the communication care plan have been made. - UM□s and MDS staff were educated on the facility□s responsibility to develop and implement a comprehensive care plan for each resident to meet resident□s medical,	

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4 149	Continued From page 66 08/11/21 (08:37 AM, 10:19 AM, 11:48 AM), surveyor noted resident R56 was not wearing hearing aids to left nor right ear. During an interview on 08/12/21 at 09:53 AM, the physical therapist (PT) confirmed hearing aides were not worn to right nor left ear. During an interview on 08/12/21 at 10:00 AM, RN15 verbalized "hearing aides had been on the cart for one and a half years, but they never worked, I think we followed up with the daughter about the broken hearing aids." During an interview on 08/12/21 at 10:05 AM, social worker (SW)2 stated, "I have been onboard 6 months and have not been in contact with the daughter regarding the hearing aid	4 149	nursing, and psychological needs. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice. - The alleged practice has the potential to affect facility residents. - A review of comprehensive care plans for all residents within the facility was initiated by the Director of Nurses (DON), Minimum Data Set (MDS) Manager, and/or designees to identify residents with incomplete or inaccurate comprehensive care plans. - To identify other residents having the potential to be affected by the identified deficient practice, the Aloha Nursing & Rehab Centre (ANRC) F-655 & F-656 Baseline Care Plan Auditing Tool was created. - The DON, Minimum Data Set (MDS) Manager and Coordinators, or designee is to monitor and manage compliance by performing a facility wide assessment of compliance with application of the Aloha Nursing & Rehab Centre (ANRC) F-655 & F-656 Baseline Care Plan Auditing Tool. - Completed forms are to be kept in a binder in the Nursing Home Administrator□s (NHA□s) office or designee. 3) What measures will be put into place or	

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(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
4 149	Continued From page 67	4 149	what systemic changes will you make to ensure that the deficient practice does not recur? - On 9/24/21, the MDS Manager, MDS coordinators, and licensed staff were in-serviced by the DON on the development, revision, and implementation process of person-centered comprehensive care plans. - A comprehensive person-centered care plan will be developed, implemented, and updated for each resident. - Residents identified with incomplete or inaccurate comprehensive care plans will have their care plans reviewed and updated immediately by the assigned MDS coordinator, or designee, to reflect their current goals, interventions, and appropriate approaches to address their medical and treatment needs. - In-services will be ongoing as needed, and will also be conducted with MDS Manager, MDS Coordinators, and licensed staff at new hire orientation and, at least, annually. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality	

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	125038		08/12/2021

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4 149	Continued From page 68	4 149	assurance system. - The DON and the MDS Manager are responsible for maintaining compliance. - To ensure quality assurance and effectiveness of the aforementioned systemic changes to promote quality of care and services for our residents to attain or maintain their highest practicable physical, mental, and psychosocial well-being, the DON, MDS Manager, or designee will perform weekly comprehensive care plan audits coinciding with the MDS assessment calendar to monitor for compliance with application of the Aloha Nursing & Rehab Centre (ANRC) F-655 & F-656 Baseline Care Plan Auditing Tool for all new admissions. - Any or all findings will be reported to the assigned MDS Coordinator or designee for immediate correction. - Completion of this tool is to occur weekly x 1 month, bimonthly x 1 month and monthly x 1 month by the DON or designee for a minimum of 12 weeks to ensure compliance. - For a minimum of 3 months, or until compliance is achieved, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for analysis, and further recommendations. - If further corrective action is needed, the auditing will continue until such time that	

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4 149	Continued From page 69	4 149	the QAPI committee determines consistent substantial compliance has been met. - Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate. Included dates when corrective action will be completed: - Corrective action completion date by Nursing Home Administrator and/or designee.	
4 160	11-94.1-41(b) Storage and handling of food (b) Effective procedures to promptly and consistently clean all equipment and work areas shall be enforced. This Statute is not met as evidenced by: Based on observation, staff interview, and policy review, the facility failed to follow acceptable sanitation practices in the kitchen. As a result, the facility increased the potential for development of foodborne illnesses. Findings Include: On 08/09/21 at 08:00 AM, during the initial tour of the kitchen, a blanket cloth that appeared wet and dirty was noted under the grill on the floor in a puddle of water. The Kitchen Supervisor (KS) explained to the surveyor the blanket cloth was placed there because the grill was leaking. On 08/11/21 at 10:49 AM during an additional tour	4 160	4160 Storage and Handling of Food F812 Food Procurement, Store/Prepare/Serve-Sanitary Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility□s credible allegation of	9/30/21

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4 160	Continued From page 70 of the kitchen, the blanket cloth under the grill remained in the same place in a puddle of water. The Kitchen Manager (KM) was queried and acknowledged that the blanket cloth appeared dirty and had the potential for the development of foodborne illnesses. KM stated that they would remove the dirty blanket cloth. KM also stated that the facility planned to have the kitchen professionally cleaned in July and/or December. A review of facility policy on sanitation guidelines stated: Policy, it is the policy of this facility that food service areas shall be maintained in a clean and sanitary manner. Procedure, all kitchen, and dining areas shall be kept clean, free from litter and rubbish...	4 160	compliance. 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. - It continues to be the practice of the facility to ensure a safe and sanitary food service environment, to promote corrective action for the cited deficiency, on 8/11/21, the Food & Nutritional Services Manager (FNS) removed the identified cloth that was located beneath the grill. - On 9/16/2021, the FNS Manager in-serviced staff members of the Nutritional Services Department/Dietary Department to utilize a catchment pan when cleaning the grill, and on the rationale of these applied changes; use of the pan is to replace use of the identified cloth. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice. - The alleged practice has the potential to affect facility residents. 3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?	

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4 160	Continued From page 71	4 160	- On 9/14/21, an Aloha Nursing Rehab Centre - Grease Catcher Cleaning Log auditing tool was created to promote sanitary food procurement, storage, preparation, and serving. - This log is to be completed on a daily basis by the FNS Manager or designee. - Corrective measures are to be taken immediately, and dietary staff will be trained and retrained as deemed necessary. - Weekly auditing of the Aloha Nursing Rehab Centre - Grease Catcher Cleaning Log is to be completed by the FNS Manager or designee - All residents have the potential to be affected by the identified deficient practice. FNS Manager in-serviced the FNS cook staff regarding temporary protocol utilizing the catchment pan when cleaning the grill until a permanent fix is completely. - The FNS staff were in-serviced on proper sanitation and cleaning protocol at new hire orientation, at least annually, and ongoing as deemed necessary. - Employee cleaning schedule and list of duties will be assigned to FNS staff at the beginning of each week. - FNS Manager will review cleaning list at the end of each week. - Frequency of outside professional cleaning service will be changed from	

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4 160	Continued From page 72	4 160	biannually to quarterly. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. - To ensure quality assurance and effectiveness of promoting sanitary food procurement for the wellbeing of our residents, and upholding the residents rights for systemic changes, ongoing monitoring and random evaluation with application of the Aloha Nursing Rehab Centre - Grease Catcher Cleaning Log, the auditing tool is to be completed daily by the FNS Manager or designee. - Auditing of this tool is to occur weekly by the FNS Manager, or designee, for a minimum of 12 weeks to ensure compliance. - Corrective action is to be taken immediately and staff education is to be provided as deemed necessary. - To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved.	

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4 160	Continued From page 73	4 160	- If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met. - Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate. Included dates when corrective action will be completed: - Corrective action completion date by Nursing Home Administrator and/or designee.	
4 192	11-94.1-46(i) Pharmaceutical services (i) Appropriately licensed and trained staff shall be responsible for the entire act of medication administration, which entails removing an individual dose from a container properly labeled by a pharmacist or manufacturer (unit dose included), verifying the dosage with the physician's orders, giving the specified dose to the proper resident, and promptly recording the time, route, and dose given to the resident, and signing the record. Only a licensed nurse, physician, or other individual to whom the licensed professional has delegated the responsibility pursuant to chapter 16-89, subchapter 15, may administer medications. This Statute is not met as evidenced by:	4 192		9/30/21

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4 192	Continued From page 74 Based on observation, interview and record review, the facility failed to ensure its nursing staff administered medications correctly to one resident, R61. The deficient practice places the residents at an increased risk for illness and/or an adverse event. The Licensed Nurse (LN) failed to follow procedures within professional standards of practice that resulted in missed medications for R61. Findings include: During an observation on 08/11/21 at 08:25 AM, Licensed Practical Nurse (LPN) 10 administered medication to R61. After medications were administered, LPN10 returned to the medication cart and stated, "all my medications are done." Surveyor asked if LPN10 would be signing the medications off as given. LPN 10 stated "I am done." Surveyor asked to see the Medication Administration Record (MAR). LPN10 opened the EMR, and the MAR reflected that LPN had signed all the 08:00 AM medications prior to administering medications. Surveyor asked LPN 10 if she typically signed the medications prior to administering them? LPN 10, smiled and stated, "I know." During record review to reconcile the medications on 08/11/21 at 09:30 AM, surveyor noted two 08:00 AM medications (Ventolin and Aspirin) were not administered during observation with LPN10. During an interview on 08/11/21 at 10:24 AM with LPN 10: Surveyor stated to LPN10 when reconciling the medication administration observation with you for the medication administered to resident R61 with the EHR, physician orders, and the MAR, noted two medications that were not administered and were	4 192	4192 Pharmaceutical Services F759 Medication Error RTs 5 Prcnt or More Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility□s credible allegation of compliance. 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. - On 10/1/21, Resident R61 was physically assessed for the resident□s well-being by the Director of Nursing (DON); the resident□s vital signs were assessed to be within normal limits specific to the resident - Licensed nurses have been educated on professional standards of practice for medication administration to decrease the risk for illness and/or an adverse event □ Preparation and General Guidelines: Medication Administration- General Guidelines.	

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4 192	Continued From page 75 signed off. The medications were Ventolin and Aspirin" LPN10 stated, "it was an honest mistake. I administered the Ventolin." Surveyor asked when was the medication given? LPN10 paused ... then stated, "I went to give the medication after I administered the medications with you (Surveyor). The aspirin is every other day." Surveyor asked, "Is the aspirin due today?" LPN 10 stated, "No, the aspirin is not due today, it is due tomorrow." The MAR noted that the 08:00 AM dose of Aspirin was administered as representative of LPN 10 having signed the medication off in the EHR prior to administering to R 61. The medication order stated Mon, Wed and Friday.	4 192	2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice. - The alleged practice has the potential to affect facility residents. - On 9/20/21, an associate of the facility□s partnered pharmacy completed a station check of random medication carts and observed a nurse complete a medication pass - preparation and administration of medication. - To identify other residents having the potential to be affected by the identified deficient practice, the F-759 & F-761 Medication Pass and Storage Audit form was created. - The DON or designee is to monitor and manage compliance by performing random assessments of compliance during weekly completion of the F-759 & F-761 Medication Pass and Storage Audit form. - Completed forms are to be kept in a binder in the Nursing Home Administrator□s (NHA□s) office or designee. 3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? - To ensure quality assurance and effectiveness, licensed nurses have been	

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4 192	Continued From page 76	4 192	in-serviced on professional standards of practice for medication administration (including timeliness, safe administration, and accuracy of documentation) to decrease the risk for illness and/or an adverse event - Preparation and General Guidelines: Medication Administration-General Guidelines. - A copy of the referenced document has been provided to the in-serviced licensed nurses. - Upon return from previously schedule time off, Licensed Practical Nurse (LPN), referenced as LPN 10, will be provided with education regarding the importance of adhering to procedures within professional standards of practice for medication administration. - LPN 10 will be in-serviced on not to sign off on medications prior to administering the medication to a resident. - LPN 10 will be in-serviced on the medication rights of administration. - LPN 10 will be in-serviced on adhering to professional standards of practice for medication administration. - A copy of the Preparation and General Guidelines: Medication Administration-General Guidelines will be provided to LPN 10 - In-services will be ongoing as needed 4) Indicate how the facility plans to monitor	

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4 192	Continued From page 77	4 192	its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. - An associate of the facility□s pharmacy partner will continue to conduct a quarterly pharmacy station check of random medication carts, and a monthly observation of a random nurse medication pass - preparation and administration of medication. However, frequency of occurrence may be subject to change as a result of COVID-19 safety rules and regulations set forth in the best interest of all stakeholders. - To ensure quality assurance and effectiveness of promoting the wellbeing of our residents, and upholding the residents□ rights for systemic changes, ongoing monitoring and random evaluation with application of the F-759 & F-761 Medication Pass and Storage Audit form will be completed. - Completion of this tool is to occur weekly x 1 month, bimonthly x 1 month and monthly x 1 month by the DON or designee for a minimum of 12 weeks to ensure compliance. - Corrective action is to be taken immediately and staff education is to be provided as deemed necessary.	

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4 192	Continued From page 78	4 192	- To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved. - If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met. - Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate. Included dates when corrective action will be completed: - Corrective action completion date by Nursing Home Administrator and/or designee.	
4 197	11-94.1-46(n) Pharmaceutical services (n) Discontinued and outdated prescriptions and containers with worn, illegible, or missing labels shall be disposed of according to facility policy. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to store biologicals (purifired protein derivitive) in accordance with accepted professional principles within the expiration date.	4 197	4197 Pharmaceutical Services F761 Label/Store Drugs and Biologicals	9/30/21

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4 197	Continued From page 79 Findings include: On 08/11/21 at 08:52 AM Surveyor inspected the second-floor refrigerator in the medication room on the second floor nursing station. One vial of purified protein derivitive (PPD), (used for Tuberculin skin testing) was found with an open date 07/05/21 written on the box. Confirmed with RN16, the vial of PPD expired on 08/05/21. RN16 removed the vial and discarded it into the discard bin.	4 197	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility□s credible allegation of compliance. 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. - On 8/12/21, to ensure that the facility stored biologicals in accordance with accepted professional principals within the expired date, nursing associates immediately conducted a facility-wide sweep of medication refrigerators to ensure there were no other instances of expired and/or undated biologicals being stored. - Licensed nurses have been educated on professional standards of practice for storage of drugs and biologicals □ Medication Storage in the Facility. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	

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4 197	Continued From page 80	4 197	All residents have the potential to be affected by this alleged deficient practice. After the facility medication refrigerators sweep on 8/12/21 it was determined that no residents could be affected by this cited alleged deficiency. - The alleged practice has the potential to affect facility residents. - On 9/20/21, an associate of the facility□s partnered pharmacy completed a station check of random medication carts to assess for proper label/store of drugs and biologicals. - To identify other residents having the potential to be affected by the identified deficient practice, the F-759 & F-761 Medication Pass and Storage Audit form was created. - The Director of Nursing (DON) or designee is to monitor and manage compliance by performing random assessments of compliance during weekly completion of the F-759 & F-761 Medication Pass and Storage Audit form. - Completed forms are to be kept in a binder in the Nursing Home Administrator□s (NHA□s) office or designee. 3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?	

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4 197	Continued From page 81	4 197	- In-service education will be conducted with licensed staff by the DON or designee upon hire and at least annually regarding the facilities Medication Storage Policy and Procedure. - On 09/12/21, refrigerated medication was assessed and audited by licensed staff to ensure proper labeling and storage of medication and biologicals was in compliance with accepted professional principles within the expiration date. - To ensure quality assurance and effectiveness, licensed nurses have been in-serviced on professional standards of practice for proper storage of drugs and biologicals - Medication Storage in the Facility. - A copy of the referenced document has been provided to the in-serviced licensed nurses. - In-services will be ongoing as needed 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. - The DON or designee will conduct random audits of medication refrigerators to ensure facility is in compliance. Audit	

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	125038		08/12/2021

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4 197	Continued From page 82	4 197	findings will be reviewed at the monthly QA meetings and continued randomly until such time consistent satisfaction is reported. - An associate of the facility□s pharmacy partner will continue to conduct a quarterly pharmacy station check of random medication carts. However, the frequency of occurrence may be subject to change as a result of COVID-19 safety rules and regulations set forth in the best interest of all stakeholders. - To ensure quality assurance and effectiveness of promoting the wellbeing of our residents, and upholding the residents□ rights for systemic changes, ongoing monitoring and random evaluation with application of the F-759 & F-761 Medication Pass and Storage Audit form will be completed. - Completion of this tool is to occur weekly x 1 month, bimonthly x 1 month and monthly x 1 month by the DON or designee for a minimum of 12 weeks to ensure compliance. - Corrective action is to be taken immediately and staff education is to be provided as deemed necessary. - To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved.	

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4 197	Continued From page 83	4 197	- If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met. - Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate. Included dates when corrective action will be completed: - Corrective action completion date by Nursing Home Administrator and/or designee.	
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, interview and record review, the facility failed to ensure it provided a safe, sanitary environment to prevent the development and transmission of communicable diseases and infections for its residents. The facility staff created a breach in its infection control when staff improperly donned personal protective equipment (PPE) and did not properly	4 203	4203 Infection Control F880 Infection Prevention & Control Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is	9/30/21

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4 203	Continued From page 84 isolate residents with infections. The deficient practice jeopardizes the health and safety for its vulnerable residents and staff working in the facility. Findings include: 1) On 08/09/21 at 11:05 AM observed one R15 sitting in his wheelchair in the doorway of his room. Noted contact precaution signs outside the door and a PPE cart outside of the room. Per RN17 he is on contact precautions for an abscess of the stoma that tested positive for MRSA. R15's colostomy bag was visible and hanging below the front of his shirt. At 12:09 PM R16 walked out of his room pushing the overbed table and gave his lunch plate to the staff. His colostomy bag was visible hanging out under his shirt. Surveyor noted that another resident's family member was near R15's room visiting in the hallway. At 1:52 PM, R15 was observed sitting up in his wheelchair in the second-floor activity room. Surveyor asked the unit manager if R15 was supposed to be in his room since he is on contact precautions, the unit manager (UM2) replied that the infected area is covered so he can be out of his room, although his bag needs to be covered. Surveyor made additional observations during the survey of R15 outside of his room wheeling around the unit and sitting and speaking with staff in the activity/ dining area on the second floor. Noted the colostomy bag was visibly hanging outside of his shirt. 2) PM During an observation in front of room 220 on 08/10/21 at 04:11 PM, noted contact isolation signage at the door. Surveyor observed staff go into the room with a Hoyer lift wearing only a mask. Surveyor asked RN17 why the resident was on contact precautions which she stated was	4 203	also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility□s credible allegation of compliance. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. Director of Nursing Services (DON) or designee will infection control compliance. Audit weekly x 1 month, bimonthly x 1 month, and monthly x 1 month. All findings of concern will be immediately addressed with the individual staff member. Audit findings will be reviewed and discussed during the monthly QA meetings until such time consistent satisfaction is reported. Included dates when corrective action will be completed: Corrective action completed on 9/26/21, DPOC due 10/7/21. 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.	

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4 203	Continued From page 85 because he has a wound on his toe with MRSA. When asked if the staff should be gowning and masking before going in, she looked at the sign and said yes. The CNA came out of the room and stated only if we are providing care to the toe we will gown and glove. RN17 stated while pointing at the resident who was sitting in the Geri chair outside the room in the hall, he has his wound covered and he's on antibiotics. 3) On 08/09/21 at 10:08 AM noted R12 was laying sideways on his bed sleeping. Urinary catheter bag was laying on the bed next to the resident. Surveyor validated with the UM that the urinary bag should be hanging down to the side, below the resident. Surveyor reviewed the EMR for R12 on 08/10/21 at 01:47 PM. The Care plan stated, R12 is diagnosed with acute bacteremia and on oral antibiotics. Start date 04/23/21, Review Date 09/10/21. Diagnosis Chronic kidney disease, stage four, severe fever unspecified on 04/16/21. On 08/12/21 at 09:00 AM, noted R12 Wheeling his self-down the hallway in his wheelchair, noted the catheter was laying on the seat of the wheelchair. Surveyor reviewed the facility assessment on 08/11/21 at 02:00 PM and noted high rates of infections, wound, UTI, septicemia, and MDRO. Surveyor interviewed the infection preventionist (IP) on 08/12/21 at 10:23 AM. Surveyor asked to discuss the log of identified breaches and what type of breaches were identified. The IP stated that on Monday, there were possibly two breaches, the staff went into an isolation room without wearing any PPE. The second was when a staff went in without a face shield. The IP explained that the staff are required to put on	4 203	- On 8/10/21, CNA44 was provided remediation in regards to donning and doffing of personal protective equipment (PPE) and proper droplet isolation precautions requirements. -On 8/10/21, regarding Resident R262, appropriate PPE was made available at point of care location required for droplet isolation precautions. -On 8/10/21, Resident R314 received negative PCR COVID test results clearing the resident of isolation precautions. -On 8/11/21, Resident R315 received negative PCR COVID test results clearing the resident of isolation precautions. - On 8/12/21, physician□s orders were received for Resident R15 and Resident R32, allowing the residents to be out in common areas as long as the wound is covered. -Resident R15 was encouraged to perform hand hygiene and secure colostomy pouch under waistband prior to exiting room. -On 8/12/21, to promote infection control, Environmental Services (ES) provided additional cleaning in common areas and all high touch surfaces. -On 9/18/21, Resident R12 was discharged from the facility - To promote infection prevention and control, facility staff were in-serviced on	

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4 203	Continued From page 86 (don) PPE according to the sign. When a resident is on contact precautions, they should be wearing gloves and gowns, whenever touching the resident's intact skin or articles near the resident. Staff should remove (doff) their PPE in the room prior to the exit. Surveyor asked if the resident who is on the contact precautions is allowed to be out of the room? the IP responded that if the wound can be managed and contained by dressings. When they are outside of the room, we want to just ensure any areas will be provided for cleaning, including equipment in the vicinity of the resident. 4) R262 was newly admitted to the facility on 08/07/21 and was not vaccinated for COVID-19. As a result of the resident's COVID-19 vaccination status and the facility's COVID-19 mitigation plan, the resident was paced in isolation and droplet transmission based precautions was implemented. On 08/10/21 01:24 PM, observed CNA44 enter R262's room with with only a gown and surgical mask (covered nose and mouth only) and assisted the resident with lunch. While this surveyor was obseving CNA44 while still in the resident's room, the Assistant Director of Nursing (ADON) approached this surveyor and also observed CNA44 donned in only a gown and a surgical mask in R262's room. Inquired with the ADON regarding the type of PPE CNA44 should have donned. The ADON confirmed CNA44 was not wearing the appropriate PPEs and in addition to the gown and face mask, CNA44 should have been wearing a face shield and gloves. Pointed out to the ADON, the plastic storage bin located outside of R262's room contained only four to five protective gowns. Asked the ADON if there was	4 203	establishing and maintaining infection control measures to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice. - The alleged practice has the potential to affect facility residents. 3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? - On 8/16/21, the facility hired an Infection Control Preventionist (IPC) / Wound Care Specialist - Facility-wide review of PPE distribution protocol/guidelines and update to ensure staff have adequate supply of PPE to provide necessary care in a safe manner was conducted; ongoing assessment and review is to continue to promote infection prevention and control - All residents on isolation precautions will require a physician order if care guidelines deviate from said isolation protocol. The facility will use cohorting guidelines set forth by the Centers for Disease Control and Prevention (CDC) and Centers for Medicare & Medicaid Services (CMS) in	

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4 203	Continued From page 87 a designated place for staff to store reusable face shields and what staff shold use to santize their face shields after use. The ADON stated staff store their face shields in their personal lockers and should wipe their shields down with sanitiing wipes which were stored in the medication cart. The ADON confirmed supplies staff would need to adhere to infection control protocol to mitigate the spread of COVID-19 was not readily avaiable for staff use. 5) An initial observation was made of R314 and R315 on 08/09/21 at 10:40 AM in a room they shared. R314 was wearing a hospital gown, lying in bed with his head of bed (HOB) raised. His eyes remained closed, and he was slow to respond to the surveyor's salutation. R315 was also lying in bed wearing a hospital gown with his eyes closed. R315 was observed at 12:13 PM the same day with a staff member performing range of motion (ROM) of his lower extremities. On 08/10/21 at 09:10 AM, a red sign posted on the wall outside of R314 and R315's room stated, "Please see nurse before entering room." Another sign was also posted, "Special droplet/contact precautions." A document from The Centers for Disease Control and Prevention (CDC) outlining the process to don personal protective equipment (PPE) was located on top of a plastic chest located to the left of the doorway. R314 and R315 were noted to be lying in their beds. An interview with the QCM was done in the training room later that day at 4:10 PM. She stated that R314 had a fever yesterday and was tested for COVID-19. She further stated that R314 should have been isolated and without a	4 203	regards to isolating residents suspected of COVID-19 infection. - A required deadline of 10/07/21 was set forth for facility staff to complete specified COVID-19 infection control and prevention measures, to promote infection control measures, and to prevent this deficient practice from occurring: " Facility staff will view training videos on Relias training platform: 1) Use PPE correctly for COVID-19, 2) Keep COVID-19 OUT!, and 3) Closely Monitor Residents for COVID-19. " Facility staff in-serviced on COVID-19 Infection Control and Essentials of Infection Prevention for Nursing Homes, Contact Precautions, Droplet Precautions, and information on PPE location and storage (it is everyone□s responsibility to ensure PPE is available at the point of care). " Facility staff was also provided with education on donning / doffing PPEs, appropriate use of PPE, and on adherence to infection control precautionary measures for residents on isolation precaution. - In-services will be ongoing as needed, and will also be conducted with the Director of Nursing (DON), IPC, or designee at new hire orientation and, at least, annually addressing the continuity of care by combining Hospice and Facility care plans at new hire orientation and at least annually. - Facility staff has been in-serviced on CDC□s Interim Infection Prevention and	

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4 203	Continued From page 88 roommate. On 08/11/21 at 09:32 AM, R315 was noted to be the only resident in a room across the hall from where he previously resided and the door to his room was open. R314 was also alone in the room with the door open. The CDC's "Interim Infection Prevention and Control Recommendation to Prevent SARS-CoV-2 (COVID-19) Spread in Nursing Homes" updated on March 29, 2021, stated, "Ideally a resident with suspected SARS-CoV-2 infection should be moved to a single-person room with a private bathroom while test results are pending. In general, it is recommended that the door to the room remain closed to reduce transmission of SARS-CoV-2. This is especially important for residents with suspected or confirmed SARS-CoV-2 infection being cared for outside of the COVID-19 care unit." 6) R32 is a 90-year-old on hospice care for dysphagia due to a past stroke with left sided weakness. Record Review of R32 EMR on 8/11/2021 showed that per Nurses notes on 7/4/2021 and 7/23/2021, R32 suffered a wound injury to the left 2nd toe after kicking the footrest of the geriatric chair that R32 was laying supine in, and wound care was started thereafter. R32's toe wound progressed to cellulitis (bacterial infection of the skin) and paronychia (an infection of the tissue folds around the nails). The wound was cultured on 7/23/2021 after staff observed pus and was found positive on 8/26/2021 for MRSA (methicillin resistant staphylococcus aureus). Per R32's care plan, nursing diagnosis of Joint infection was identified on 7/23/2021 with treatment of antibiotics, monitoring for signs of infection, and contact precautions for MRSA.	4 203	Control Recommendations to Prevent SARS-CoV-2 (COVID-19) Spread in Nursing Homes: " Nursing staff to continue to take daily temperatures of all facility residents every shift as a part of the monitoring process " On a daily basis, and on every shift, nursing staff to continue to assess residents for COVID-19 signs and symptoms " An order is to be obtained for COVID-19 testing " Any resident with assessed COVID-19 signs and symptoms is to tested for COVID-19 and moved to a single-person room with a private bathroom while test results are pending; the door is to remain closed to reduce the transmission of COVID-19 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. - The IPC, DON, or designee is to continue to perform routine-weekly assessments of proper infection control practices with application of the Log of Identified Breaches in Infection Control to record identified incidents and to apply corrective actions through education and follow up.	

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4 203	Continued From page 89 On 8/9/2021 at 8:45AM, surveyor observed contact precautions sign and isolation cart outside of R1's room. The isolation gown had a bag of gowns and 2 boxes of gloves. No wipes available in cart. R32 not present in room. Roommate of R32 lying in bed behind curtain. On 8/9/2021 at 11:55AM, S3 observed R32 being fed lunch by staff member in the hibiscus common dining area. Staff member wore gloves but no gown. S3 asked R32's nurse (N)24 if R32 was allowed out of room due to contact precautions posted and if gowns and gloves were needed to be worn by staff. N24 said it's okay to wear no gown if they are not touching the wound and that the wound is covered. 08/11/21 at 08:20 AM, S3 observed R32 sitting in geriatric chair with left foam boot on left foot in Hibiscus dining area. CNA10 wearing mask and gloves, and no gown while feeding R32. 08/11/21 at 01:58 PM, first floor nursing station in an interview with Physician (P)1, surveyor asked if it was safe for R32 to be outside of room in common areas due to MRSA diagnosis and contact precautions. P1 said that R32 can go outside of room since MRSA infection is localized to the left toe and is covered with a bandage. The infection is not in R32's urine, bowel movements, blood, or lungs so it is okay for R32 to have a roommate. P1 said that staff do not need to wear gown when feeding R32 if they are not directly touching the site that is infected and that wound is covered. Record review in EMR on 08/12/21 09:06 AM, showed no physician orders for contact precautions. R32's care plan under Problem Joint Infection listed "Contact precautions	4 203	- The Aloha Nursing & Rehab Centre Resident Focus Rounds was created to promote respect, dignity, and care for each resident in a manner and environment that promotes maintenance or enhancement of each resident□s quality of life. This auditing tool is for monitoring through resident interview query and observation. This tool includes assessment of infection control measures. - To ensure infection control, quality assurance, and effectiveness of the aforementioned systemic changes random monitoring and evaluation with application of the Log of Identified Breaches in Infection Control and the Aloha Nursing & Rehab Centre Resident Focus Rounds will be applied. - Completion of this tool is to occur weekly x 1 month, bimonthly x 1 month and monthly x 1 month by the DON or designee for a minimum of 12 weeks to ensure compliance. - Corrective action is to be taken immediately and staff education on infection control measures is to be provided as deemed necessary. - To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved. - If further corrective action is needed, the auditing will continue until such time that	

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4 203	Continued From page 90 + (positive) MRSA" with no specifications on when and how client can go to common areas. Interview with Unit Manager (UM)3 at MDS office on 08/12/21 at 10:06 AM, UM3 acknowledged no physician orders for contact precautions in R32's electronic medical record. UM3 acknowledged that contact precautions, reason for contact precautions, and any other details (such as resident being able to leave room if wound covered) should be documented in both R32's care plan and physician orders. UM3 will contact P1 to input physician orders. On 08/12/21 at 01:30 PM, EMR review of R32 showed under Physician Orders on 8/12/2021 at 11:34AM: OK for resident on contact precautions to enter common meeting areas if wound is covered. On 8/12/21 at 1:00PM, ANRC's Facility Policy effective 6-1-90 for Transmission Based Precautions (Contact) states "wear gown whenever anticipating that clothing will have direct contact with the resident or potentially contaminated environmental surfaces or equipment in close proximity to the resident."	4 203	the QAPI committee determines consistent substantial compliance has been met. - Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate. Included dates when corrective action will be completed: - Corrective action completion date by Nursing Home Administrator (NHA) and/or designee. - Compliance and completion of corrective DPOC by the NHA and/or designee.	