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	125009	A. BUILDING ______ B. WING ______	07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALUHIA	**1027 HALA DRIVE HONOLULU, HI 96817**

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 07/20/21 to 07/23/21. The facility was not in substantial compliance with 42 CFR §483 subpart B. One complaint (ACTS #8972) was investigated and not substantiated. Survey dates: 07/20/21 to 07/23/21. Survey Census: 81 Sample Size: 32	F 000		
F 576 SS=D	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal	F 576		9/6/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 08/19/2021

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

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F 576	Continued From page 1 service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to facilitate the residents' right to communicate with family members by ensuring reasonable access to the use of a telephone for one resident (R) 130 in the sample. As a result of this deficient practice, R130 experienced frustration that she could not call her family member(s) when she wanted to. This deficient practice has the potential to affect all residents on the third-floor unit. Findings Include: R130 is an 81-year-old female admitted on 06/25/21 for hospice care. Her diagnoses included COPD (chronic obstructive pulmonary disease), dementia, depression, and multiple fractures (breaks) of her right femur (large bone in the leg). During an interview with R130 on 07/20/21 at 11:59 AM, in her room on the third floor, R130 stated that she gets frustrated when	F 576	The Head Nurse (HN), Charge Nurse (CN), and Health Unit Clerk (HUC) will implement corrective actions for (R130) affected by this practice, including: 1) The resident was not provided use of the cordless phone when requested. Health unit clerks were reminded that the cell phone on each unit is available for resident use. 07/30/21 2) The unit cell phone will be brought out by the night shift nurse after charging overnight to be readily available for resident use at the nurses station. 08/18/21 - ongoing 3) The unit managers cordless phone will be made available at the nurses station when not in use. 08/18/21 - ongoing Head Nurse (HN), Charge Nurse (CN) , and Health Unit Clerk (HUC) will identify other residents having the potential to be	

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F 576	Continued From page 2 she asks staff to bring her the cordless phone to call her daughter, and staff tells her they "cannot do that". R130 further explained that staff will bring her the cordless phone if her family calls the unit and asks to speak to her, so she doesn't understand why she can't also use it to call out. On 07/20/21 at 12:06 PM, an observation and concurrent interview were done with the health unit clerk (UC)3 on the third floor. Whenever the phone rang, UC3 was observed answering it on a red cordless phone placed directly to the right of her computer at the front of the nurses' station. When asked about the availability of phones on the unit for resident use, UC3 pointed to the red cordless phone by her computer and stated that is the phone that the residents use as well. UC3 further explained that there are two phones on the unit, but only one of them is cordless. The second (corded) phone was observed positioned in the back of the nurses' station. When asked, UC3 stated that she and other staff often use the cordless phone due to its convenient location in the front and confirmed that there was no dedicated phone for resident use.	F 576	affected by the same deficient practice, including: 1) All residents that are able to have private telephone conversations will be identified and informed that there is a unit cell phone available for their use. 7/30/21 2) The unit cell phone will be made available to residents for use when requested. The cordless phone will be a secondary backup for residents to use when the cell phone is in use. 08/18/21 ongoing 3) Charge nurses on each shift will be notified to allow residents to use the cell phone or cordless phone upon request. 08/18/21 4) A log will be created to track telephone requests by residents. 08/17/21 Head Nurse (HN), Charge Nurse(CN) and Health Unit Clerk (HUC) Will Implement Measures To Ensure That This Practice Does Not Recur, Including: 1) The unit cell phone will be passed to the health unit clerk, charge nurse or head nurse for resident use on each shift. 7/30/21 2) Staff will ensure that there is always at least one open phone line available at any given time for residents to use. 08/18/21 - ongoing 3) A log will be utilized to track resident phone requests to ensure the resident's phone requests are being accommodated. 08/18/21 - ongoing Director of Nursing (DON), Nursing Supervisor (SRN) and Head Nurse(HN) Will Monitor Corrective Actions To Ensure The Effectiveness Of These Actions, Including:	

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F 576	Continued From page 3	F 576	1) Resident phone request log will be submitted to the quarterly QAPI meeting for review. 11/4/21	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to	F 623		9/6/21

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F 623	Continued From page 4	F 623		

allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and

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F 623	Continued From page 5 advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide proper notification of discharge for one resident in the sample, who was discharged to an acute care hospital. Specifically, the facility failed to issue written notification of discharge to the resident or her representative and failed to send notification of the discharge to the Office of the State LTC [long-term care] Ombudsman (LTCO). This deficient practice has the potential to affect all residents at the facility who are discharged or transferred. Findings Include: Resident (R)40 is a 72-year-old female originally	F 623	Head Nurse (HN), Nursing Supervisor (SRN) and License Nurse (LN) Will Implement Corrective Action For R40 Affected By The Deficient Practice By: 1) R40 had multiple unplanned transfers for the past month. For unplanned discharges, the Discharge/Transfer notice will be sent to the Hawaii State Long Term Care Ombudsman via electronic mail on the day of discharge by (licensed nurse) LN and the Transfer/Discharge notice will be mailed to the resident□s family by the Health Unit Clerk. Resident had an unplanned discharge on 7/6/2021; Discharge/Transfer notice was sent to State Long Term Care Ombudsman after	

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F 623

Continued From page 6

admitted to the facility on 09/12/18. During a review of her electronic health records (EHR) on 07/23/21 at 08:49 AM, it was noted that R40 was sent and admitted to an acute care hospital on 07/06/21 with a severe urinary tract infection. There was no discharge notification or LTCO notification found in the EHR for this discharge.

On 07/23/21 at 09:00 AM, a copy of the discharge notifications was requested from the Day Nurse Supervisor (NS)3. At 09:50 AM, two Transfer/Discharge Notices addressed to R40's family representative (FR), both dated "7/6/21", were received from NS3. The only visible difference between the two notices were the Attending Physicians listed. A handwritten Discharge/Transfer Notice for the LTCO, documenting "Date Discharge Notice Given: 7/6/2021" was also received from NS3 at this time. A subsequent review of R40's EHR revealed two of these documents had just been uploaded by a Health Unit Clerk (UC) on the second floor.

On 07/23/21 at 10:11 AM, an interview was done with UC2 at her assigned nurses' station. UC2 confirmed that she had recently uploaded the notification documents. UC2 stated she was asked by "the nurse supervisors" to create a discharge notice to the FR this morning and date it "7/6/21", but she made a mistake on the first one, documenting the wrong attending physician, so she created a second Transfer/Discharge Notice. Although she did upload the Discharge/Transfer Notice for the LTCO, UC2 explained that Registered Nurse (RN)7 created that notification.

On 07/23/21 at 10:13 AM, an interview was done

F 623

being questioned by surveyor. 7/23/2021
2) For a planned discharge, the Discharge/Transfer notice will be sent to Hawaii State Long Term Care Ombudsman via electronic mail on the day of the discharge and the Transfer/Discharge notice will be mailed to the resident□s family by the Social Worker.
Head Nurse (HN) and Nursing Supervisor (SRN) Will Identify Other Residents Having The Potential To Be Affected By The Same Deficient Practice By:
1) For both planned and unplanned discharge, unit□s appointment calendar will be updated of the date of the discharge. The Transfer/Discharge Notice to resident/family and Discharge/Transfer Notice to the State Ombudsman forms are in our discharge/transfer packet. Checklist on packet will be revised to remind licensed nurses to ensure proper documentation and notifications were made and were sent out to the families and to Hawaii State Long Term Care Ombudsman. 8/19/2021
2) Discharge/Transfer notice will be uploaded to PointClickCare Miscellaneous module by HUCs with the date and time of when the documents were sent. 8/23/21 ongoing
Head Nurse (HN) and Nursing Supervisor (SRN) Will Implement Measures To Ensure That This Practice Does Not Recur, Including:
1) Education will be provided to LNs and Health Unit Clerks (HUCs) to ensure that Discharge/Transfer Notice to the Ombudsman were sent in a timely

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F 623	Continued From page 7 with RN7 at his assigned nurses' station on the second floor. RN7 confirmed that he created the handwritten Discharge/Transfer Notice for the LTCO this morning and documented on it that discharge notice was given on "7/6/2021", at the request of NS3. On 07/23/21 at 12:18 PM, during an interview with NS3 in the Nursing Office on the first floor, NS3 admitted that after being asked for the discharge notifications and noticing in the EHR that they had not been done, she went to the second-floor unit that discharged R40 on 07/06/21 and asked staff there to create and upload the documents. On 07/23/21 at 12:45 PM, during a review of the Bed-hold/Readmission for Hospitalization of Residents policy, dated 05/01/19, Attachment A. Notice of Bed Hold Policy Maluhia, the following was noted under Transfer/Discharge Notice, "A written notice will be given to the resident or responsible party prior to or upon transfer or discharge of the resident."	F 623	manner on the day of the transfer. 8/23/2021 ongoing 2) HN/SRN will audit/check charts of unplanned discharges to make sure completion and proper documentation/notices were sent to the family and the Ombudsman and all documents were uploaded to PointClickCare in a timely manner. 8/23/2021 ongoing 2Head Nurses, Nursing Supervisors Will Monitor Corrective Actions To Ensure The Effectiveness Of These Actions, Including: 1) HN/SRN will perform audits/review for all unplanned discharges to monitor if proper notifications were sent to families and to the Hawaii State Long Term Care Ombudsman and to ensure all discharge documentations were uploaded to PointClickCare in a timely manner. 8/23/2021 ongoing 2) Audit results will be reported to QAPI committee during quarterly meetings. 11/4/2021 next QAPI	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing	F 625		9/6/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 625	Continued From page 8 facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure written notification of the facility's bed hold policy was provided to Resident (R)40 or her representative (FR) upon any of her three discharges to an acute care hospital during July 2021. This deficient practice has the potential to affect all residents at the facility who are discharged to an acute care hospital. Findings Include: Resident (R)40 is a 72-year-old female originally admitted to the facility on 09/12/18. During a review of her electronic health records (EHR) on 07/23/21 at 08:49 AM, it was noted that R40 was sent and admitted to an acute care hospital on 07/06/21, 07/17/21, and 07/22/21. There was no documentation found in the EHR that written notification of the facility's bed hold policy was issued for any of these discharges.	F 625	1) Bed hold notification for R40 was done over the phone upon discharge with the Resident/Family Representative (FR) by charge nurse or designee but was not provided in writing. If the FR agrees to pay for the bed hold, the Financial Counselor (FC) would call the FR, prepare the bed hold agreement, arrange for the FR to come to the facility to sign and make advance pay for the agreed bed hold days. Date: New policy to be effective 8/25/21 2) A discharge checklist to be developed for both Nursing and the Business Office to utilize that includes providing written bed hold notification. Date: 08/25/21 3) HIM revised the discharge chart checklist to include a line item for the bed hold notification Date: 08/17/21	

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F 625

Continued From page 9

On 07/23/21 at 11:15 AM, an interview was done with the Unit Manager (UM)3 outside her office on the third floor. UM3 explained that bed hold notifications are usually done over the phone with the FR and documented in a nursing progress note. UM3 stated that most families do not ask for bed holds because of the expense, however if the FR agrees to pay the bed hold daily rate, then a Bed Hold Agreement is completed, signed, and uploaded into the EHR.

On 07/23/21 at 12:18 PM, an interview was done with the Day Nurse Supervisor (NS)3 and the Evening Nurse Supervisor (NS2) in the Nursing Office on the first floor. Both NS3 and NS2 confirmed that written notification of the bed hold policy is given and reviewed as part of the admission process only, and not at discharge or transfer. NS3 continued to state when a resident is transferred to an acute care hospital, the FR is normally called either the day after transfer, or once admission to the hospital is confirmed, and asked if they want to bed hold. Documentation of whether bed hold is desired or not is then documented in a nurse progress note.

F 625

The Billing Supervisor, Head Nurses, And Financial Counselor Will Identify Other Residents Having The Potential To Be Affected By This Practice, Including:
1) All Resident/Family Representative contact information was updated/confirmed in electronic health record system. DATE: 8/18/21
2) The Billing Supervisor will review the discharges of residents to an acute care facility weekly for proper written notification and completion of bed hold agreement. DATE: 8/30/21
3) The Billing Supervisor will review the discharge checklist requirements with the Financial Counselor. DATE: 8/30/21
4) The Head Nurses will review the nursing discharge checklist requirements with licensed staff.
Date: 08/30//21
5) HIM department will schedule a meeting to inform Health Unit Clerks about the revisions on the discharge chart checklist to ensure a copy is in the resident□s chart. Date: 8/19/21
The Financial Counselor, Charge Nurse or Designee will implement measures or systemic changes to ensure that the deficient practice will not recur, including:
1) The Financial Counselor will prepare and provide instruction for the written Bed Hold Agreement to the resident and/or FR. 8/25/21
2) Upon discharge of the resident, the charge nurse on duty or designee will prepare the Notification of Changes to Resident Information Form 164, to inform FC of the discharge. The FC would then prepare the Bed hold agreement and

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MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

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F 625	Continued From page 10	F 625	email /mail it to the FR. The FC will then call to provide instruction regarding Bed Hold agreement to the resident and/or FR. On the weekends or holidays the charge nurse or designee will call the FR with bed hold instructions and email the bed hold agreement. 8/25/21 3) If the resident or FR wishes to bed hold, he/she and or their FR must complete the bed hold agreement with the advance payment 8/25/21 4) If the resident or FR wishes to decline the bed hold, he/she must email or mail the declined bed hold agreement to the FC. 8/25/21 5) A copy of the bed hold agreement will be scanned into PointClickCare under Documents Tab, Category: Bed hold Documents. Date: 8/25/21 ongoing 6) FC and supervisory nurse will be trained on the above corrective measure. Date: 8/25/21 The Billing Supervisor And Chief Financial Officer Will Monitor Corrective Actions To Ensure Effectiveness Of These Actions, Including: 1) Conduct monthly audits of resident discharges to acute care facilities for proper written notification and completion of the bed hold agreement. The results of the audits will be submitted at the quarterly QAPI Committee meeting. Date: 08/30/21 - Ongoing	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		9/6/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125009	A. BUILDING ______ B. WING ______	07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALUHIA	**1027 HALA DRIVE HONOLULU, HI 96817**

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F 656	Continued From page 11 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

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F 656	Continued From page 12 section. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews the facility failed to ensure a comprehensive person-centered care plan was developed and implemented for 6 of 21 residents sampled (Resident (R)50, R3, R43, R69, R28, and R38). Non-pharmacological interventions to address behaviors related to the use of psychotropic medication was not developed for R50. Positioning interventions were not implemented for R3, who is totally dependent on staff for positioning needs. Staff did not implement interventions to prevent the worsening contractures to R43's left hand, despite documenting the intervention was implemented. R69's care plan documented verbal interventions despite R69 being legally deaf. R28's care plan to encourage the resident to eat due to poor intake and assistance with repositioning for the prevention of pressure injury was not implemented. Interventions were not implemented for repositioning and the application of prevalon boots to prevent the development/worsening of deep tissue injury. As a result of this deficiency, residents are at risk of potential negative quality of life outcomes. Findings Incude: 1) Cross Reference to F758. Resident (R)50 receives psychotropic medications, lorazepam for anxiety, agitation, restlessness, biting linen/clothes/diaper; seroquel for dementia with behavior; and paxil for agitation and diagnosis of mild dementia. Record review on 07/22/21 at 12:03 PM found no documentation of non-pharmacological interventions to address the	F 656	Director of Nursing (DON), Nursing Supervisors (SRN), Head Nurses (HN) and Social Workers (SW) Will Implement Corrective Actions For R50 Affected By This Practice, Including: 1) DON reviewed R50s chart and confirmed she is prescribed lorazepam 0.5mg at bedtime for anxiety, agitation, restlessness, biting linen/clothes/diaper, Seroquel 6.25mg two times a day for dementia with behavior, and paxil 10mg once a day for agitation and diagnosis of mild dementia. R50s behavior was not consistently monitored since her behavior monitoring log was not completed for five days on day shift from 7/16/21-7/20/21. R50s care plan did not have non-pharmacologic interventions. DATE(7/26/2021) 2) DON reminded involved nurses (HN, LN, SRN) to complete documentation in the Behavior/Intervention Monthly Flow Chart at the end of each shift. Currently the Behavior/Intervention Monthly Flow Chart log is not part of our EMR and is a paper document that is filed in a binder on each unit. To ensure that this document is completed every shift, HIM is assisting Nursing in incorporating the Behavior/Intervention Flow Chart log into PCC. DATE(7/26-8/6/2021) 3) HN reviewed R50s care plan and revised to include non-pharmacological interventions to address behaviors related to the use of psychotropic medications. (7/22/2021, 8/17/2021)	

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F 656	Continued From page 13	F 656		

behaviors related to the use of psychotropic medication. Interview with the Day Nurse Supervisor and Social Worker on 07/22/21 at 03:00 PM confirm non-pharmacological interventions were not documented in R50's care plan.

2) R3 was admitted to the facility on 11/06/1998 with diagnoses which include persistent vegetative state, quadriplegia, and epilepsy.

On 07/20/21 at 10:33 AM, conducted an initial observation of R3 lying in bed with both legs positioned towards the right side of the bed and both feet dangling off the bed. Multiple subsequent observations were R3's lower torso positioned to the right side of the bed with one or both feet dangling off the bed (07/20/21 at 2:08 PM; 7/21/21 at 08:45 AM, 10:52 AM, and 1:30 PM; 07/22/21 at 08:10 AM and 11:45 AM; and 07/23/21 at 10:15 AM). Staff was observed in R3's room (07/20/21 at 2:08 PM, 7/21/21 at 08:45 AM, and 07/22/21 at 11:45AM) and did not reposition R3 prior to leaving the room.

On 07/21/21 at 2:28 PM, conducted a record review of R3's Electronic Medical Record (EMR). R3's care plan documented interventions for staff to turn and reposition R3 every 2 hours as R3 tends to turn back to the right side (legs will turn to the right as well). Review of R3's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/23/21, R3 is totally dependent on staff for bed mobility as requires two or more-person physical assist.

On 07/22/21 at 11:56 AM, conducted an interview with Unit Manager (UM)2. Shared observation of R3 turned to the right side of the bed with both

Director of Nursing (DON), Nursing Supervisor (SRN), Head Nurses (HN) and Social Services (SW) Will Assess Other Residents Having The Potential To Be Affected By This Practice, Including:
1) All residents who are receiving psychotropic medication will be identified. (8/18/2021)
2) HN and SW will review care plans for residents receiving psychotropic medication and ensure that person-centered non-pharmacological interventions are included. (9/3/2021)

Head Nurses (HN), Will Implement Measures To Ensure That This Practice Does Not Recur, Including
1) Upon admission/readmission, quarterly, annually, with significant changes, or as needed when resident is placed on psychotropic medications, HN and SW to review or revise care plan to ensure each behavior has person-centered non-pharmacological interventions. (8/30/2021 ongoing)
(Responsible Staff) Will Monitor Corrective Actions To Ensure The Effectiveness Of These Actions, Including:

1) HN, SRN, SW will perform monthly reviews of care plans for residents receiving psychotropic care plan that person-centered non-pharmacological interventions are documented and implemented. HN/SRN will submit monthly report of their findings to DON for review of any deficiencies and DON will report as indicated to the QAPI committee quarterly meeting for further discussion

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 656	Continued From page 14 feet dangling off the right side of the bed. UM2 confirmed due to R3's involuntary spasms which causes R3 to turn to the right side, staff should reposition R3 back to the center if the resident is observed positioned to the right side of the bed as the resident in incapable of turning or repositioning without the total assistance of staff. 3) Cross referenced to F842 Resident Records R43 was admitted to the facility on 06/20/13. R43's diagnoses include hemiplegia and hemiparesis following a cerebral infarction affecting the left non-dominant side, aphasia, dysphagia, Major depressive disorder, and dementia with behavioral disturbances. R43 has impairment to both upper and lower extremities and has a contracture to the left hand. On 07/20/21 at 10:45 AM, observed R43 lying in bed with observable contracture to the resident's left hand and no brace, splint, or towel roll applied. R43 did not have a brace, splint, or towel roll applied to the left hand for contractures during multiple observations (7/20/21 at 12:00 PM and 1:57 PM; 7/21/21 at 08:27 AM and 10:49 AM; and 07/22/21 at 09:30 AM). Review of R43's care plan on 07/22/21 at 01:05 PM, documented R43 has a left-hand contracture and staff should encourage R43 to use a thin towel roll on my left hand for contracture management 2 to 3 hours, every AM and PM shift as tolerated. On 07/22/21 at 11:52 AM, conducted an interview with UM2 regarding R43's left hand contracture. UM2 stated R43 should have a paper roll placed in the resident's left hand to prevent further	F 656	and appropriate interventions. (9/3/2021 ongoing, 11/4/2021 next QAPI) Director of Nursing (DON), Nursing Supervisor (SRN), Physical Therapist (PT), Direct Care Staff (CNA) and Interdisciplinary Team (IDT) Will Implement Corrective Actions For (Residents) Affected By This Practice, Including: 1) HN reassess resident□s need for repositioning by staff. HN re-educated direct care staff regarding proper repositioning of the residents using pillows, etc.(8/11/2021) 2) DON and SRN reviewed with unit staff importance of following interventions on resident□s care plan. DATE 07/23/2021 and ongoing 3) DON and PT observed CNAs repositioning R3 on his left side. Discussed with CNAs resident□s tendency to turn self to his right when coughing/having spasm and possible interventions to prevent resident from turning to the right side with legs dangling. Resident has history of using wedge but ineffective and resident would place self in an unsafe, diagonal positioning on the bed. Also with history of skin tears to lower extremity and pressure injury to toes from side rails with cushion placed at his lower extremities. DATE 08/16/2021 4) Interdisciplinary Team (IDT) reviewed and updated R3□s care plan to address prevention of skin/pressure injury. DATE 08/16/2021 Head Nurse (HN), Wound Education Nurse (WEN), Supervisor Nurse (SRN)	

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F 656

Continued From page 15

contracture. UM2 reviewed R43's Kardex in the EMR and stated according to the Kardex, the task of applying the paper roll to R43's left hand from 9:00 AM to 12:00 PM, was marked completed on 07/20/21, 07/21/21, and 07/22/21. Informed UM2 of my observation of no paper towel applied to R43's contracture. UM2 made an immediate observation of R43 and confirmed although the Kardex was marked staff implemented the intervention to prevent the worsening of contracture to R43's left hand, the intervention did not occur. Queried UM2 as to where staff documents R43's refusal to apply the paper roll. UM2 stated there is no real place where staff would document R43's refusal other than not marking the task in the Kardex.

4) R69 was observed in bed with throughout the survey (07/20/21 at 2:30 PM; 07/21/21 at 08:29 AM and 10:50 AM; 07/22/21 at 9:28 AM and 07/23/21 at 8:15 AM). R69 did not respond attempts to verbally communicate with R69.

Conducted a record review of R69's Electronic Medical Record (EMR) on 07/22/21 at 1:07 PM). Throughout R69's care plan documented interventions for multiple goals were for staff to speak to R69 using simple sentences, ask R69 simple yes/no questions, talk to me (R69) and explain things to be done at all times, repeat when needed, and encourage me to express myself and address any of my concerns. However, the care plan also documented R69's primary language is Cantonese, cannot understand English, and is legally deaf. Review of R69's admission Minimum data Set (MDS) with an Assessment Reference Date (ARD) of 06/15/21 documented in Section B- Hearing, Speech, and Vision, B0200. Hearing- ability to

F 656

Will Identify Other Residents Having The Potential To Be Affected By The Same Deficient Practice By:
1) HN/SRN will identify other residents who are dependent on staff to turn and reposition them to prevent skin breakdown or pressure injury. DATE (8/23/2021)
2) HN, SRN will audit/spot check direct care staff□s documentation regarding turning and repositioning these residents and observe for compliance. Direct care staff should follow care plan and document right after task is done. Immediate feedback/correction will be provided as necessary. DATE08/23/2021 □ on going
Head Nurse (HN), Wound Education Nurse (WEN), Supervisor Nurse (SRN) Will Implement Measures To Ensure That This Practice Does Not Recur, Including
1) HN/LN will assess if residents need assistance in turning and repositioning. DATE(8/23/2021 ongoing)
2) HN/LN will develop care plan to turn and reposition resident. IDT will discuss/review and revise care plan on admission/readmission, quarterly, annually, significant change and as necessary. DATE 08/23/2021 □ on going
3) Direct care staff will follow care plan and document intervention/tasks when completed. DATE 08/23/2021 □ on going
4) WEN/HIM will re-educate staff to the importance of following care plan and accurately documenting tasks when completed. DATE 8/23/21 □ ongoing until appropriate staff receive education
5) LN, HN, and SRN will huddle with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 656

Continued From page 16

hear (with hearing aid or hearing appliances if normally used), R69 is highly impaired- absence of useful hearing and B0300. Hearing Aid documented a hearing aid is not used.

On 07/22/21 at 11:57 AM, conducted an interview with UM2 navigating R69's EMR. UM2 confirmed R69 is legally deaf and primary language is Cantonese, which the resident can read. Inquired with UM2 regarding how staff communicates with R69. UM2 stated staff has cards with pictures that staff use to communicate with R69. Requested for UM2 to show this surveyor the communication cards used. UM2 looked at R69's bedside, the nursing station, and asked passing staff where the communication cards were but was unable to locate the cards on the unit. UM2 confirmed staff is unable to verbally communicate with R69 due to being legally deaf and the care plan was not person-centered to R69's needs.

5) R28 was admitted on 09/03/11 with diagnoses that include non-traumatic brain dysfunction (Alzheimer's Disease), heart failure, hypertension, hypothyroidism, unspecified hearing loss, unspecified ear; atrial fibrillation, constipation, pruritus, cervicalgia, dysphagia.

On 07/22/21 11:48 AM, observed staff place resident lunch tray on the bedside table in front of R28. The resident was seated in a wheelchair in the doorway of R28's room. Observed resident the duration of lunch. R28 consumed 0% of lunch. Staff interacted minimally with resident and did not provide cueing or encouragement to drink Ensure Compact with meals.

Conducted a record review of R28's Electronic Medical Record (EMR). R28 care plan

F 656

staff whenever there is a new case of resident(s) requiring routine repositioning. DATE 08/23/2021 □ on going
Director of Nursing (DON), Head Nurse (HN), and Supervisor Nurse (SRN) Will Monitor Corrective Actions To Ensure The Effectiveness Of These Actions, Including:
1) HN, SRN will perform monthly review/surveillance on the proper repositioning and accurate documentation of the residents. DATE(9/3/2021 ongoing)
2) HN/SRN will submit monthly report of their findings to DON for review of any deficiencies. DATE(9/3/2021 ongoing)
3) DON will report as indicated to the QAPI committee quarterly meeting for further discussion and appropriate interventions. DATE(9/4/2021 next QAPI)

Director Of Nursing (DON), Occupational Therapist (OT), And Health Information Management (HIM) Will Implement Corrective Actions For R43 Affected By This Practice, Including:
1) According to R43□s care plan, paper towel should be placed every AM and PM for 2-3 hours_____(frequency) to his left hand to prevent worsening contractures. HN reviewed contracture care plan with staff and re-educated direct care staff on proper use and placement of the hand rolls and splints. DON and SRN stressed importance of staff following care plan. DON instructed staff if unable to place due to resident consistently refusing, staff should communicate to LN/HN and document in the EMR Point of Care task. LN/HN should refer to OT to reassess and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 656 Continued From page 17

documents that R28 is at risk for weight loss because of poor intake. Intervention includes staff to encouragement to drink Ensure Compact each mealtime.

On 07/22/21 at 2:39 PM conducted an interview with UM2 regarding R28's intake and my observation of the resident not having been cued to take in ensure and meals presented. UM2 states numbers of staff to assist with meals. We go to room and encourage her an tell her it's time for you lunch and if she doesn't like it we offer alternative. If she wants to eat it she will eat it. When meal has not been touched or eaten - we encourage her. if she really doesn't like it, we offer alternative. If she declines, we will give a snack (family, house). She is on supplements (milkshake three times a day between meals, ensure with meals). As well, UM2 confirmed meal nor Ensure Compact had not been consumed in part or whole and no staff present to cue.

6) R28 was admitted on 09/03/11 with diagnoses that include non-traumatic brain dysfunction (Alzheimer's Disease), heart failure, hypertension, hypothyroidism, unspecified hearing loss, unspecified ear; atrial fibrillation -unspecified; constipation, pruritus, cervicalgia, dysphagia.

On 07/20/21 at 10:33 AM, conducted an initial observation of R28 in bed with head of bed elevated approximated 90 degrees leaning towards the right side. Multiple subsequent observations (07/20/21 10:33 AM, 07/20/21 12:30, 07/20 01:48 PM, 07/20/21 03:26 PM) were made of R28 in the same position.

On 07/22/21 conducted a record review of R28 Electronic Medical Record (EMR) the care plan

F 656

provide alternative recommendation. DATE(8/14/2021)
2) DON interviewed staff assigned to resident on 7/20, 7/21 and 7/22 day shift. According to staff, resident might refuse or after paper towel is placed he would remove it. DATE(8/14/2021)
3) DON consulted with OT regarding resident□s need for paper towel roll, splint or brace. Placing splint or carrot were unsuccessful in the past. Paper towel roll is to be placed to extend fingers/ROM and for moisture. IDT met to discuss R43 and revised care plan to clean hands and observe for redness, moisture, and skin irritation. DATE(8/16/2021)
4) HIM created a custom task on PointClickCare to address new approach. WEN and HIM will educate direct care staff on how to properly document this task. DATE(8/16/2021)
Head Nurse (HN), License Nurse (LN), Occupational Therapist (OT), Health Information Management (HIM) and Direct Care Staff (CNA) Will Assess Other Residents Having The Potential To Be Affected By This Practice, Including:

1) HN/SRN will work with OT to identify other residents currently with positioning devices for contracture management. (8/23/2021)
2) Education Nurse/HIM will re-educate direct care staff on how to properly document placing and removing device and how to document resident□s refusal on EMR Point of Care task. DATE(8/23/2021 ongoing)
3) HN, SRN will audit/spot check direct

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 656	Continued From page 18 documented R28 is at risk for skin breakdown related to decreased mobility. The interventions include for staff to assist the resident turn and reposition every 2-3 hours when in bed or on wheelchair. On 07/22/21 at 2:39 PM, conducted an interview with UM2 regarding R28's repositioning needs. Shared observations with the UM2 of R28's remaining in the same position for multiple observations. UM2 confirmed R28 should be repositioned by staff every 2-3 hours while in bed or wheelchair. 7) R38 was admitted 05/28/21 with diagnoses including pressure induced deep tissue damage of right heel, age-related osteoporosis. Multiple observations (07/20/21 at 10:32 AM; 07/20/21 at 02:10 PM; and 07/21/21 at 08:33 AM) were made of R38's prevalon boots located at the foot of the bed and not applied to protect the resident's heels. Observed staff enter room, walk past R38 to assist the resident's roommate, and not stop to reapply R38's boots prior to exiting the room. Record review of R38's EMR on 07/21/21 at 09:05 AM, documented a Physician's Order, which started on 05/08/21, for Prevalon boot to bilateral foot every shift for Deep Tissue Injury (DTI) right heel. Conducted an interview with UM2 on 07/22/21 at 12:40 PM, regarding R38 not wearing Prevalon boot. UM2 verbalized although R38 kicks the boots off resident should be wearing the Prevalon boots as ordered and care planned.	F 656	care staff□s documentation regarding placing devices these residents and observe for compliance. Direct care staff should follow care plan and document right after task is done. Immediate feedback/discussion/correction will be provided as necessary. (8/24/2021 ongoing) Head Nurse (HN), Nursing Supervisor (SRN) and Occupational Therapist (OT)Will Implement Measures To Ensure That This Practice Does Not Recur, Including: 1) Residents with contracture or at risk for contractures, OT will be consulted for recommendations. Occupational Therapist to provide written instructions and education/return demo on proper placement of hand rolls and splints. OT to also initiate huddle(s) with the staff whenever there is a new case of resident(s) requiring hand rolls and/or splints. DATE(8/23/2021 ongoing) 2) Comprehensive care plan will be developed to include devices. IDT will discuss/review and update care plan on admission/readmission, quarterly, annually, with significant changes, and as needed. IDT will discuss/evaluate appropriateness and effectiveness of device and determine continuation or if alternative device should be used. (8/30/2021 ongoing) 3) Direct care staff will follow care plan and properly place device per instructions of OT.(8/23/2021 ongoing) 4) Reminders in eTAR for license nurse to check and acknowledge that hand rolls	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 656

Continued From page 19

8) R38 was admitted 05/28/21 with diagnoses of pressure induced deep tissue damage of right heel, age-related osteoporosis,

On 07/20/21 at 10:32 AM, 12:30 PM, 02:10 PM observed R38 laying supine (on back) position in bed.

On 07/21/21 at 09:05 AM, conducted a review of R38's EMR. The care plan documented that R38 is to be turned and repositioned every 2-3 hours for the prevention/worsening of DTI.

Conducted an interview with UM2 on 07/22/21 at 12:40 PM, regarding R38 not having been turned and repositioned every 2-3 hours. UM2 confirmed R38 should be turned and repositioned every 2-3 hours.

F 656

and splints are being placed/implemented properly.(8/30/2021 ongoing)

Head Nurse (HN), Nursing Supervisor (SRN) and Occupational Therapist (OT) Will Monitor Corrective Actions To Ensure The Effectiveness Of These Actions, Including:
1) Will perform monthly random review/surveillance on the proper use and placement of hand rolls and splints. HN/SRN/OT will submit monthly report of their findings to DON for review of any deficiencies and DON will report as indicated to the QAPI committee quarterly meeting for further discussion and appropriate interventions. DATE(9/3/2021 ongoing, 11/4/2021 next QAPI)

Responsible Staff Will Implement Corrective Actions For (Residents) Affected By This Practice, Including:
R69s primary language is Cantonese, cannot understand English, and is legally deaf. According to residents family, hearing aid doesnt help resident; no hearing aid used for the last two years.
1) Cantonese OT staff wrote to her in Cantonese and translated questions from SW and other staff members. Resident could read but could not answer most of the questions. Amplifier was attempted but did not help. Resident was admitted 6/9/2021. Since late June, SW and Cantonese OT staff were reviewing old communication cards to improve by utilizing clip art/pictures, expanding words

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	125009	A. BUILDING ______ B. WING ______	07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

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F 656	Continued From page 20	F 656	and categories with IDT□s input. It was decided that a communication board by categories would be easier for staff and resident to use. The Communication board will contain pictures with English words and Chinese characters written. Commands ie sit up or stand, items in bedroom, body parts, parts of face, clothes, exercises, direction (ie up/down, left/right, entertainment/activities, equipment (i.e. walker, wheelchair, families son/daughter, feelings happy, sad, pain. Common food items, greetings, grooming/hygiene, medical doctor/nurse, medicine, weight temperature, personal items eye glasses, hearing aid, cell phone). SW trialed communication board with another resident that speaks English and Cantonese for input. Resident stated it was good and that she can see the Chinese characters well. Communication board will be used to facilitate communication with this resident. DATE(7/26-8/12/2021) 2) Social Worker (SW) revised care plan to face directly to me using simple sentences/questions when possible through hand/facial gestures and pictures, and writing to me. I can understand gestures and able to understand Cantonese by reading and writing. DATE(8/9/2021) 3) Interdisciplinary Team (IDT) reviewed and revised R69□s communication care plan to include goal that needs will be met effectively. DATE(08/16/2021) Head Nurse (HN), Licensed Nurse (LN), Supervisor Nurse (SRN), Social Worker (SW), and Interdisciplinary Team (IDT)	

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F 656	Continued From page 21	F 656	Will Assess Other Residents Having The Potential To Be Affected By This Practice, Including: 1) Will identify other residents who are non-English speaking and/or legally deaf. DATE(8/23/2021) 2) Will audit care plan if appropriate and effective in communicating for these residents. If ineffective or inappropriate, Interdisciplinary Team (IDT) reviewed and revised care plan. DATE(8/24/2021 ongoing) Head Nurse (HN), Licensed Nurse (LN), Social Worker (SW), and Interdisciplinary Team (IDT) Will Implement Measures To Ensure That This Practice Does Not Recur, Including: 1) HN/LN/SW/IDT will assess if resident□s communication strength and needs upon admission/readmission, quarterly, annually and as needed, and develop/revise care plan that is appropriate and effective. DATE(8/23/2021 ongoing) 2) Staff will follow care plan to effectively communicate with residents. DATE(8/23/2021 ongoing) 3) SW will finalize the Cantonese communication board/cards and make available for use.. DATE(9/3/2021) 4) Human Resources updated staff language bank listing staff members able to speak other languages. DATE(07/28/2021) Director of Nursing (DON), Head Nurse (HN), Nursing Supervisor (SRN), Social Worker (SW), and Interdisciplinary Team (IDT)Will Monitor Corrective Actions To Ensure The Effectiveness Of These	

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F 656	Continued From page 22	F 656	Actions, Including: 1) HN, SRN, and SW will perform monthly random review/surveillance on the residents including their care plan to ensure communication with non-English speaking residents and residents who are legally deaf are able to effectively communicate with the staff, either through use of translation cards, communication boards. Language bank interpreter (staff), and/or language interpreter hotline, as appropriate. DATE(9/3/2021 ongoing) 2) HN, SRN, SW will submit monthly report of their findings to DON for review of any deficiencies. DATE(9/3/2021 ongoing) 3) DON will report as indicated to the QAPI committee quarterly meeting for further discussion and appropriate interventions. DATE(11/4/2021 next QAPI) 4) These findings will also be shared with SW, RAI and other IDT members to review and update/revise care plan with appropriate interventions. DATE(9/3/2021 ongoing) Head Nurse, Social Worker, and IDT will implement corrective actions for (R28) affected by This Practice, Including: Head Nurse reviewed resident's record with poor PO intake/refusing meals. 8/11/21 RN, Social Worker and IDT reviewed and revised R28s Care plan to "encourage me to eat my meals, if I don't like the food please offer me options, if I decline,	

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F 656	Continued From page 23	F 656	provide me snacks from my son". 8/16/21 Head Nurse, Nurse Supervisor (SRN) will Assess Other residents Having the Potential to Be Affected by this Practice, Including: Head Nurse/SRN will identify residents with poor PO intake. 8/23/21 Head Nurse/SRN to remind direct care staff to follow care plan in encouraging, cueing and assisting resident to eat/drink supplements. 8/23/21 - ongoing Head Nurse, SRN, Registered Dietitian and IDT will Implement measures to Ensure this Practice does not Recur, including: Upon admission/readmission, quarterly, annually, with significant change, or with weight loss, Head Nurse and IDT to review and revise Care Plan. 8/23/21 - ongoing Head Nurse/Licensed Nurse/SRN will consult with dietitian for residents with weight loss regarding meal preferences and recommendations. 8/23/21 - ongoing Head Nurse/SRN, Licensed staff huddle with direct care staff to encourage, cue, and assist residents with weight loss to eat and drink. 8/23/21 - ongoing Head Nurse/SRN/DON will Monitor Corrective Actions to ensure the	

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F 656	Continued From page 24	F 656	Effectiveness of these Actions, Including: Head Nurse, SRN, DON will monitor during meal times to ensure staff is encouraging, cueing, and assisting residents with meal intake. Monthly findings will be discussed at the Nurse Manager's meeting. 8/23/21 - ongoing Director of Nursing (DON), Nursing Supervisor (SRN), Physical Therapist (PT), Head Nurse (HN) and Interdisciplinary Team (IDT) Will Implement Corrective Actions For (R28) Affected By This Practice, Including: 1) HN reassess R28□s need for repositioning by staff. HN re-educated direct care staff regarding cuing and assisting proper repositioning of the resident using pillows, etc. (8/11/2021) 2) DON and SRN reviewed with unit staff importance of following interventions on resident□s care plan. (7/23/2021 ongoing) 3) DON and PT checked resident□s repositioning. Resident was lying her on back and properly positioned. (8/16/2021) 4) Interdisciplinary Team (IDT) reviewed and updated R28□s care plan on risk for skin breakdown due to decrease in mobility. Confounding Problem is resident□s strong preference for position of comfort.(8/16/2021) Head Nurse (HN), Wound Education Nurse (WEN), Supervisor Nurse (SRN) and Direct Care Staff (CNA) Will Assess Other Residents Having The Potential To Be Affected By This Practice, Including 1) HN/SRN will identify other residents	

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MALUHIA	**1027 HALA DRIVE HONOLULU, HI 96817**

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F 656	Continued From page 25	F 656	who are dependent on staff to turn and reposition them to prevent skin breakdown or pressure injury. (8/23/2021) 2) HN, SRN will audit/spot check direct care staff□s documentation regarding turning and repositioning these residents and observe for compliance.(8/23/2021 ongoing) 3) Direct care staff should follow care plan and document right after task is done.(8/23/2021 ongoing) Head Nurse (HN), Wound Education Nurse (WEN), Nursing Supervisor (SRN), License Nurse (RN), and Direct Care Staff (CNA) Will Implement Measures To Ensure That This Practice Does Not Recur, Including: 1) HN/LN will assess if residents need assistance in turning and repositioning upon admission/readmission, quarterly, annually, with significant change or as needed. 8/23/21 - ongoing 2) HN/LN will develop care plan to turn and reposition resident. IDT will discuss/review and revise care plan on admission/readmission, quarterly, annually, significant change and as necessary. DATE 08/23/2021 □ on going 3) Direct care staff will follow care plan and document intervention/tasks when completed.(8/23/2021 ongoing) 4) WEN will re-educate staff to The importance of following care plan and accurately documenting tasks when completed. DATE 8/23/21 - ongoing until appropriate staff receive education 5) LN, HN, and SRN will huddle with the staff whenever there is a new case of resident(s) requiring routine repositioning	

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F 656	Continued From page 26	F 656	or to discuss challenges in following/complying to care plan. 8/23/21 - ongoing Director of Nursing (DON), Head Nurse (HN), and Nursing Supervisor (SRN), Will Monitor Corrective Actions To Ensure The Effectiveness Of These Actions, Including: 1) HN, SRN will perform monthly review/surveillance on the proper repositioning and accurate documentation of the residents(9/3/2021 ongoing) 2) HN/SRN will submit monthly report of their findings to DON for review of any deficiencies.(9/3/2021 ongoing) 3) DON will report as indicated to the QAPI committee quarterly meeting for further discussion and appropriate interventions.(11/4/2021 next QAPI) Director of Nursing (DON), Nursing Supervisor (SRN), Physical Therapist (PT), Head Nurse (HN) and Interdisciplinary Team (IDT) Will Implement Corrective Actions For (R38) Affected By This Practice, Including: 1) HN reassess R38s need for repositioning by staff. HN re-educated direct care staff regarding proper repositioning of the resident using pillows, etc. DATE(8/11/2021) 2) DON and SRN reviewed with unit staff importance of following interventions on resident□s care plan. DATE(7/23/2021 ongoing) 3) DON and PT checked resident□s repositioning. Resident is low air loss mattress and properly positioned. DATE(8/16/2021) 4) Interdisciplinary Team (IDT) reviewed	

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F 656	Continued From page 27	F 656	and updated R38s care plan to address prevention of skin/pressure injury. DATE(8/16/2021) Head Nurse (HN), Supervisor Nurse (SRN) and Direct Care Staff (CNA) Will Assess Other Residents Having The Potential To Be Affected By This Practice, Including 1) HN/SRN will identify other residents who are dependent on staff to turn and reposition them to prevent skin breakdown or pressure injury. DATE(8/23/2021) 2) HN, SRN will audit/spot check direct care staffs documentation regarding turning and repositioning these residents and observe for compliance. DATE(8/23/2021 ongoing) 3) Direct care staff should follow care plan and document right after task is done. DATE(8/23/2021 ongoing) Head Nurse (HN), Wound Education Nurse (WEN), Nursing Supervisor (SRN), License Nurse (RN), and Direct Care Staff (CNA) Will Implement Measures To Ensure That This Practice Does Not Recur, Including: 1) HN/LN will assess if residents need assistance in turning and repositioning. DATE(8/23/2021 ongoing) 2) HN/LN will develop care plan to turn and reposition resident. IDT will discuss/review and revise care plan on admission/readmission, quarterly, annually, significant change, and as necessary. DATE(8/23/2021 ongoing) 3) Direct care staff will follow care plan and document intervention/tasks when completed.(8/23/2021 ongoing)	

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MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

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F 656	Continued From page 28	F 656	4) WEN/HIM will re-educate staff to the importance of following care plan and accurately documenting tasks when completed. DATE(8/23/2021 ongoing) 5) LN, HN, and SRN will huddle with the staff whenever there is a new case of resident(s) requiring routine repositioning. DATE(8/23/2021 ongoing) Director of Nursing (DON), Head Nurse (HN), and Nursing Supervisor (SRN), Will Monitor Corrective Actions To Ensure The Effectiveness Of These Actions, Including: 1) HN, SRN will perform monthly review/surveillance on the proper repositioning and accurate documentation of the residents DATE(9/3/2021 ongoing) 2) HN/SRN will submit monthly report of their findings to DON for review of any deficiencies. DATE(9/3/2021 ongoing) 3) DON will report as indicated to the QAPI committee quarterly meeting for further discussion and appropriate interventions. DATE(11/4/2021 next QAPI) Head Nurse (HN), Education/Wound Nurse (WEN) Will Implement Corrective Action For R38 Affected By The Deficient Practice By: 1) R38 has pressure induced deep tissue damage of her right heel. Prevalon boot should be placed on the right foot to off-load pressure to her right heel. Based on multiple observations, the Prevalon boot was not applied to protect the resident□s heel. 2) HN re-educated direct care staff regarding proper use and placement of the Prevalon boots. Since resident has	

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MALUHIA	**1027 HALA DRIVE HONOLULU, HI 96817**

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F 656	Continued From page 29	F 656	tendency to kick off the boot and not protecting her heel, HN/WEN reassessed the resident□s Prevalon boots use if no longer appropriate. WEN ordered another positioning device (foot/heel elevator) to trial if it is more appropriate than the Prevalon boots. Prevalon boot will be placed until alternate off-loading positioning device is available. DATE(8/11/2021) Head Nurse (HN) And Education/Wound Nurse (WEN) Will Identify Other Residents Having The Potential To Be Affected By The Same Deficient Practice By: 1) HN and WEN will identify residents with orders or care plan instructing use of Prevalon boots. DATE(8/19/2021) 2) WEN will evaluate for appropriateness and effectiveness of the device. DATE(8/30/2021) Head Nurse (HN), Licensed Nurse (LN), Education/Wound Nurse (WEN), and Supervisor Nurse (SRN) will implement Measures To Ensure That This Practice Does Not Recur, Including: 1) HN/LN will consult with WEN on residents with possible need for positioning devices. If a positioning device is needed, HN/SRN/WEN to initiate huddle(s) with the staff whenever there is a new case of resident(s) requiring positioning device and provide education on proper use of positioning device. DATE(8/23/2021 ongoing) 2) HN/LN/SRN will huddle with direct care staff to elicit feedback regarding positioning device. As in this situation,	

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F 656	Continued From page 30	F 656	staff knew that resident was kicking off the device and a more resident-appropriate/acceptable device should have been obtained. HN/LN/SRN to consult WEN if re-evaluation of the positioning device is needed. DATE(8/30/2021 ongoing) 3) Reminders in electronic Treatment Administration Record (eTAR) for LN to check and acknowledge that Prevalon boots are being placed/implemented properly. DATE(8/6/2021) Will Monitor Corrective Actions To Ensure The Effectiveness Of These Actions, Including: 1) HN/WEN will perform monthly review/surveillance (during Wound Rounds) on the proper use and placement of positioning device. Any issues with the use of these devices will be discussed and if needed other positioning devices will be considered. DATE(9/3/2021 ongoing) 2) HN and WEN will submit monthly report/surveillance of their findings to DON for review of any deficiencies and DON/SRN will report as indicated to the QAPI committee quarterly meeting for further discussion and appropriate interventions. DATE(9/3/2021 ongoing, 11/4/2021 next QAPI)	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include,	F 758		9/6/21

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F 758	Continued From page 31	F 758		

but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic

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MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

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F 758	Continued From page 32 drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview with staff members, the facility failed to ensure one Resident (R) 50 of five residents selected for unnecessary medication review received consistent behavioral monitoring and a person-centered care plan to include non-pharmacological interventions. The inaccurate documentation of behavior monitoring and lack of documentation in the behavior flow sheet has the potential to result in unnecessary use of medications to address behavior (determining efficacy of medication, need for gradual dose reduction, need for care plan revision). The lack of documentation of non-pharmacological interventions has the potential to result in possible unnecessary continued use psychotropic medications and a decrease in R50's ability to maintain the resident's highest practicable psycho-social well-being. Findings include: Cross Reference to F842 and F656. Resident (R)50's medical record was incomplete, missing entries of behavior monitoring. And the facility did not assure non-pharmacological interventions were documented in R50's care plan to address related behaviors. R50 was admitted to the facility on 05/10/20 and is diagnosed with unspecified dementia without behavioral disturbance.	F 758	Director of Nursing (DON), Nursing Supervisors (SRN), Head Nurses (HN) and Social Workers (SW) Will Implement Corrective Actions For R50 Affected By This Practice, Including: 1) DON reviewed R50s chart and confirmed she is prescribed lorazepam 0.5mg at bedtime for anxiety, agitation, restlessness, biting linen/clothes/diaper, Seroquel 6.25mg two times a day for dementia with behavior, and paxil 10mg once a day for agitation and diagnosis of mild dementia. R50s behavior was not consistently monitored since her behavior monitoring log was not completed for five days on day shift from 7/16/21-7/20/21. R50s care plan did not have non-pharmacologic interventions. DATE(7/26/2020) 2) DON reminded involved nurses (HN, LN, SRN) to complete documentation in the Behavior/Intervention Monthly Flow Chart at the end of each shift. Currently the Behavior/Intervention Monthly Flow Chart log is not part of our EMR and is a paper document that is filed in a binder on each unit. To ensure that this document is completed every shift, HIM is assisting Nursing in incorporating the Behavior/Intervention Flow Chart log into PCC. DATE(7/26-8/6/2021) 3) HN reviewed R50s care plan and revised to include non-pharmacological	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125009	A. BUILDING ______ B. WING ______	07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

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F 758

Continued From page 33

On 07/20/21 during initial screening of residents, R50 was observed in her room, lying in her bed biting the edge of her bed sheet. R50 would bite down on the sheet and with clenched teeth pull the sheet out. Unit Manager (UM)1 entered the room to discontinue the resident's enteral feeding. R50 asked UM1 for a glove. During the disconnection, R50 placed fingers in her mouth and would tug and touch UM1's gloves. UM1 asked R50 if she wanted something to eat, pink ice cream? R50 responded affirmatively.

On the afternoon of 07/22/21, R50 was observed laying in bed with music playing and toward the end the 12:00 PM enteral feeding. R50 was biting down on her sheet, and pulling the sheet out from her clenched teeth. R50 engaged in conversation regarding her family. While speaking, R50 would stop biting the sheet.

Record review was done on 07/21/21 at 02:48 PM and at 03:03 PM. Review of the physician's order found R50 is prescribed with lorazepam 0.5 mg. (start date 05/03/21) at bedtime for anxiety, agitation, restlessness, biting linen/clothes/diaper; seroquel 6.25 mg (start date 02/23/21) two times a day for dementia with behavior; and paxil 10 mg (start date 08/15/20) once a day for agitation and diagnosis of mild dementia.

Record review done on 07/22/21 at 12:03 PM found R50's Behavior/Intervention Monthly Flow Chart log for July 2021. The identified behaviors related to the use of lorazepam and paxil included biting linen and clothes, ripping underpad/bed sheet, talking to self/counting out loud and restlessness/fidgeting. There was no documentation of the number of behaviors

F 758

interventions to address behaviors related to the use of psychotropic medications. (7/22/2021, 8/17/2021)
Director of Nursing (DON), Nursing Supervisor (SRN), Head Nurses (HN) and Social Services (SW) Will Assess Other Residents Having The Potential To Be Affected By This Practice, Including:
1) All residents who are receiving psychotropic medication will be identified. DATE(8/18/2021)
2) HN and SW will review care plans for residents receiving psychotropic medication and ensure that person-centered non-pharmacological interventions are included. DATE(9/3/2021)
3) Resident□s behaviors will be inputted in PCC eMAR. For each specific behavior the following will be documented: a) Number of behavior episodes; b) Intervention codes. The option to select other to note person-centered, non-pharmacologic interventions for each specific behavior has been included; c) Outcomes (improved, no change or worsen) will be recorded for each interventions; and d) Was behavior observed. DATE(8/30/2021 ongoing)
Head Nurses (HN), Will Implement Measures To Ensure That This Practice Does Not Recur, Including
1) Upon admission/readmission, quarterly, annually, with significant changes, or as needed when resident is placed on psychotropic medications, HN and SW to review or revise care plan to ensure each behavior has person-centered non-pharmacological

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125009	A. BUILDING ______ B. WING ______	07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALUHIA	**1027 HALA DRIVE HONOLULU, HI 96817**

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F 758 Continued From page 34

exhibited and initials by the day shift from 07/16/21 through 07/20/21. Interview and concurrent review of the documents was done with UM1 on 07/22/21 at 12:11 PM. UM1 confirmed the missing documentation by the day shift for 07/16/21 through 07/20/21. Further review of the flow chart found no documentation of the behavior observed by surveyors on the morning of 07/20/21 with UM1. Review of the progress notes, found no documentation of R50 biting the sheet as observed on 07/20/21 with staff member.

R50's care plan included identified problem of R50's fixed ideas of a "conspiracy theory". Interventions included utilizing a "Buddy System". Further review of the care plan found no documentation of non-pharmacological interventions to address R50's behaviors related to the use of psychotropic mediations.. On 07/22/21 Day Nurse Supervisor (NS)3 provided a copy of the Behavior/Intervention Monthly Flow Chart and reported the intervention codes listed on the flow chart are the interventions to address the behaviors. These interventions (assess for pain, redirect, give food, etc.) are standardized and not person-centered or unique to R50. The NS3 also reported she consulted with the Social Worker (SW) and confirmed the interventions are not documented in the care plan.

Interview was done with NS3 and SW on 07/22/21 at 03:00 PM in the hall outside of the SW office. The staff members reported usually food is helpful to distract R50. SW further reported aromatherapy (lavender) is calming for R50 as well as oldies music. SW reported R50's aroma diffuser became moldy and has been discontinued. The staff members also stated R50

F 758

interventions. DATE(8/30/2021 ongoing)
2) Each behaviors will be inputted in PCC eMAR under order category Other and order type Monitor. For each specific behavior the following will be documented: a) Number of behavior episodes; b) Intervention codes. The option to select other to note person-centered, non-pharmacologic interventions for each specific behavior has been included; c) Outcomes (improved, no change or worsen) will be recorded for each interventions; and d) Was behavior observed. DATE(8/30/2021 ongoing)
3) Education Nurse/HIM will educate LNs on completing and documenting on the new electronic Behavior/Intervention Monitoring form. DATE(8/23/2021 ongoing)
LNs will complete this Behavior/Intervention Monitoring form for each behavior by the end of their shift. DATE(8/30/2021 ongoing)
4) HN/SRN/TA will run an audit prior to the end of each shift and contact any LN to inform that Behavior/Intervention Monitoring form in PCC needs to be completed before leaving. DATE(8/30/2021 ongoing)
(Responsible Staff) Will Monitor Corrective Actions To Ensure The Effectiveness Of These Actions, Including:
1) Night Shift LNs will conduct a nightly audit report to make sure all items under Monitor tab are signed and completed. DATE(8/30/2021 ongoing)
2) HN/SRN will provide a summary of daily audits which will be submitted weekly to the DON. Based on compliance rate,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125009	A. BUILDING ______ B. WING ______	07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

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F 758	Continued From page 35 also responds to one-to-one interactions and does video chat with her son. Inquired whether triggers for behavior were identified, staff member responded there are days when R50 does not display any behaviors. Overall, staff reports there has been a decrease in behavior in response to pharmacological interventions. Staff members acknowledged the non-pharmacological interventions are not documented in R50's which include person-centered interventions.	F 758	audit schedule will be revised. Results will discussed at the monthly Nurse Managers meeting. A summary of findings will be submitted to QAPI committee quarterly meeting for further discussion and recommendations. DATE(9/6/2021 ongoing, 11/4/2021 next QAPI) 3) HN, SRN, SW will perform monthly reviews of care plans for residents receiving psychotropic care plan that person-centered non-pharmacological interventions are documented and implemented. HN/SRN will submit monthly report of their findings to DON for review of any deficiencies and DON will report as indicated to the QAPI committee quarterly meeting for further discussion and appropriate interventions. DATE(9/6/2021 ongoing, 11/4/2021 next QAPI)	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		9/6/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125009	A. BUILDING ______ B. WING ______	07/23/2021

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F 812	Continued From page 36 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the storage of food in a safe and sanitary manner. Food items in the refrigerator were kept past the "use by date" and scoopers were left in dry good boxes/container. The deficient practice has the potential to create a risk of food borne illness. Findings Include: During the initial observation of the kitchen with the food service manager (FSM) on 07/20/21 at 09:22 AM, in a walk-in refrigerator observed a bottle of chocolate sauce dated 6/30/21 and a tub of Sunglow butter dated 07/15/21. There were approximately more than half the contents remaining for the chocolate sauce and butter. At 09:32 AM, on a table with various dry good items, observed a scooper in three (3) separate dry good items: box of powdered mash potatoes, container of Propass Protein powder, and a plastic container of thickener powder. During the initial observation of the kitchen, the FSM was queried about the facility's system of dating food items located in a walk-in refrigerator, when items should be discarded, and observations of scoopers in dry goods items. FSM stated food in the walk-in refrigerators are labeled with the date the item is opened and should be discarded three (3) days after opening. FSM acknowledged the bottle of chocolate sauce and tub of Sunglow butter were past three (3)	F 812	Dietary Manager, Cooks And Cook TAs Will Implement Corrective Action For These Practices Including: 1) All expired items were discarded immediately. DATE: 07/23/21 Dietary Manager, Cooks, Cook TAs and Helpers Will Assess Other Residents Having The Potential To Be Affected By This Practice, Including: 1) All walk-in and reach-in refrigerators will be inspected daily to ensure that all items are labeled appropriately and any expired items are discarded immediately. DATE: 07/23/21 Dietary Manager, Dietitians, Education RN, Cooks And Cook TAs Will Implement Measures To Ensure That This Practice Does Not Recur, Including: 1) All Dietary staff will review the policy on food storage and expirations. Completed: 08/17/21 2) Double check labels daily for appropriate open and use by dates. All expired items will be discarded immediately. 07/23/21 – On-going 3) Education nurse and kitchen manager will conduct an in-service with staff to ensure understanding of facility and DOH regulations pertaining to proper labeling and monitoring of expiring foods. Completed: 08/17/21 Dietary Manager, Dietitians And Administration Will Monitor Corrective	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

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F 812	Continued From page 37 days after opening and confirmed the items should have been discarded. FSM then removed the items from the walk-in refrigerator. FSM also confirmed the scoopers observed in the dry good items should not have been left inside the box/container to minimize contamination and potential bacterial growth.	F 812	Actions To Ensure The Effectiveness Of These Actions, Including: 1) Environment of Care Rounds Kitchen master template will be used to Monitor and audit that the above procedural changes are being carried out consistently. Start 08/23/21 On-going 2) Quarterly audit reports will be submitted to the QAPI Committee starting 11/04/21. Dietary Manager, Dietitians, Cooks And Cook TAs Will Implement Corrective Action For These Practices Including: 1) All dry good items were immediately checked to ensure that no scoopers were left in containers. DATE: 07/23/21 Dietary Manager, Cooks, Cook TAs and Helpers Will Assess Other Residents Having The Potential To Be Affected By This Practice, Including: 1) During all three meals, the cooks or cook TAs will check all dry good containers to ensure that no scoopers are left in containers. Start 07/23/21 On-going Dietary Manager, Dietitians, Education RN, Cooks and Cook TAs Will Implement Measures To Ensure That This Practice Does Not Recur, Including: 1) Education nurse and dietary manager will conduct an in-service with staff to ensure understanding of facility and DOH regulations pertaining to best practices for infection control and food safety. Completed 08/17/21 Dietary Manager, Dietitians And Administration Will Monitor Corrective Actions To Ensure The Effectiveness Of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125009	A. BUILDING ______ B. WING ______	07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

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F 812	Continued From page 38	F 812	These Actions, Including 1) Environment of Care Rounds Kitchen master template will be used to monitor and audit that the above procedural changes are being carried out consistently. Start 08/23/21 On-going 2) Quarterly audit reports will be submitted to the QAPI Committee for review 11/04/21	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;	F 842		9/6/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125009	A. BUILDING ______ B. WING ______	07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

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F 842	Continued From page 39	F 842		

(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125009	A. BUILDING ______ B. WING ______	07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

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F 842 Continued From page 40

Based on record review and interview with staff member, the facility failed to ensure residents' records reviewed were accurate and complete for 3 of 21 residents sampled (Resident (R)50, R43, and R28). R50's behavior monitoring log was not completed for a period of five days during the day shift. Also, the observed behavior was not documented in R50's record. The deficient practice has the potential for continued unnecessary use of psychotropic medication for the residents. R43's Kardex documented staff applied towel rolls to prevent the worsening of the resident's left hand contracture, but was not implemented. R43 is at risk for worsening of contracture to the resident's left hand. Staff documented R28 ate 26%-50% of lunch, despite observation of the resident eating 0% of lunch. As a result of this deficiency, residents are at risk of potential negative physical and psychosocial outcomes.

Findings include:

1) Record review done on 07/22/21 at 12:03 PM found R50's Behavior/Intervention Monthly Flow Chart log for July 2021. The identified behaviors related to the use of Lorazepam and Paxil included biting linen and clothes, ripping underpad/bed sheet, talking to self/counting out loud and restlessness/fidgeting. There was no documentation of the number of behaviors exhibited and initials by the day shift from 07/16/21 through 07/20/21. Interview and concurrent review of the documents was done with Unit Manager (UM)1 on 07/22/21 at 12:11 PM. UM1 confirmed the missing documentation by the day shift for 07/16/21 through 07/20/21.

The behavior observed on the morning of

F 842

Head Nurse (HN), Nursing Supervisor (SRN) Will Implement Corrective Action For R50 Affected By The Deficient Practice By:

1) Behavior/Intervention Monthly Flow Chart log is currently not part of our EMR and is filed in a binder on each unit. This behavior monitoring log was not completed for five days on day shift. LN/HN/SRN did not document behavior and interventions from 7/16/21-7/20/21 for day shift. DON reminded involved nurses to complete documentation in the Behavior/Intervention Monthly Flow Chart at the end of each shift. To ensure that this document is completed every shift, HIM is assisting Nursing in incorporating the Behavior/Intervention Flow Chart log into Point Click Care (PCC). DATE(7/26-8/6/2021)

Head Nurse (HN), Nursing Supervisor (SRN) Will Identify Other Residents Having The Potential To Be Affected By The Same Deficient Practice By:

1) All residents who are currently being monitor for behavior will be identified. DATE(8/18/2021)

2) Resident's behaviors will be inputted in PCC eMAR. For each specific behavior the following will be documented: a) Number of behavior episodes; b) Intervention codes. The option to select other to note person-centered, non-pharmacologic interventions for each specific behavior has been included; c) Outcomes (improved, no change or worsen) will be recorded for each interventions; and d) Was behavior

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125009	A. BUILDING ______ B. WING ______	07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 842

Continued From page 41

07/20/21 was not documented by staff member. During the discontinuation of enteral feeding by Unit Manager (UM)1, R50 was biting her sheet and this was not documented in the flow chart or progress note.

On 07/22/21 at 03:00 PM, Day Nursing Supervisor provided a copy of the July 2021 Behavior/Intervention Monthly Flow Chart. Review found that the missing entries were now completed.

2) Cross Reference to F656 Development/Implementation of Care Plan

R43 has impairment to both upper and lower extremities and has a contracture to the left hand. On 07/20/21 at 10:45 AM, observed R43 lying in bed with observable contracture to the resident's left hand and no brace, splint, or towel roll applied. R43 did not have a brace, splint, or towel roll applied to the left hand for contractures during multiple observations (7/20/21 at 12:00 PM and 1:57 PM; 7/21/21 at 08:27 AM and 10:49 AM; and 07/22/21 at 09:30 AM).

On 07/22/21 at 11:52 AM, conducted an interview with UM2 regarding R43's left hand contracture. UM2 stated R43 should have a towel roll placed in the resident's left hand to prevent further contracture. UM2 reviewed R43's Kardex in the EMR and stated according to the Kardex, the task of applying the towel roll to R43's left hand from 9:00 AM to 12:00 PM, was marked completed on 07/20/21, 07/21/21, and 07/22/21. Informed UM2 of surveyors observation of no towel roll applied to R43's contracture. UM2 made an immediate observation of R43 and confirmed although the Kardex was marked staff implemented the

F 842

observed. DATE(8/30/2021 ongoing)

Head Nurse (HN), Licensed Nurse (LN), And Supervisor Nurse (SRN) Will Implement Measures To Ensure That This Practice Does Not Recur, Including:
1) Each behaviors will be inputted in PCC eMAR under order category Other and order type Monitor. For each specific behavior the following will be documented: a) Number of behavior episodes; b) Intervention codes. The option to select other to note person-centered, non-pharmacologic interventions for each specific behavior has been included; c) Outcomes (improved, no change or worsen) will be recorded for each interventions; and d) Was behavior observed. DATE(8/30/2021 ongoing)
2) Education Nurse/HIM will educate LNs on completing and documenting on the new electronic Behavior/Intervention Monitoring form. DATE(8/23/2021 ongoing)
3) LNs will complete this Behavior/Intervention Monitoring form for each behavior by the end of their shift. DATE(8/30/2021 ongoing)
4) HN/SRN/TA will run an audit prior to the end of each shift and contact any LN to inform that Behavior/Intervention Monitoring form in PCC needs to be completed before leaving. DATE(8/30/2021 ongoing)

Head Nurse (HN), Nursing Supervisor (SRN) and License Nurse (LN) Will Monitor Corrective Actions To Ensure The Effectiveness Of These Actions, Including:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125009	A. BUILDING ______ B. WING ______	07/23/2021

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F 842

Continued From page 42

intervention to prevent the worsening of contracture to R43's left hand, the intervention did not occur. Queried UM2 as to where staff documents R43's refusal to apply the towel roll. UM2 stated there is no real place where staff would document R43's refusal other than not marking the task in the Kardex.

Review of R43's care plan on 07/22/21 at 01:05 PM, documented R43 has a left-hand contracture and staff should encourage R43 to use a thin towel roll to his left hand for contracture management two to three hours, every AM and PM shift as tolerated.

3) Cross Reference to F656 Develop and Implement Care Plan

R28's care plan documented the resident is at risk of weight loss due to poor intake. On 07/22/21 at 11:48 AM, this surveyor observed R28 did not eat any of the lunch provided to the resident. However, staff documented R28 ate 26% to 50% of lunch.

F 842

1) Night Shift LNs will conduct a nightly audit report to make sure all items under “Monitor” tab are signed and completed. DATE(8/30/2021 ongoing)
2) HN/SRN will provide a summary of daily audits which will be submitted weekly to the DON. Based on compliance rate, audit schedule will be revised. Results will discussed at the monthly Nurse Managers meeting. A summary of findings will be submitted to QAPI on a quarterly basis for further discussion and recommendations. DATE(9/6/2021 ongoing, 11/4/2021 next QAPI)

Director Of Nursing (DON), Occupational Therapist (OT), And Health Information Management (HIM) Will Implement Corrective Actions For R43 Affected By This Practice, Including:
1) According to R43’s care plan, paper towel should be placed every AM and PM for 2-3 hours_____(frequency) to his left hand to prevent worsening contractures. HN reviewed contracture care plan with staff and re-educated direct care staff on proper use and placement of the hand rolls and splints. DON and SRN stressed importance of staff following care plan. DON instructed staff if unable to place due to resident consistently refusing, staff should communicate to LN/HN and document in the EMR Point of Care task. LN/HN should refer to OT to reassess and provide alternative recommendation. (8/14/2021)
DON interviewed staff assigned to

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	125009	A. BUILDING ______ B. WING ______	07/23/2021

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F 842	Continued From page 43	F 842	resident on 7/20, 7/21 and 7/22 day shift. CNAs stated they had placed the paper towel on those days. According to staff, resident might refuse or after paper towel is placed he would remove it. CNAs should communicate that resident has tendency to remove paper towel after applied so intervention can be evaluated. (8/14/2021) DON reviewed POC tasks which included handroll applied/removed and Left Thin Towel Roll under Splint task. Task should have been placed under handroll task and not splint to avoid duplication and confusion. In addition, when CNAs documented by selecting only applied which did not show removal times. (8/16/2021) HIM reviewed with HN including IDT how to create new and custom tasks and reminder to look at task description to avoid duplication. When entering information for the specific task the approaches should be clear and concise. (8/18/2021) 2) DON consulted with OT regarding resident’s need for paper towel roll, splint or brace. Placing splint or carrot were unsuccessful in the past. Paper towel roll is to be placed to extend fingers/ROM and for moisture. IDT met to discuss R43 and revised care plan to “clean hands and observe for redness, moisture, and skin irritation.” (8/16/2021) 3) HIM created a custom task on PointClickCare to address new approach. WEN and HIM will educate direct care staff on how to properly document this	

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F 842	Continued From page 44	F 842		

task. (8/16/2021)
Head Nurse (HN), License Nurse (LN), Occupational Therapist (OT), Health Information Management (HIM) and Direct Care Staff (CNA) Will Assess Other Residents Having The Potential To Be Affected By This Practice, Including:

HN/SRN will work with OT to identify other residents currently with positioning devices for contracture management. (8/23/2021)
HN/SRN/DON will review all residents with tasks related to contracture devices. Based on findings recommendations will be made to ensure approaches are clear and concise.(8/30/2021 ongoing)

Education Nurse/HIM will re-educate direct care staff on how to: a) properly document placing and removing device and how to document resident's refusal on EMR Point of Care task; and b) for documentation accuracy, staff will be reminded to document completion of task in a timely manner. Due to the current pandemic for infection control precautions staff are not carrying iPads. Therefore, they will need to use the option in POC to document actual times completed.. (8/23/2021 ongoing)
1) HN, SRN will audit/spot check direct care staff's documentation regarding placing devices these residents and observe for compliance. Direct care staff should follow care plan and document right after task is done. Immediate feedback/discussion/correction will be provided as necessary. (8/24/2021

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F 842	Continued From page 45	F 842	ongoing) Head Nurse (HN), Nursing Supervisor (SRN) and Occupational Therapist (OT)Will Implement Measures To Ensure That This Practice Does Not Recur, Including: 2) Residents with contracture or at risk for contractures, OT will be consulted for recommendations. Occupational Therapist to provide written instructions and education/return demo on proper placement of hand rolls and splints. OT to also initiate huddle(s) with the staff whenever there is a new case of resident(s) requiring hand rolls and/or splints. (8/23/2021 ongoing) 3) Comprehensive care plan will be developed to include devices. IDT will discuss/review and update care plan on admission/readmission, quarterly, annually, with significant changes, and as needed. IDT will discuss/evaluate appropriateness and effectiveness of device and determine continuation or if alternative device should be used. (8/30/2021 ongoing) 4) Direct care staff will follow care plan and properly place device per instructions of OT.(8/23/2021 ongoing) 5) Direct care staff will accurately document and use options to document actual times completed.(8/23/2021 ongoing) 6) Reminders in eTAR for license nurse to check and acknowledge that hand rolls and splints are being placed/implemented properly.(8/30/2021 ongoing)	

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F 842	Continued From page 46	F 842	Head Nurse (HN), Nursing Supervisor (SRN) and Occupational Therapist (OT) Will Monitor Corrective Actions To Ensure The Effectiveness Of These Actions, Including: 1) will perform monthly random review/surveillance on the proper use and placement of hand rolls and splints. HN/SRN/OT will submit monthly report of their findings to DON for review of any deficiencies and DON will report as indicated to the QAPI committee quarterly meeting for further discussion and appropriate interventions. (9/3/2021 ongoing, 11/4/2021 next QAPI) R28 PO Documentation pending IDR. Resident record in Point Click Care shows CNA documented lunch intake as 0-25% on 7/22/21.	
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of equipment service manual, the facility failed to ensure routine maintenance of the cabinet filter, based on the manufacturer's recommendation, for one of three oxygen concentrators reviewed. This deficient practice put Resident (R) 229 at risk for the development and transmission of communicable diseases and infections.	F 908	Head Nurses And Licensed Staff Will Implement Corrective Actions For This Resident Affected By This Practice, Including: 1) HN immediately removed and cleaned the oxygen concentrator filter for R229. 07/23/2021 2) Oxygen concentrator filter was cleaned and documented in a timely	9/6/21

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F 908	Continued From page 47 Findings Include: During an observation, on 07/21/21 at 09:24 AM, of R229's room, an Invacare Platinum 10 Oxygen Concentrator was noted at bedside providing oxygen to R229. The cabinet filter located on the side of that oxygen concentrator appeared dirty with dust on it. A review of the Electronic Health Record (EHR) showed that R229 was admitted on 07/07/21 with a diagnosis of Cerebral Infarction, Aphasia, Heart Failure, Hyperlipidemia, Muscle Spasm, Pneumonitis, Vitamin D Deficiency, Dysphagia, Hemiplegia, Hypertensive Heart Disease, Pain Right Lower Leg, Diabetes. R229 had a doctor's order to use oxygen. On 07/23/21 at 10:30 AM, Unit Manager (UM) 1 was queried about the cabinet filter cleaning process. UM1 stated that there was a cleaning process in place but it was not done for R229. UM1 said that R229 was recently moved from another nursing unit and the cleaning process did not continue. UM1 immediately removed the cabinet filter and proceeded to have it cleaned. On 07/23/21 at 11:00 AM, a review of the Service manual for the Invacare Platinum Oxygen Concentrator - Cleaning the Cabinet Filter stated the following: at a minimum, preventive maintenance MUST be performed according to the maintenance record guidelines. In places with high dust or soot levels, maintenance may need to be performed more often ... CAUTION! Risk of Damage. To avoid damage to the internal components of the unit, DO NOT operate the concentrator without the filter installed or with a dirty filter.	F 908	manner. 7/23/21 3) Paper log sheet will be discontinued and replaced with electronic treatment order/eTAR (07/24/21) 8/18/21 Head Nurses And License Staff Will Assess Other Residents Having The Potential To Be Affected By This Practice, Including: 1) Identify all residents on oxygen concentrators to schedule filter cleaning and documentation.7/23/21 and ongoing Identified all residents on oxygen concentrators and a treatment order/TAR was entered into the PointClickCare (PCC) Electronic Health Record for scheduled cleaning. 8/18/21 The Nursing Supervisors (SRN), Head Nurses (HN) and Education RN will implement measures to ensure that this practice does not recur, including: 1) Education will be provided to all nurses to ensure that when a resident is on oxygen, the licensed nurse on duty will write an order regarding cleaning. Oxygen concentrator filter cleaning will be entered as a treatment order/TAR in PCC: Oxygen concentrator filter to be washed in mild soap every Wednesday. 08/23/21 – ongoing 2) Night shift LN to perform medication/treatment administration record audit daily to make sure all orders were carried out and signed in a timely manner 8/23/21- on going 3) Conduct random/weekly visual checks to ensure the filter is cleaned. (8/23/2021 ongoing)	

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F 908	Continued From page 48	F 908	4) Copy of audit will be submitted to HN/SRN for review and follow-up. (8/23/2021 ongoing) The Director Of Nursing, Nursing Supervisors And Head Nurses Will Monitor Corrective Actions To Ensure The Effectiveness Of These Actions, Including: 1) Conducting weekly audits of the TAR to ensure cleaning is being completed. 8/23/21-on going 2) HN/SRN will summarize findings of night shift audit and weekly audits. 8/27/21- on going 3) Audit results will be submitted to the quarterly QAPI committee meeting for review. Next QAPI Scheduled 11/04/21	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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E 000	Initial Comments The facility met the Health Safety Requirements of Appendix "Z", for emergency preparedness and response; in accordance with 42 CFR 483.73 requirement for Long term care facilities.	E 000		

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

Electronically Signed — 08/19/2021

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