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	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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4 000	Initial Comments The State Agency (SA) conducted a re-licensing survey on 07/16/21. The facility was not in compliance with Hawaii Administrative Rules, Title 11, Chapter 94.1, for Nursing Facilities. The State Agency 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 ACTS #8837 was substantiated. The facility reported a census of 104 residents at the entrance conference.	4 000		
4 115	11-94.1-27(4) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to ensure a resident's right to a dignified existence. The facility did not assure Resident (R)10 was	4 115	Corrective Action Resident #10's communication care plan was reviewed and updated on 8/5/21, reflecting communication skills he	8/11/21

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4 115	Continued From page 1 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: 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. As a result of R10's medical diagnoses, R10 is totally dependent on staff for all care, is unable to verbalize needs, and is unable to appropriately use a call light button. 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	4 115	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 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	

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4 115	Continued From page 2 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 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	4 115	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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4 115	Continued From page 3 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 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	4 115		

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4 115	Continued From page 4 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 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. 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.	4 115		
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	4 159		8/6/21

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4 159	Continued From page 5 proper temperatures to conserve nutritive value and prevent spoilage. This Statute 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 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	4 159	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. 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	

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4 159	Continued From page 6 product when applicable. The "use by date" guide is easily accessible to all associates involved with resident food storage ...	4 159	monitoring and achievement of compliance.	
4 176	1-94.1-43(d) Interdisciplinary care process (d) Implementation of the overall plan of care shall be documented in each resident's medical record. This Statute is not met as evidenced by: Based on observations, 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 potential of a negative impact on the resident's quality of life, as well as quality of care and services received. Findings Include: 1) 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,	4 176	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. 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	8/13/21

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4 176	Continued From page 7 dysphagia, and tachycardia. 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 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	4 176	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 fore review and further recommendations. The QAPI committee will determine the frequency of ongoing monitoring and achievement of substantial compliance.	

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4 176	Continued From page 8	4 176		

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 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

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4 176	Continued From page 9 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) Regarding observations on 07/15/21 at 2:40 PM 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.	4 176		

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4 176	Continued From page 10 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 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	4 176		

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) COMPLETE DATE
4 176	Continued From page 11 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 (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."	4 176		