STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125045	A. BUILDING _____ B. WING _____	07/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE ANUENUE RESTORATIVE CARE	1333 WAIANUENUE AVENUE HILO, HI 96720

(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 000	INITIAL COMMENTS The State Survey Agency (SA) Office of Health Care Assurance (OHCA) conducted a recertification survey from 07/13/21 to 07/16/21. The facility was found not to be in substantial compliance with the requirements of §42 CFR 483, Subpart B for Long Term Facilities. The SA also investigated the following Aspen Complaints/Incidents Tracking System (ACTS) Facility Reported Incidents (FRIs) #8404,#8701, #8837, and complaint #8749. Complaint #8749 and FRI #8701 were both not substantiated. FRI ACTS #8404 was substantiated at: F689, Free of Accident Hazards/supervision/devices; F725, Sufficient Nursing Staff; and F842, Resident Records. ACTS #8837 was substantiated at F689, Free of Accident Hazards/supervision/devices and F725, Sufficient Nursing Staff. Survey Dates: 07/13/21 to 07/16/21. Census: 104 residents Sample Size: 21	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from	F 600		8/11/21

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

Electronically Signed | 08/09/2021

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F 600	Continued From page 1 corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to ensure a resident's right to be free from neglect. The facility did not assure Resident (R)10 was provided the care to address positioning needs and as a result of this deficiency, R10 experienced psychosocial harm and an increased potential for physical harm. Findings Include: Cross Reference to F656 Development/Implement Comprehensive Person-Centered Care Plan and F725 Sufficient Nursing Staff R10 had a stroke and was admitted to the facility on 10/19/15. R10's diagnoses including Epilepsy, Hemiplegia and hemiparesis following a non-traumatic intracerebral hemorrhage affecting the left non-dominant side, abnormal posture, muscle weakness, hypertension, vascular dementia without behavioral disturbances, aphasia, dysphagia, and tachycardia. Review of R10's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 04/07/21 documented R10 is totally	F 600	Corrective Action Resident #10's communication care plan was reviewed and updated on 8/5/21, reflecting communication skills he currently possesses. Moaning and vocalizations are typical of his communication, and do not consistently reflect a need for care or attention. Care Staff report that he is only able to respond with a thumbs up or "Shaka" gesture. His care plan for positioning was also reviewed with the Director of Rehabilitation on 8/5/21. She indicated that the intervention continues to be appropriate, and make recommendations for the tear drop pillow. Care plan was reviewed and revised accordingly on the same date. A referral was made for ST and OT to screen Resident #10 to further clarify communication abilities and positioning needs. Due to his inability to use a call light the resident will be placed on hourly checks. A timer will be placed on his door frame cuing the staff when the hour is up and ensuring the check, attending to any needs identified. All staff were educated to respond to his verbalizations due to his communication	

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F 600	Continued From page 2 dependent on 2+ staff physical assistance for bed mobility, transfer (between surfaces) dressing, eating (1 staff assist), toileting, bathing, hygiene (1 staff assist), and incontinence care. R10 is unable to operate a call light system or clearly verbalize needs. Multiple observations (07/13/21 at 1:55 PM; 07/15/21 at 9:54 PM and 1:39 PM; 07/16/21 at 08:57 AM) were made of R10 heard making loud moaning sounds which could only be hear from immediately outside the resident's room. There were no staff in the area to hear R10's moans and no staff went to check on or address the resident. On 07/15/21 at 1:39 PM, this surveyor heard a loud crying/wailing type of noise coming from R10's room. The crying/wailing could be heard from 3 doors down the hallway from Room #110. Two (2) staff members were observed to be in Room #110, were R10 was loudly crying/wailing and did not check on R10 or address the resident's needs. This surveyor entered the room and saw Certified Nurse Aide (CNA)11 assisting R10's roommate with a meal and Facility Staff (FS)99 finished cleaning the floor and exited the room. The privacy curtain was drawn between R10 and the roommate which blocked CNA11 from any visual contact of R10. Observed R10 crying, the resident's entire face was red in color and teary-eyed. R10 was dressed in a shirt and incontinent brief only, with a small blanket placed between the resident's knee and wall (knee leaning on the wall) and right side of R10's forehead was resting directly on the wall. No pillows or cushions were observed on R10's bed and observed a call light clipped to the lower left part of R10's bed. CNA11 did not come over to	F 600	capabilities. Identification of Others A whole house audit was conducted on 8/4/21 identifying eleven residents who could be at risk based on communication capabilities. Systemic Changes Residents identified with communication deficits will be placed on the hourly check system. All staff will be educated on specific resident centered alternate communication methods to anticipate and address resident needs. Hourly checks will be recorded by CNAs on a log in the resident's bathroom. Monitoring Checks will be monitored by licensed nurses on each shift, with daily spot checks by DON or her designee. The DON/designee will audit the resident care plan monthly to ensure residents with communication challenges have the proper interventions in place and that they are addressed on the Kardex. Those residents will be reviewed on an on-going basis during daily rounds. The audit results, along with any corrective action taken, will be presented to the Quality Assurance Process Improvement Committee for review and further recommendations. The QAPI committee will determine the frequency of ongoing monitoring and the achievement of substantial compliance.	

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F 600	Continued From page 3	F 600		

assess R10 despite the resident's continued crying. This surveyor finally verbally requested for CNA11 to assess and attend to R10. CNA11 came over and immediately started to raise the head of R10's bed (HOB) prior to repositioning the resident which caused R10's right forehead to drag along the surface of the wall. Immediately instructed CNA11 to stop raising the head of the bed and reposition R10. Inquired with CNA11 as to why R10 was not checked on or addressed when staff heard the resident crying loudly. CNA11 reportedly was busy assisting R10's roommate with a meal and confirmed other staff was not alert that R10 required assistance. Queried CNA11 regarding R10's positioning needs and ability. CNA11 stated R10 is unable to reposition without 1-2 staff assistance and is known to lean towards the wall (the resident's right side). CNA11 further stated R10 usually makes noises when he needs to be repositioned. Inquired with CNA11 if R10 is able to reach and/or appropriately use the call light that was clipped to R10's bed (on the lower left corner). CNA11 confirmed R10 is unable to reach or appropriately utilize the call light button and reiterated R10 will make noises when the resident needs help.

On 07/15/21 at 3:10 PM, conducted a record review of R10's Electronic Medical Record (EMR). Review of R10's care plan documented R10 has Activity of Daily living (ADL) self-care deficit as evidenced by R10 requires total assistance with ADLs related to the resident's diagnoses and impaired mobility. The care plan documents that a tear- drop bolster for proper bed positioning and for staff to frequently check the resident's positioning and reposition to prevent R10 from leaning up against the wall

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F 600	Continued From page 4	F 600		

which was not implemented by staff. As a result of not implementing frequent checks R10 was in direct contact with the wall more than once, placing the resident at an increased risk of injury and potential for pressure ulcers. The care plan documented also documented for communication, staff should anticipate and meet needs per non-verbal indicators or discomfort/distress and follow-up as indicated. CNA11 failed to meet R10's communication needs despite R10 crying out in distress.

On 07/16/21 at 08:45 AM, queried Nursing Staff (NS)60 regarding the use of a call light for R10. NS60 confirmed R10 is not capable of appropriately and physically using the call light button. NS60 stated R10 will make noises when the resident needs help or is uncomfortable, however, if staff is not in the area and does not hear R10's noises, then R10 does not receive assistance. Inquired if the location of R10's room, which is one of two rooms at the end of a hall away from the nurse's station on the Keolamau Unit. NS60 confirmed due to the distance of R10's room for the nursing station and the noise of the activities, residents and other staff make it difficult to hear when R10 is making noise and needs assistance. NS60 stated staff attempt to do frequent rounds to check R10, however, staff is not always able to complete rounds frequently.

On 07/16/21 at 09:18 AM, conducted a concurrent interview with the Director of Nursing and the Assistant Director of Nursing regarding observations made of R10. The DON and ADON confirmed staff should have assisted R10 with positioning needs or alerted other staff to assist R10. After reviewing R10's comprehensive care

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F 600	Continued From page 5 plan, the DON and ADON confirmed a cushion or cushion device should be used to ensure R10 is not leaning directly on the wall according to R10's individual care plan interventions but was not implemented. Further queried the DON and ADON regarding the observation of the call light clipped to R10's bed. The DON and ADON confirmed R10 is unable to appropriately use and operate a call light due to the resident's medical condition. Queried the DON and ADON regarding staff's ability to hear R10's verbal noises used to alert staff for assistance given that the resident is in the last room down the hall and in the bed furthest from the door if the staff is not in the area. The DON and ADON confirmed it would be difficult for staff to hear R10 from the nursing station.	F 600		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		8/13/21

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F 656	Continued From page 6 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 section. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the failed to ensure a comprehensive person-centered care plan was developed and/or implemented with measurable objectives and individualized interventions for 2 residents (Resident (R)10 and R36) in the sample. Interventions related to R10's positioning and communication needs were not implemented according to the resident's comprehensive care plan. R36's care plan was not followed for fall prevention when staff did not ensure that R36's call light was within his reach. As a result of this deficient practice, residents are at risk of not attaining or maintaining their highest practicable physical, mental, and psychosocial well-being and	F 656	Corrective Action Resident #10's care plan was reviewed and updated to reflect his current communication and positioning requirements. The Director of Rehab completed a screening on 8/5/21 to evaluate his current seating and positioning equipment. The resident's care plan was reviewed and revised to clarify his needed positioning support. Resident #36 was assess for the ability to use a call light by the Director of Rehab on 8/4/21. She identified and alternate placement option that may be more effective and accessible to the resident.	

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F 656	Continued From page 7 potential of a negative impact on the resident's quality of life, as well as quality of care and services received. Findings Include: 1) Cross Reference to F600 Free from Abuse and Neglect R10 was admitted to the facility on 10/19/15 with diagnoses including Epilepsy, Hemiplegia and hemiparesis following a non-traumatic intracerebral hemorrhage affecting the left non-dominant side, abnormal posture, muscle weakness, hypertension, vascular dementia without behavioral disturbances, aphasia, dysphagia, and tachycardia. Review of R10's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 04/07/21 documented R10 is totally dependent on 2+ staff physical assistance for bed mobility, transfer (between surfaces) dressing, eating (1 staff assist), toileting, bathing, hygiene (1 staff assist), and incontinence care. On 07/13/21 2:40 PM, observed R10's bed was positioned parallel to and directly against the wall for the length of the bed. R10 was resting in bed with the right side of R10's body leaning up against the wall and R10's head rested up against the wall. There were no pillows or cushions placed between R10 and the wall. R10 remained in that position until after 3:10 PM. On 07/15/21 at 1:39 PM, this surveyor heard a loud crying/wailing type of noise coming from R10's room. The crying/wailing could be heard from 3 doors down the hallway. Two (2) staff	F 656	Care Plan reviewed and updated to include the new placement alternative. Identification of Others A whole house audit was conducted identifying residents who were considered "non-interview-able" due to communication deficits. Eleven Residents were identified at potential risk. A whole house audit was also conducted regarding call light operation. If the resident could not use a push button call light, it was replaced with a pancake call light. Systemic Changes Resident identified and "non-interview-able" during the MDS quarterly assessment will be screened by ST for alternate communication strategies and integrate them into their care plan and daily care. Education will be provided to staff through daily huddles updating them on the resident's needs and directions for care. During monthly nursing meetings, education will include resident needs and care solutions, including communication challenges and other risk factors. Monitoring The DON/designee will audit the resident care plan monthly to ensure resident with communication challenges have the proper interventions in place and that they are addressed on the Kardex. Those residents will be reviewed on an on-going basis in daily rounds. The audit results, along with any correction action taken will be presented to the QAPI committee for review and further recommendations. The QAPI committee will determine the frequency of ongoing monitoring and	

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F 656	Continued From page 8 members were observed to be in the room of the crying/wailing and did not address the resident making the crying/wailing sound. Upon entering the room, observed Certified Nurse Aide (CNA)11 assisting R10's roommate with a meal and Facility Staff (FS)99 carried on with cleaning the room floor. CNA11 was unable to directly see R10, while assisting R10's roommate because the privacy curtain separated the two residents. Observed R10 with a red face, with tears due to crying, with a small blanket between R10's right knee and the wall and the right side of R10's forehead was resting directly on the wall. There were no pillows or cushions observed on R10's bed. Also observed a call light clipped to the lower left part of R10's bed. CNA11 approached R10 only after this surveyor requested assistance for R10. CNA11 came over and immediately started to raise the head of R10's bed (HOB) prior to repositioning the resident which caused R10's right forehead to drag along the surface of the wall. Requested for CNA11 to stop and reposition R10 before elevating the HOB further and CNA11 complied. Inquired with CNA11 as to why R10 was not checked on or addressed when staff heard the resident crying loudly. CNA11 reportedly was busy assisting R10's roommate with a meal and confirmed other staff was not alert that R10 required assistance. Queried CNA11 regarding R10's positioning needs and ability. CNA11 stated R10 is unable to reposition without 1-2 staff assistance and is known to lean towards the wall (the resident's right side) due to the resident's medical condition. Inquired with CNA11 if R10 is able to reach and/or appropriately use the call light that was clipped to R10's bed (on the lower left corner). CNA11 confirmed R10 is unable to reach or appropriately utilize the call light button due to the resident's	F 656	achievement of substantial compliance.	

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medical condition.

On 07/15/21 at 3:10 PM, conducted a record review of R10's Electronic Medical Record (EMR). Review of R10's care plan documented R10 has Activity of Daily living (ADL) self-care deficit as evidenced by R10 requires total assistance with ADLs related to the resident's diagnoses and impaired mobility. The care plan documented for bed positioning, a tear- drop bolster for proper bed positioning, the angle side needs to be placed underneath R10's right shoulder and arm and staff should check R10's positioning frequently and reposition as needed to prevent R10 from leaning too much the right, towards the wall. Staff did not implement the tear-drop bolster (cushion) or reposition R10 away from the wall during observations made on 07/13/21 at 2:40 PM and 07/12/21 at 1:39 PM.

On 07/16/21 at 09:18 AM, conducted a concurrent interview with the Director of Nursing and the Assistant Director of Nursing regarding observations made of R10. The DON and ADON confirmed staff should have assisted R10 with positioning needs or alerted other staff to assist R10. After reviewing R10's comprehensive care plan, the DON and ADON confirmed a cushion or cushion device should be used to ensure R10 is not leaning directly on the wall according to R10's individual care plan interventions but was not implemented. Further quired the DON and ADON regarding the observation of the call light clipped to R10's bed.

2) Cross Reference to F600 Free from Abuse and Neglect

Regarding observations on 07/15/21 at 2:40 PM

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of R10 leaning in direct contact with the wall. This surveyor heard R10 crying/wailing loudly, from approximately 3 doors down the hallway immediately outside the resident's room. Despite the presence of two staff in the room, staff did not immediately check on R10 or address R10's needs until this surveyor requested staff to assist R10. Observed a call light button clipped to the lower left portion of R10's bed, away from the resident's legs. Inquired with CNA11 regarding the placement of the call light. CNA11 confirmed R10 is not capable of physically using the call light or have the cognitive capacity to appropriately utilize the call light. Inquired with CNA11 as to how R10 can alert staff of needs and if so how does R10 alert staff. CNA11 stated R10 will generally make noises to alert staff for assistance.

On 07/15/21 at 3:10 PM, conducted a record review of R10's Electronic Medical Record (EMR). Review of R10's care plan documented interventions foe staff to anticipate and meet needs per physical/non-verbal indicators r discomfort/distress and follow-up as indicated.

On 07/16/21 at 08:45 AM, queried Nursing Staff (NS)60 regarding the use of a call light for R10. NS60 confirmed R10 is not capable of appropriately and physically using the call light button. NS60 stated R10 will make noises when the resident needs help or is uncomfortable, however, if staff is not in the area and does not hear R10's noises, then R10 does not receive assistance. Inquired if the location of R10's room, which is one of two rooms at the end of a hall away from the nurse's station on the Keolamau Unit. NS60 confirmed due to the distance of R10's room for the nursing station and

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F 656	Continued From page 11	F 656		

the noise of the activities, residents and other staff make it difficult to hear when R10 is making noise and needs assistance. NS60 stated staff attempt to do frequent rounds to check R10, however, staff is not always able to complete rounds frequently.

On 07/16/21 at 09:18 AM, conducted a concurrent interview with the Director of Nursing and the Assistant Director of Nursing regarding the use of a call light for R10. The DON and ADON confirmed R10 is unable to appropriately use and operate a call light due to the resident's medical condition. Inquired how the facility is addressing R10 making noises as a means of alerting staff of needs.

3) An observation of R36 was made on 07/15/21 at 09:32 AM. R36 was sitting up in bed with his eyes closed and he was slow to respond when his name was called several times in a loud tone. His breakfast tray was hardly touched and sat on the rolling bedside table in front of him. A vital signs (VS) monitor (equipment to check blood pressure (BP) and heart rate) on a rolling apparatus was placed next to his bed. He had difficulty opening his eyes and groggily stated that he needed help with his eggs. Surveyor noted that R36's call light was up high on the right side of his pillow. Surveyor asked RN12 if R36 can reach up and activate his call light. RN12 looked for R36's call light and found it on the right side of his pillow and stated, "No." CNA10 entered the room and stated, "I left him (R36) because I had to help someone else." (Refer F919)

A review of R36's care plan was done at 08:50 AM on 07/16/21. Under "Focus - FALLS: Resident is at risk for falls due to impaired balance, hx

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F 656	Continued From page 12 (history) of falls, RLE (right lower extremity) cellulitis (serious bacterial infection of the skin), LE (lower extremity) venous stasis ulceration. Date initiated: 01/06/21," "Goal - The resident will not sustain serious injury requiring hospitalization through the review date. Date Initiated 01/06/2021," "Interventions/Tasks ...Call light within reach. Remind frequently to call and wait for assistance as needed. Date Initiated: 01/06/2021."	F 656		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to protect three residents, R103, R302 and R39, from falls while residing at the facility. R103 and R302 had sustained major injuries after their falls and R39 continues to suffer from falls. The deficient practice resulted in the decline and expiration of R103; R302 was transferred to acute care and R36 could potentially suffer from a major injury if he continues to have falls in the facility. Findings Include: 1) Surveyor reviewed the electronic medical record (EMR) on 07/14/21 at 03:14 PM. The	F 689	Residents #103 and 302 no longer reside at the facility. Resident #36 had an air mattress added to his sleep surface on 7/15/21 to provide him better and safer support while in bed. Identification of others A whole house audit was completed that focused residents who were at high risk for falls. High Risk residents identified were residents with three or more falls within the last quarter and falls with major injuries since August, 2020. A total of eleven residents were identified to be in these two groups of high risk residents. Systemic Changes	8/11/21

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F 689	Continued From page 13 event completed report dated 05/06/21 stated that R103 was found on the floor lying next to her bed. The nursing assessment noted that she had swelling to her right shoulder. R103 was sent to an acute care Emergency Department (ED) at 07:25 AM. At 07:25 the ED informed the facility staff that R103 sustained a proximal right humeral fracture (right upper arm) verified by x-ray. Detailed description of the report: "R103 is an 88-year-old female admitted to facility on 04/30/21 for long term care. At 04:35 resident was observed lying on the floor beside her bed lying on her right shoulder and right hip. R103 had a small amount of hard stool noted on the floor and in her brief...The resident indicated that she had right shoulder pain and demonstrated unequal strength in her right hand. Physician (MD) ordered resident to be sent to the ED for evaluation." "Night shift nurse was interviewed and stated that resident appeared to be asleep twenty minutes prior to the fall when the certified nurse aide (CNA) checked on her. Resident was toileted approximately two hours before fall...After a thorough investigation, staff felt that it is likely that resident was incontinent of BM and moved around in bed, and consequentially rolled out of bed landing on the floor..." Surveyor reviewed discharge summary from the acute care hospital on 07/16/21 at 1:00 PM. "05/04/21 07:05 Impression: 1. Acute fracture of the surgical neck of the proximal humerus (shoulder X-ray) ...." Surveyor noted the following: "Findings...A large amount of stool is noted throughout the entire colon, consistent with	F 689	The eleven high fall risk residents fall care plans were reviewed and updated by the IDT on 8/6/21. Education of the high fall risk care plans was completed with all nursing staff and CNAs on 8/6/21. Nursing staff will be educated on fall prevention and interventions post falls. Licensed nursing staff will be educated on conducting a root cause analysis at the time of the fall. The current practice is a fall huddle immediately after the fall with the resident's care providers. The huddle and the interventions will be documented and added to the care plans, nurses and CNAs will be updated on changes during the pre-shift huddle by reading and signing the communication report. Residents will be referred for therapy by nursing for post fall screening. All staff was educated on call lights and the need to answer lights in a timely manner to prevent falls. Monitoring The DON/designee will audit the completion of the pre-shift huddle by reviewing the communication reports. Falls will be discussed by the IDT during the next Grand Round to evaluate the completion and effectiveness of the documentation, interventions and care plan updates associated with the fall. Falls will be discussed during the weekly Resident at Risk meeting by members of the IDT. The audit results, along with any corrective action taken, will be presented to the QAPI committee for review And further recommendations. The QAPI committee will determine the frequency of ongoing monitoring and achievement of	

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constipation or colonic impaction (Pelvis and right hip radiographs) ..."

Surveyor reviewed the Electronic medical record (EMR) for R103 on 07/14/21 at 4:12 PM. Progress notes reviewed revealed:

"05/06/21 15:57. Admission assessment. Admitted from care home on 04/30/21 with diagnosis of dementia, Mild Protein Malnutrition, Hearing loss, Constipation On 5/4/21 found on floor and got sent to HMC for further evaluation and returned on same day with diagnosis of right proximal humeral fracture. Requires extensive to total one to two-person assist for activities of daily living (ADL's). Resident complained of right upper extremity (RUE) pain with movement, rated pain medium. Sling is in place."

"05/13/21 14:47 R103 continue to complain of pain and discomfort to right shoulder. Continue to have poor oral intake even tried to encourage and feed resident. Continue to have cough during mealtime and resident refused to eat when staff helped her with her meals. MD ordered and started on intravenous (IV) fluids."

"05/16/21 13:59 Resident stayed in bed...continues with poor oral intake, refused meals, noted grimacing with movements, applied Lidocaine patch to right shoulder for pain management."

On 05/24/21 R103 had a second unattended fall while sitting up in her wheelchair, it was presumed that she fell face first to the floor after being left unsupervised in her wheelchair after a physical therapy session. R103 was taken the ED for evaluation and treatment and diagnosed

substantial compliance.

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with a fracture of the right greater trochanter and questionable incomplete nondisplaced fracture of the base of the neck of the right femur.

Surveyor reviewed the discharge summary from the acute care hospital dated 05/24/21. MD documentation at 20:13 (8:13 PM) "...Had a discussion with son which I explained that R103 will not be able to use a walker anymore because of her shoulder fracture and that if she is non-ambulatory and bed-bound there may be no indication to fix her hip."

"05/25/21 at 15:20 (3:20 PM) ...Impression: Right hip greater trochanteric fracture with unlikely extension into femoral neck. Given both upper and lower extremity injuries I do not recommend surgery based on frailty and comorbidities."

"05/27/21 09:16 Physical therapy (PT) screen. Patient is unable to follow commands. Moans in pain with bed mobility and passive range of motion to bilateral extremities, dependent for mobility. Not presenting with need for skilled PT at this time."

Surveyor reviewed the EMR on 07/15/21 at 2:00 PM. The progress notes revealed that R103 was re-admitted to the facility on 05/27/21. Further review showed:

Care plan dated 05/27/21: "R103 is at risk for falls. Goal: R103 will not sustain serious injury requiring hospitalization through the review date. Initiated: 04/30/21 (initial admission). The resident will be free from fall over the next review. initiated: 05/13/21."

Surveyor noted interventions for constipation

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were implemented on 05/13/21. R103 was noted to have constipation at the time of her first fall on 05/04/21 when hard stool was found on the floor. R103 was noted to have colon impaction when she was evaluated at the ED.

Progress note written on 06/03/21 15:03 (3:03 PM). "IDT meeting to discuss R103's fall on 05/27/21. It was noted that she was lying face down and was overheard making a slight moaning noise. Her right upper extremity (RUE) was in a splint due to a previous fall with a fracture. The certified nurse aide (CNA) reported that the resident had just returned from working with rehabilitation. It appears likely that the resident may have fallen asleep and fell forward landing on the floor in front of her wheelchair. Resident was assisted back in bed and a full head-to-toe assessment was completed by RN. Resident was noted to be guarding her right hip/leg and moaned when asked if she had pain there. She denied pain to any other areas. Scattered small bruises were noted to her knees. She had a purplish bruise that appeared on her left cheek bone. When asked what happened, resident stated, "Ow, ow, ow." Continued moaning and grimacing was noted during assessment. Notifications were made appropriately."

Surveyor reviewed the minimum data set (MDS) on 07/16/21 at 10:15 AM.
Assessment review date (ARD) 06/03/21. R103 was noted to have a significant change; Her functional abilities changed from extensive assist (admission assessment) to total dependence.

Progress note on 06/21/21 at 15:18 (03:18 PM), telephone call from Unit registered nurse (RN)

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who reported resident expired at 1320 (1:20 PM) today and daughter was in the room.

Surveyor interviewed the director of nursing (DON) and assistant director of nursing (ADON) on 07/16/21 at 09:26 AM. Surveyor asked if the resident was considered a high risk for falls and if so what type of interventions were in place prior to the first fall? Details of the interview are as follows:

The DON summarized the first fall that occurred on 05/04/21. It was believed that R103 was lying in bed, repositioned herself in bed and slid onto the floor. She was toileted before that. She couldn't recall how she fell; she had a small amount of hard stool (BM). She did say bathroom. She was a heavy sleeper and sleeps a lot during the day. Historically was sleepy, she would fall asleep easily while sitting up in her chair. The root cause was related to waking up in the middle of the night needing to have a BM and trying to get up and slid out of bed.

We gave her a pressure sensitive call light so if she repositioned in bed, the call light would go on. We cannot stop all falls, but we can keep it safe as possible. The second fall happened on 05/24/21 when R103 was left in her room in her wheelchair after her physical therapy session. The therapist left her sitting up in her chair with the call light.

Surveyor asked if R103 was safe to be left in her chair unsupervised, especially since it was documented that she frequently would fall sleep in her chair? The DON replied that the Therapist stated that R013 was safe to stay in her chair. It was believed that she fell forward after falling

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asleep.

Surveyor asked when R103 came back from the acute care hospital after the second fall, did she have a change in her health status? Did she have decline in her activities of daily living (ADL's)? The DON responded yes; a Hospice referral was started while she was at the acute care hospital. When she came back to the facility she declined. Hospice was started on 06/03/21 and she expired on 06/21/21.

2) On 07/13/21 at 1:45 PM, surveyor reviewed the facility's Office of Health Care Assurance (OHCA) completed Event Report for a facility reported incident (FRI) about R302's fall on 08/03/20 at 2:45 PM. Details included that the certified nursing assistant (CNA) checked R302's blood pressure (BP) at "1420" or 2:20 PM that day. She had low BP. R302 was lying in bed when the CNA left the room to report to the nurse about R302's low BP. At "1445" or 2:45 PM, R302 was found lying on the floor in front of the bathroom. R302 was not responding to painful stimuli. Staff then elevated R302's legs and checked her BP, "it was low at 99/59, HR (heart rate) 100." R302 opened her eyes and became verbally responsive.
The physician and daughter were notified. R302 sustained skin tears to both arms and a bruise to the "back of her scalp."

A "Health Status Note" written on 08/04/20 at 07:21 (AM) by the RN revealed that R302 was sent to the emergency room (ER) at 0415 (04:15 AM). R302 was not responding verbally to the staff, and she was not following their commands to test for motor function.

A "Health Status Note" documented on 08/04/20

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at 10:38 (AM) showed that R302 was admitted to the hospital for bleeding in the brain and "bladder rapture" (sic).

Continued review of R302's EMR revealed that R302 is a 99-year-old female with diagnoses of: Alzheimer's disease (gradual and progressive brain disorder affecting memory, thinking and behavior), dementia (a group of symptoms affecting memory, thinking and social abilities severe enough to interfere daily life), heart failure, chronic kidney disease (CKD, failure of the kidneys to filter waste in the blood and fluid in the body), uterovaginal prolapse (pelvic floor muscles and ligaments stretch and weaken and no longer provide enough support for the uterus causing urinary leakage and the sensation of pelvic heaviness) and frequent falls.

R302's care plan revealed for "Focus - Resident is at risk for falls due to poor safety awareness related to Dementia, comorbidities. Date Initiated: 12/18/2019" "Goal - The resident will not sustain serious injury requiring hospitalization through the review date. Date Initiated: 12/19/2019," "Interventions/Tasks ...FREQUENT SAFETY CHECKS RESIDENT WILL NOT CALL FOR HELP AND HAS URINARY FREQUENCY ISSUES. Date Initiated: 06/12/2020"

In the afternoon of 07/15/21, surveyor reviewed R302's facility incident reports for falls. R302 had a fall on 06/07/20 at 02:30 AM and sustained a bruise on her left hand. A fall occurred on 06/08/20 at 11:30 PM (23:30) and R302 did not have any visible injury. R302 fell in the bathroom on 06/12/20 at 2:20 PM (14:20) with no visible injury but she complained of pain to her right leg and hip. On 07/02/20 at 11:25 PM (23:35), R302

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stated to staff that she fell in the bathroom, and she was found to have a skin tear on her left wrist and cut to her left knee. R302 experienced a fall on 07/03/20 at 11:45 PM (23:45) with complaints of left knee pain and no visible injury. R302 had a fall on 07/27/20 at 09:45 AM which she sustained a small lump to the left side of her head and redness to her left knee. On 08/03/20 at 2:45 PM (14:45), R302 had her final fall in the facility where she sustained a bruise on her scalp and ruptured bladder. She was transferred to an acute care facility on 08/04/20.

The ADON and DON were interviewed on 07/16/21 at 09:20 AM. Surveyor asked them if R302 was considered for one-to-one care with staff. The DON stated that they didn't think she needed one to one care because "when she slept, she slept very soundly." The DON further stated that R302 was difficult to care for because she was "up 20 times at night, had muscle spasms, medications for hemorrhoids, co-morbidities (other medical diagnoses) that made her feel uncomfortable and she was not a surgical candidate." Surveyor then queried the DON that if R302 was difficult to care for, then wouldn't she have one to one care? The DON stated,
"She would get tired if she had one to one care."
(Refer F725)

3) An observation of R36 was made on 07/15/21 at 09:32 AM. R36 was sitting up in bed with his eyes closed and was slow to respond when his name was called several times in a loud tone. His breakfast tray was hardly touched and sat on the rolling bedside table in front of him. A vital signs (VS) monitor (equipment to check BP and heart rate) on a rolling apparatus was placed next to his

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F 689	Continued From page 21 bed. He had difficulty opening his eyes and groggily stated that he needed help with his eggs. Surveyor noted that R36's call light was up high on the right side of his pillow. Surveyor asked RN12 if R36 can reach up and activate his call light. RN12 looked for R36's call light and found it on the right side of his pillow and stated, "No." CNA10 entered the room and stated, "I left him (R36) because I had to go help someone else." (Refer F919) A review of R36's EMR was done in the morning of 07/16/21. A review of "Event Notes" in R36's progress notes revealed that R36 has had multiple falls. R36 had sustained a fall on 07/15/21 at 08:03 AM. He had two open areas to his 4th and 5th toes on his right foot. Further review of R36's EMR revealed that R36 had previous falls on 01/07/21, 04/06/21 and 05/16/21. R36 is receiving Hospice care and has diagnoses of history of falls, generalized muscle weakness, cognitive communication deficit and retention of urine. A subsequent review of R36's care plan was done. Under "Focus - FALLS: Resident is at risk for falls due to impaired balance, hx (history) of falls, RLE (right lower extremity) cellulitis (serious bacterial infection of the skin), LE (lower extremity) venous stasis ulceration. Date initiated: 01/06/21," "Goal - The resident will not sustain serious injury requiring hospitalization through the review date. Date Initiated 01/06/2021," "Interventions/Tasks ...Call light within reach. Remind frequently to call and wait for assistance as needed. Date Initiated: 01/06/2021." (Refer F656)	F 689		
F 725 SS=E	Sufficient Nursing Staff	F 725		8/13/21

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F 725	Continued From page 22 CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure it adequately assigned staff to meet the needs of its residents. The deficient practice has the potential to impact the health and safety of all the residents. R103 and R302 had unattended falls with injuries. R36 is dependent on staff, on Hospice care, and his safety was not ensured.	F 725	Corrective Action Resident #103 and 302 no longer reside in the facility. Resident #10 was reviewed with his care plan revised to addressing positioning and communication needs. Resident #157's identity was not disclosed in the survey resident list provided to the facility.	

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F 725	Continued From page 23 Staff did not respond to R10 crying or other sounds for staff assistance. R10 is dependent on staff for positioning needs and all care needs and is able to alert staff through various sound for assistance. R10 is unable to appropriate use the call light system. Findings Include: 1) R103 had an unattended fall on 05/04/21 at the facility and sustained a fracture of the upper arm. A few weeks later R103 had a second unattended fall on 05/24/21 after being left unsupervised in her wheelchair when she fell face first to the floor and sustained a hip fracture. After returning to the facility on 05/27/21 R103 significantly declined and expired on 06/21/21. (Refer F689). 2) Surveyor interviewed an anonymous staff on 07/15/21 at 9:45 AM who stated that today the minimum data set (MDS) nurse is helping to with the medication administration pass, because there is a nurse out sick today. Surveyor asked if the staffing is often short on this unit, (W unit). The Staff replied that lately we have been short, staff are out sick. 3) Surveyor interviewed R157 on 07/15/21 at 02:13 PM who was alert and oriented to name, place, and time. When the surveyor asked if there were enough staff to help or the other resident when she needed help and do staff come when she presses the call light? R157 replied, not all the time. The other day there were only two CNA's here. I didn't press the call light because I knew they were busy with the others. I try not to call for help when I know they don't have enough staff.	F 725	Identification of others A whole house audit was conducted identified eleven residents who were considered un-interview-able due to communication deficits. Without the identification of Resident #157, the facility identified 14 potential residents who would be able to provide feedback similar to the situation described in the deficiency. Systemic Changes 14 interview-able residents were identified and asked about consistent use of call lights when needed. All 14 were provided with education on 8/8/21 and reassurance of the importance of using the call light system to address their needs irrespective of their perceptions of staffing. Regarding an MDS Nurse supporting residents direct care, it is an industry as well as best practice to cross-train staff to ensure the uninterrupted 24 hour provision of resident care and services, particularly in the event that staffing is challenged. The nurse providing services during the date identified is an experienced nursing home RN, who has full capabilities and competencies to serve our residents when called upon. The facility utilized an online application system to recruit and hire new employees. This system "spiders" other online application systems such as Indeed, Glass Door, Google, and many more employment websites to attract applicants. The online application system allows us to monitor our applicant flow, which is reviewed on a daily basis, allowing us an opportunity to quickly respond to and immediately engage	

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F 725	Continued From page 24 4) 07/16/21: During the Quality Assurance Performance improvement (QAPI) interview, the DON and Administrator stated that when the facility is short, assigned staff, the MDS or assistant ADON will step in to cover those areas where appropriate. The W wing has a higher priority for staffing due to the higher acuity of the residents who are receiving skilled nursing. The unit manager is currently on vacation and the unit manager on the K unit is not currently filled. The facility requires one registered nurse on each shift. R10 was admitted to the facility on 10/19/15 with diagnoses including Epilepsy, Hemiplegia and hemiparesis following a non-traumatic intracerebral hemorrhage affecting the left non-dominant side, abnormal posture, muscle weakness, hypertension, vascular dementia without behavioral disturbances, aphasia, dysphagia, and tachycardia. Review of R10's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 04/07/21 documented R10 is totally dependent on 2+ staff physical assistance for bed mobility, transfer (between surfaces) dressing, eating (1 staff assist), toileting, bathing, hygiene (1 staff assist), and incontinence care. R10 is unable to operate a call light system or clearly verbalize needs. Multiple observations (07/13/21 at 1:55 PM; 07/15/21 at 9:54 PM and 1:39 PM; 07/16/21 at 08:57 AM) were made of R10 heard making loud moaning sounds which could only be hear from immediately outside the resident's room. There were no staff in the area to hear R10's moans and no staff went to check on or address the	F 725	applicants. We also monitor competitor wages through external resources. Our benefits package is exceptional, particularly our generous PDO (paid day off) program. We work closely with area nursing and CNA training schools and provide a clinical site to those students. It serves as a recruiting pool for us, as well as an opportunity to have a hand training health care professionals in the area. We have obtained a generous bonus incentive plan, targeting CNA's, to encourage coming to work, and help in covering open shifts. We additionally scrutinize all admissions to ensure that we are able to meet their individual needs in order to avoid creating a hardship on our staff, and providing the proper care needs of our residents. We will continue to cross train our nursing staff to promote our internal capabilities to ensure proper support and supervision to our residents. Monitoring The DON will present staffing reports to the QAPI committee for review and recommendations. The QAPI committee will determine the frequency of the ongoing monitoring and achievement of substantial compliance.	

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resident.

On 07/15/21 at 1:39 PM, R10 could be heard from the hallway crying/wailing loudly, which could be heard from three rooms down the hall. There were two (2) staff members in R10's room upon entering the room. Certified Nurse Aide (CNA)11 was assisting R10's roommate with a meal and Facility Staff (FS)99 finished cleaning the floor and exited the room. The privacy curtain was drawn between R10 and the roommate which blocked CNA11 from any visual contact of R10. Observed R10 in bed, the resident's entire face appeared red with observable tears. Inquired with CNA11 as to why R10 was not checked on or addressed when staff heard the resident crying loudly. CNA11 stated he/she was busy assisting R10's roommate with a meal and confirmed he/she did not alert other staff to assist R10 required. Queried CNA11 regarding R10's positioning needs and ability. CNA11 stated R10 is unable to reposition without 1-2 staff assistance and is known to lean towards the wall (the resident's right side). CNA11 further stated R10 usually makes noises when he needs to be repositioned. Inquired with CNA11 if R10 is able to reach and/or appropriately use the call light that was clipped to R10's bed (on the lower left corner). CNA11 confirmed R10 is unable to reach or appropriately utilize the call light button and reiterated R10 will make noises when the resident needs help.

On 07/15/21 at 3:10 PM, conducted a record review of R10's Electronic Medical Record (EMR). Review of R10's care plan documented R10 has Activity of Daily living (ADL) self-care deficit as evidenced by R10 requires total assistance with ADLs related to the resident's

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diagnoses and impaired mobility. The care plan documents that a tear- drop bolster for proper bed positioning and for staff to frequently check the resident's positioning and reposition to prevent R10 from leaning up against the wall which was not implemented by staff. As a result of not implementing frequent checks R10 was in direct contact with the wall more than once, placing the resident at an increased risk of injury and potential for pressure ulcers. The care plan documented also documented for communication, staff should anticipate and meet needs per non-verbal indicators or discomfort/distress and follow-up as indicated. CNA11 failed to meet R10's communication needs despite R10 crying out in distress.

On 07/16/21 at 08:45 AM, queried Nursing Staff (NS)60 regarding the use of a call light for R10. NS60 confirmed R10 is not capable of appropriately and physically using the call light button. NS60 stated R10 will make noises when the resident needs help or is uncomfortable, however, if staff is not in the area and does not hear R10's noises, then R10 does not receive assistance. Inquired if the location of R10's room, which is one of two rooms at the end of a hall away from the nurse's station on the Keolamau Unit. NS60 confirmed due to the distance of R10's room for the nursing station and the noise of the activities, residents and other staff make it difficult to hear when R10 is making noise and needs assistance. NS60 stated although staff attempt to do frequent rounds to check on R10, staff are not always able to assist R10 or made aware that the resident needs help.

On 07/16/21 at 09:18 AM, conducted a concurrent interview with the Director of Nursing

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and the Assistant Director of Nursing regarding observations made of R10. The DON and ADON confirmed staff should have assisted R10 with positioning needs or alerted other staff to assist R10 when staff heard the resident vocalizing the need for help. Further queried the DON and ADON regarding the observation of the call light clipped to R10's bed. The DON and ADON confirmed R10 is unable to appropriately use and operate a call light due to the resident's medical condition. Queried the DON and ADON regarding staff's ability to hear R10's verbal noises used to alert staff for assistance given that the resident is in the last room down the hall and in the bed furthest from the door if the staff is not in the area. The DON and ADON confirmed it would be difficult for staff to hear R10 from the nursing station.

5) In the afternoon of 07/15/21, surveyor reviewed R302's facility incident reports for falls. R302 had a fall on 06/07/20 at 02:30 AM and sustained a bruise on her left hand. A fall occurred on 06/08/20 at 11:30 PM (23:30) and R302 did not have any visible injury. R302 fell in the bathroom on 06/12/20 at 2:20 PM (14:20) with no visible injury but she complained of pain to her right leg and hip. On 07/02/20 at 11:25 PM (23:35), R302 stated to staff that she fell in the bathroom, and she was found to have a skin tear on her left wrist and cut to her left knee. R302 experienced a fall on 07/03/20 at 11:45 PM (23:45) with complaints of left knee pain and no visible injury. R302 had a fall on 07/27/20 at 09:45 AM which she sustained a small lump to the left side of her head and redness to her left knee. On 08/03/20 at 2:45 PM (14:45), R302 had her final fall in the facility where she sustained a bruise on her scalp and ruptured bladder. She was transferred to an acute

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care facility on 08/04/20.

The ADON and DON were interviewed on 07/16/21 at 09:20 AM. Surveyor asked them if R302 was considered for one-to-one care with staff. The DON stated that they didn't think she needed one to one care because "when she slept, she slept very soundly." The DON further stated that R302 was difficult to care for because she was "up 20 times at night, had muscle spasms, medications for hemorrhoids, co-morbidities (other medical diagnoses) that made her feel uncomfortable and she was not a surgical candidate." Surveyor then queried the DON that if R302 was difficult to care for, then wouldn't she have one to one care? The DON stated,
"She would get tired if she had one to one care."

6) An observation of R36 was made on 07/15/21 at 09:32 AM. R36 was sitting up in bed with his eyes closed and was slow to respond when his name was called several times in a loud tone. His breakfast tray was hardly touched and sat on the rolling bedside table in front of him. A vital signs (VS) monitor (equipment to check BP and heart rate) on a rolling apparatus was placed next to his bed. He had difficulty opening his eyes and groggily stated that he needed help with his eggs. Surveyor noted that R36's call light was up high on the right side of his pillow. Surveyor asked RN12 if R36 can reach up and activate his call light. RN12 looked for R36's call light and found it on the right side of his pillow and stated, "No." CNA10 entered the room and stated, "I left him (R36) because I had to go help someone else."

7) RN9 was interviewed on 07/16/21 at 10:50 AM. She stated that there are short-staffed "because

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F 725	Continued From page 29 of the pandemic." "We have trained nurses and CNAs, but several of them left." She further stated that she does help out by covering shifts when the facility is short-staffed, but she also needs to have days off.	F 725		
F 812 SS=E	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. §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, staff interview and review of policy, the facility failed to label two containers stored in the walk-in refrigerator. Findings Include: During an observation of the kitchen walk-in refrigerator on 07/13/21 at 10:30 AM, a container of Thousand Island Dressing and a container of	F 812	Corrective Action On 7/13/21, the Food Services Director immediately disposed of the two undated containers. Identification of others The Food Service Director completed routine kitchen rounds during and since the survey with no other undated containers found.	8/6/21

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F 812	Continued From page 30 Barbeque Sauce was not labeled with the dates that they were opened. There were more than half the contents remaining for the Thousand Island Dressing, and around half the contents remaining for the Barbeque Sauce. On 07/13/21 at 10:35 AM, the Food Service Director (FSD) was queried about the two containers not being labeled. FSD acknowledged that the two containers were not labeled and should have been labeled with the dates that they were opened. FSD proceeded and removed the two containers from the shelf. A review of the facility policy on Food Safety stated: Policy, Food is stored and maintained in a clean, safe and sanitary manner following federal, state and local guidelines to minimize contamination and bacterial growth. Guidelines; food is stored a minimum of six inches off the floor, pre-packaged food is placed in a leak-proof, pest-proof, non-absorbent, sanitary (NSF) container with a tight-fitting lid. The container is labeled with the name of the contents and date (when the item is transferred to the new container). "Use by Date" is noted on the label or product when applicable. The "use by date" guide is easily accessible to all associates involved with resident food storage ...	F 812	Systemic Changes Staff were educated on the Use By Date reference tools that are posted in multiple locations in the kitchen for staff reference. The Food Services Director will complete quick morning rounds to ensure all foods are dated with the Use By Date label attached on any open refrigerated foods. The evening cook will complete the Cooks Closing Checklist every night to ensure opened refrigerated containers are labeled properly. On 8/3/21 dining staff received re-training covering the labeling requirements for refrigerated food. Monitoring The Food Services Director now completes a weekly audit of all refrigerated food items and their labeling. The chef will also do the same audit weekly, resolving any issues identified at the time of of it's finding. The audit results, along with any corrective action taken, will be presented to the QAPI committee for review and further recommendations. THE QAPI committee will determine the frequency of ongoing monitoring and achievement of compliance.	
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	F 842		8/13/21

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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;
(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

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F 842	Continued From page 32 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: Based on record review and interview, the facility failed to ensure the completion of neurological (neuro) monitoring assessments for R302 after her fall. Neuro checks provide close monitoring of possible brain injury sustained after a fall and a small change from baseline could indicate the start of brain swelling. Neuro checks were not completed as indicated in the early evening after R302's fall. She was later transferred to an acute care facility in the early morning of the next day and was found to have bleeding in her brain. Finding Includes: On 07/13/21 at 1:45 PM, surveyor reviewed the facility's Office of Health Care Assurance (OHCA) completed Event Report for a facility reported incident (FRI) about R302's fall on 08/03/20 at	F 842	Corrective Action Resident #302 no longer resides at the facility. Identification of Others A whole house audit was conducted reviewing unwitnessed falls in the facility to review for completion of neurological checks. They found 3 separate checks out of 336 neurological checks for 16 residents that the neurological checks were not completed. Systemic Changes Nurses will be educated on the necessity to complete neurological assessments in their entirety and the need to document in progress notes when there are variances in completion. The DON or her designee will review neurological assessments daily	

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F 842	Continued From page 33 2:45 PM. Details included that the certified nursing assistant (CNA) checked R302's blood pressure (BP) at "1420" or 2:20 PM that day. She had low BP. R302 was lying in bed when the CNA left the room to report to the nurse about R302's low BP. At "1445" or 2:45 PM, R302 was found lying on the floor in front of the bathroom. R302 was not responding to painful stimuli. Staff then elevated R302's legs and checked her BP, "it was low at 99/59, HR (heart rate) 100." R302 opened her eyes and became verbally responsive. The physician and daughter were notified. R302 sustained skin tears to both arms and a bruise to the "back of her scalp." A "Health Status Note" written on 08/04/20 at 07:21 (AM) by the RN revealed that R302 was sent to the emergency room (ER) at 0415 (04:15 AM). R302 was not responding verbally to the staff, and she was not following their commands to test for motor function. A "Health Status Note" documented on 08/04/20 at 10:38 (AM) showed that R302 was admitted to the hospital for bleeding in the brain and "bladder rapture" (sic). R302's "NRSG: Neurological Check List - V2" series in her EMR post fall were reviewed. They revealed that RN13 did not do pupil (eye) reaction to light checks, level of consciousness and speech checks at 5:30 PM and 7:30 PM. At 9:30 PM, RN13 did not do the pupil reaction checks. A review of the R302's progress notes for that evening was done and RN13 did not document the reason for not doing the neuro checks. The ADON and DON were interviewed on 07/16/21 at 09:20 AM in the conference room.	F 842	to ensure completion and review documentation for any exceptions. When the final neurological assessment is completed, the nurse will print it and provide a copy to the DON for review. The DON will review and identify any missing documentation, Monitoring The DON will immediately follow up with the nurse and document education up to disciplinary action. The completed neurological assessments will also be presented during the weekly Risk Assessment Review to discuss any further interventions of needed education. The DON will summarize the activities for the month in review and present to the QAPI committee for review and further recommendations. The QAPI committee will determine the frequency of the ongoing monitoring and achievement of substantial compliance.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 34 Surveyor indicated the missing documentation on the paper copies of R302's "NRSG: Neurological Check List - V 2" reviewed. The DON stated that R302 could have been sleeping at the time. Surveyor then asked the DON what happens when a lapse in assessment occurs. She stated that the nurse should document the reason for the missing neuro checks in the progress notes. The DON checked R302's progress notes on her computer and confirmed that there was no note written by RN13 regarding the incomplete neuro checks.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		8/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125045	A. BUILDING _____ B. WING _____	07/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE ANUENUE RESTORATIVE CARE	1333 WAIANUENUE AVENUE HILO, HI 96720

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F 880	Continued From page 35 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 36 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to apply standard infection control precautions to ensure the health and safety of its residents and staff working in the facility. The facility failed to appropriately isolate its residents who were newly admitted and not vaccinated for the COVID-19 when staff who was not wearing personal protective equipment (PPE) entered one resident ' s room. The facility also did not ensure that common equipment used between residents were disinfected appropriately. The deficient practices placed the residents and staff in the facility at an increased risk for disease transmission. Findings Include: 1) Surveyor made observations on 07/13/21 at 10:35 AM on the W Unit. Surveyor noted a yellow line was taped to the floor that indicated the rooms past that line were for residents on contact/ droplet precautions. There were PPE signs that indicated staff were only to enter the room wearing full PPE (gown, gloves, mask, and face shield) were posted outside of the door of Room 406. The resident in the room was a new admission and not vaccinated against the COVID-19 on contact/ droplet precautions. A staff was observed in the room wearing a blue surgical mask and no PPE. The staff was putting laundry in the closet and talking to the resident. Surveyor asked the ADON who was outside the room for confirmation that any staff or person entering the room is supposed to be wearing	F 880	Corrective Action The associate identified was given and individual education 7/13/21. No residents were directly affected. Identification of others A whole house audit was conducted with no residents identified at risk. Systemic Changes A clear passable barrier will be replaced in the doorway of each isolated room to clearly identify to anyone entering of the isolation status of each specific room. Staff were educated on 7/21,22,28 and 29/21 including the proper use of PPE during, as well as sanitizing the Vital Sign Machine in between residents, which included access to the appropriate disinfectant. Staff observations were initiated on 8/4/21 to ensure compliance. A visual reminder was placed on each vital machine reminding staff to sanitize in between each resident's use. Additionally, staff received education reviewing proper disinfecting practices and ensuring the disinfectant is immediately available to each associate. Monitoring Staff observations were initiated on 8/4/21 to ensure compliance. The DON/designee will audit PPE use and Vital Sign Machine disinfection, with compliance audits for 2 weeks, and documented spot training up to disciplinary action for noncompliance as needed. The audit results, along with any	

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F 880	Continued From page 37 PPE. The ADON said yes then asked the staff to put on her PPE, and that she is in an isolation room. The staff quickly left the room and said she was in the wrong resident room. 2) On 07/13/21 at 2:35 PM, CNA50 was noted to be pushing the rolling VS monitor into R36's room and stated to R36 that she had to take his BP. At 2:39 PM, she was observed leaving R36's room and knocked on the door of R39's room rolling the VS monitor into her room. CNA50 did not disinfect the VS equipment prior to using it on R36. In a query with the restorative nursing assistant (RNA) on 07/16/21 at 10:45 AM, she stated, "Some staff wipe it and some staff don't. There is supposed to be a spray bottle on here (indicating to the VS monitor's basket) to wipe down."	F 880	corrective action, will be presented to the QAPI committee who will determine the frequency of ongoing monitoring and achievement of substantial compliance.	
F 908 SS=E	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, review of equipment service manual, and review of policy, the facility failed to: ensure routine maintenance, cleaning of the air particle filter, based on the manufacturer's recommendation, for one of four oxygen concentrators reviewed. This deficient practice put Resident (R) 98 at risk for the development and transmission of communicable diseases and infections, and 2. Ensure routine maintenance, cleaning of the air conditioner vents located in the kitchen.	F 908	Corrective Action All Oxygen Concentrators were checked and cleaned as needed on 7/15/21. Air conditioner vents were cleaned immediately on 7/13/21. Identification of Others All residents receiving oxygen via concentrator could potentially be affected. Systemic Changes All oxygen concentrator in use were check with the external filters cleaned on	8/5/21

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F 908	Continued From page 38 Findings Include: 1) During an observation, on 07/15/21 at 09:30 AM, of R98's room, a NewLife Elite Oxygen Concentrator was noted at bedside providing oxygen to R98. The air particle filter located on the back of that oxygen concentrator appeared dirty with dust on it. A review of the Electronic Health Record (EHR) showed that R98 was admitted on 04/10/19 with a diagnosis of Chronic Obstructive Pulmonary Disease, Dependence on Supplemental Oxygen, Long term use of systemic Steroids, Hypertension, Hyperlipidemia, Dementia. R98 had a doctor's order to use oxygen. On 07/15/21 at 10:00 AM, Licensed Practical Nurse (LPN) 6 was queried about the air particle filter cleaning process. LPN6 stated that the nursing staff did not clean that filter and that the Central Supply Department was responsible for that. On 07/15/21 at 10:30 AM, Central Supply (CS) Director was queried about the air particle filter cleaning process. CS Director stated that they had a cleaning process but was not aware if that process included cleaning the filters. CS Director acknowledged that the air particle filter for R98 was not cleaned and/or changed out. On 07/16/21 at 01:00 PM, a review of the Service manual for the NewLife Elite Oxygen Concentrator - Filters stated the following: Routine maintenance by the patient. To ensure accurate output and efficient operation of the unit, the patient must perform two simple routine	F 908	7/15/21. The resident's Treatment Administration Record (TAR) was updated with a check order which the resident's nurse will complete a cleaning check and document completion of the check daily. Central Supply Associate who is responsible for this task completion was re-educated on 7/29/21 regarding her responsibility for weekly cleaning of the exterior of the concentrators and washing the filters each week, and more as needed. The Food Serviced Director established a cleaning schedule to check vents for cleaning, monitoring with frequencies on a daily, weekly, monthly and periodic basis, unless otherwise indicated. Monitoring DON/designee will conduct ongoing monitoring of the completion of the daily checks by the nurse, as well as visualize concentrators randomly to ensure it's condition. The Food Service Director monitor the cleaning schedule daily and report any findings to the Executive Director. The ED will randomly check the posted cleaning schedule to validate completion. Audits, along with any corrective action, will be presented to the QAPI committee for review and recommendations. THE QAPI committee will determine the frequency of ongoing monitoring and achievement of substantial compliance.	

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F 908	Continued From page 39	F 908		

maintenance tasks: clean the air intake gross particle filter, check the alarm system battery. Cleaning the air intake gross particle filter, Note, the patient must clean this filter weekly, as described below. The filter may require daily cleaning if the NewLife unit operates in a harsh environment such as a house heated by wood, kerosene, or oil, or one with excessive cigarette smoke ...

A review of the facility policy on Oxygen Administration, Safety, Storage, Maintenance, stated the following: Policy ... Infection Control, change oxygen supplies weekly and when visibly soiled. Equipment should be labeled with patient name and dated when setup or changed out ... Clean exterior of concentrators weekly with an EPA registered hospital disinfectant. The concentrator must be stationed where there is free air movement. External filter should be checked daily and all dust should be removed. Filters should be washed with soap and water once each week and PRN. Dry with a towel and reinsert. Discard and replace when damaged.

2) During an observation 07/13/21 at 10:45 AM of the kitchen, the four air conditioner vents appeared to be dirty. The vents contained a dark brown/black material on the surface at the output air flow opening.

The Food Service Director (FSD) was queried on 07/13/21 at 10:50 AM and stated that the kitchen staff did not do the cleaning of the vents and did not know who was responsible for that.
Later, FSD acknowledged that the routine maintenance, cleaning of the air conditioner vents were not being done.

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F 908	Continued From page 40 A review of the facility policy on Sanitation and Maintenance stated; Policy, The Director of Food and Nutrition Services is responsible for ensuring that the department is maintained according to the standards of sanitation and in compliance with federal, state and local requirements. Guidelines, food and nutrition services associates are trained in the proper use, cleaning and sanitation of all equipment and utensils ... Procedures for cleaning equipment are readily available to all associates. The Director of Food and Nutrition Services develops a cleaning schedule and posts the schedule each month ... Physical facilities are cleaned as often as necessary to keep them clean. Cleaning is done during periods when the least amount of food is exposed. Mops and brooms are hung when not in use in designated areas ... A review of the facility policy on Cleaning Schedule stated; Policy, The Director of Food and Nutrition Services develops a cleaning schedule, with assistance from the Registered Dietitian, to ensure that the Food and Nutrition Services department remains clean and sanitary at all times. Guidelines, the Director of Food and Nutrition Services develops a cleaning schedule to include all equipment and areas to be cleaned. Designated cleaning tasks are assigned to each position. The cleaning schedule is posted in a location where it can be easily read. The Director of Food and Nutrition Services monitors the cleaning schedule to ensure the tasks are completed timely and appropriately.	F 908		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System	F 919		8/11/21

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F 919	Continued From page 41 The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure R36's safety by not placing his call light within his reach to help him alert staff for help. R36 could have potentially suffered further injury due to his history of falls and after receiving strong pain medication. Finding Includes: An observation of R36 was made on 07/15/21 at 09:32 AM. R36 was sitting up in bed with his eyes closed and he was slow to respond when his name was called several times in a loud tone. His breakfast tray was hardly touched and sat on the rolling bedside table in front of him. A vital signs (VS) monitor (equipment to check BP and heart rate) on a rolling apparatus was placed next to his bed. He had difficulty opening his eyes and groggily stated that he needed help with his eggs. Surveyor noted that R36's call light was up high on the right side of his pillow. Surveyor asked RN12 if R36 can reach up and activate his call light. RN12 looked for R36's call light and found it on the right side of his pillow and stated, "No." CNA10 entered the room and stated, "I left him (R36) because I had to go help someone else." RN12 agreed that before CNA10 left the room, she should have placed R36's pancake call light within his reach to call for help.	F 919	Corrective Action Resident #36 received a screen completed by the Director of Rehab to assess his capabilities, and the effectiveness of his call light equipment. She determined that an alternate placement option would be more effective and accessible to him. The care plan was updated to include the new placement option. Identification of Others A whole house audit was completed on 8/5/11 regarding call lights and proper placement identifying eleven residents who had a potential to be at risk. Systemic Changes The audit included a review of who could use a push button call light. Anyone who was unable to received a pancake light. Additionally, placement of the call light accessible to the resident is being reviewed, with care plan updated as needed, and staff advised. For any residents unable to use a call light, they will be placed on hourly checks which will be logged on a check sheet in resident bathrooms. Staff will be educated and trained during daily shift huddles. Monitoring The DON/designee will conduct random	

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F 919	Continued From page 42 In a follow up observation of R36 on the same day at 12:53 PM, he was sitting up high in bed with his eyes half open, being assisted with his lunch by RN12. His pancake call light was in his hands. She stated that R36 was still sleepy due to a pain medication given in the morning. A review of R36's EMR was done at 08:50 AM on 07/16/21. A review of "Event Notes" in R36's progress notes revealed that R36 had sustained a fall on 07/15/21 at 08:03 AM. He had two open areas to his 4th and 5th toes on his right foot. Further review of his medication administration record (MAR) showed that he was given Norco (strong pain medication) 5-325 mg (milligram) at 08:48 AM of that same morning. A subsequent review of R36's care plan was done. Under "Focus - FALLS: Resident is at risk for falls due to impaired balance, hx (history) of falls, RLE (right lower extremity) cellulitis (serious bacterial infection of the skin), LE (lower extremity) venous stasis ulceration. Date initiated: 01/06/21," "Goal - The resident will not sustain serious injury requiring hospitalization through the review date. Date Initiated 01/06/2021," "Interventions/Tasks ...Call light within reach. Remind frequently to call and wait for assistance as needed. Date Initiated: 01/06/2021."	F 919	focused rounds daily to ensure proper call light placement, as well as monitor all hourly check in logs for residents who are not able to use a call light. She will also monitor care plans no less that monthly to ensure proper interventions are in place and included in the Kardex. Audit results, along with any corrective action taken, will be presented to the QAPI committee for review and further recommendations. The QAPI committee will determine the frequency of ongoing monitoring and achievement of substantial compliance.	

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E 000	Initial Comments A recertification survey was conducted by the Office of Healthcare Assurance (OHCA) on 07/13/21 to 07/16/21. The facility was found to be in substantial compliance with Appendix Z, Emergency Preparedness, §42 CFR 483.73 for long term care facilities.	E 000		

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

Electronically Signed | 08/09/2021

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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	125045	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/19/2021**

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K 000	INITIAL COMMENTS THIS FACILITY MET THE REQUIREMENTS OF THE 2012 EDITIONS OF: NFPA 99, HEALTH CARE FACILITIES CODE AND NFPA 101, LIFE SAFETY CODE, CHAPTER 19, EXISTING HEALTH CARE OCCUPANCIES.	K 000		

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

Electronically Signed | 11/01/2021

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

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E 000	Initial Comments THIS FACILITY MET THE LIFE SAFETY REQUIREMENTS OF APPENDIX "Z"; IN ACCORDANCE WITH CFR 483.73, REQUIREMENT FOR LONG-TERM CARE (LTC) FACILITIES	E 000		

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