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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MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

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4 000	Initial Comments A relicensure 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 Census: 81 Sample Size: 32	4 000		
4 102	11-94.1-22(d) Medical record system (d) Records to be maintained and updated, as necessary, for the duration of each resident's stay shall also include: (1) Appropriate authorizations and consents for medical procedures; (2) Records of all periods, with physician orders, of use of physical or chemical restraints with justification and authorization for each and documentation of ongoing assessment of resident during use of restraints; (3) Copies of initial and periodic examinations and evaluations, as well as progress notes at appropriate intervals; (4) Regular review of an overall plan of care setting forth goals to be accomplished through individually designed activities, therapies, and treatments, and indicating which professional services or individual is responsible for providing the care or service; (5) Entries describing all care, treatments, medications, tests, immunizations, and all ancillary services provided; and	4 102		9/6/21

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4 102	Continued From page 1 (6) All physician's, physician assistant's, or APRN's orders completed with appropriate documentation (signature, title, and date). This Statute is not met as evidenced by: Based on record review and interview with staff member, the facility failed to ensure one Resident (R)50 of 21 residents' records reviewed were accurate and complete. 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. Inaccurate and incomplete records has the potential for continued unnecessary use of psychotropic medication. Findings include: 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 07/20/21 was not documented by staff member. During the discontinuation of enteral feeding by UM1, R50 was biting her sheet and this was not documented in the flow chart or progress note.	4 102	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	

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4 102	Continued From page 2 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.	4 102	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 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)	

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4 102	Continued From page 3	4 102	Head Nurse (HN), Nursing Supervisor (SRN) and License Nurse (LN) 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, 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.	

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4 102	Continued From page 4	4 102	LN/HN should refer to OT to reassess and provide alternative recommendation. (8/14/2021) DON interviewed staff assigned to 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	

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4 102	Continued From page 5	4 102	PointClickCare to address new approach. WEN and HIM will educate direct care staff on how to properly document this 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	

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4 102	Continued From page 6	4 102	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: 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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4 102	Continued From page 7	4 102	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.	
4 141	11-94.1-36(e) Admission, transfer, and discharge (e) At the time of transfer for hospitalization or therapeutic leave, the facility shall provide written information to the resident concerning the facility's bedhold policy. This Statute is not met as evidenced by: Based on 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:	4 141	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	9/6/21

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4 141	Continued From page 8 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. On 07/23/21 at 11:15 AM, an interview was done with the Unit Manager (UM)2 outside her office on the third floor. UM2 explained that bed hold notifications are usually done over the phone with the FR and documented in a nursing progress note. UM2 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.	4 141	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 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	

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4 141	Continued From page 9	4 141	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 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	

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4 141	Continued From page 10	4 141	the audits will be submitted at the quarterly QAPI Committee meeting. Date: 08/30/21 - Ongoing	
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty- first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided. This Statute 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 4 of 21 residents sampled Resident (R)50, R3, R43, and R69. Non-pharmacological interventions to address	4 149	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 R50□s chart and	9/6/21

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4 149	Continued From page 11 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 positioing 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 depp tissue injury. As a result of this deficiency, residents are at risk of potential negative quality of life outcomes. Findings Include: 1) Cross Reference to 0102. 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 behaviors related to the use of psychotropic medication. Interview with the Day Nurse Supervisor (NS)3 and Social Worker (SW) 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	4 149	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. R50□s 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. R50□s 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 R50□s 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) 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	

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4 149	Continued From page 12 vegetative state, quadriplegia, and epilepsy. R3 is totally dependent on staff for all care and mobility and requires two or more person for physical assistance. 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). 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 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 0102. R43 was admitted to the facility on 06/20/13.	4 149	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 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	

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4 149	Continued From page 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 his 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 unit manager (UM)2 regarding R43's left hand contracture. UM2 stated R43 should have a paper 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 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 surveyor observation's 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 intervention to prevent the worsening of contracture to R43's left hand, the intervention did	4 149	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) 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	

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4 149	Continued From page 14 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. 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 to surveyor attempts to verbally communicate with him. Conducted a record review of R69's EMR on 07/22/21 at 1:07 PM. R69's care plan documented interventions for multiple goals: 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 that he 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 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 while 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	4 149	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 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)	

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4 149	Continued From page 15 with R69. Surveyor requested UM2 to show 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 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	4 149	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 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	

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4 149	Continued From page 16 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 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	4 149	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 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	

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4 149	Continued From page 17 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. 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.	4 149	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 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	

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4 149	Continued From page 18 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.	4 149	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: R69□s primary language is Cantonese, cannot understand English, and is legally deaf. According to resident□s family, hearing aid doesn□t 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 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	

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4 149	Continued From page 19	4 149	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) 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	

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4 149	Continued From page 20	4 149	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 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)	

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4 149	Continued From page 21	4 149	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)	
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute 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 creates an increased risk for 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	4 159	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	9/6/21

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	125009	A. BUILDING: _____ B. WING _____	07/23/2021

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MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

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4 159	Continued From page 22 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) 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.	4 159	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 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	

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4 159	Continued From page 23	4 159	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 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	
4 243	11-94.1-64(a) Engineering and maintenance (a) The facility shall maintain all essential mechanical, electrical, and resident care equipment in safe operating condition. This Statute 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	4 243	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.	9/6/21

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4 243	Continued From page 24 risk for the development and transmission of communicable diseases and infections. 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	4 243	07/23/2021 2) Oxygen concentrator filter was cleaned and documented in a timely 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	

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4 243	Continued From page 25 concentrator without the filter installed or with a dirty filter.	4 243	to ensure the filter is cleaned. (8/23/2021 ongoing) 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	