

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

PRINTED: 10/05/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125038</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/12/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALOHA NURSING &amp; REHAB CENTRE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>45-545 KAMEHAMEHA HIGHWAY KANE OHE, HI 96744</b>		
(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  A recertification survey was conducted by the Office of Health Care Assurance (OHCA). The facility was found not to be in substantial compliance with 42 CFR 483 Subpart B. Complaints from the Aspen Complaint Tracking System (ACTS) #8713 and #9012 were found to be substantiated; #8141 and #8923 were found to be unsubstantiated.  Survey Dates: August 09 to August 12, 2021  Survey Census: 103  Sample Size: 23	F 000			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)  §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.  §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.  §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		9/30/21	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/21/2021

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

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F 550	<p>Continued From page 1</p> <p>provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review, the facility failed to treat Resident (R)13 and R80 with respect and dignity by not providing care in a manner that promotes maintenance of their quality of life. R13 was not provided appropriate and timely personal care that should have included daily grooming. R80 enjoyed crafting and creating decorative objects, which is part of his individuality. The deficient practice robs R13 and R80 of their self-worth and has the potential to affect all residents in the facility.</p> <p>Findings include:</p> <p>1) Surveyor made observations on 08/09/21 at 08:16 AM and R13 was noted to be in his bed lying on his back, facing the right side. Christmas decoration was on his bedside table with a few</p>	F 550	<p>F-550 Resident Rights/ Exercise of Rights</p> <p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility <input type="checkbox"/>s credible allegation of compliance.</p> <p>1) Address how corrective action will be accomplished for those residents found to</p>		

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F 550	<p>Continued From page 2</p> <p>other items dusty and in disarray. He was wearing a hospital type gown that was bunched up in a wad on his chest. His hair looked unclean and uncombed. His knees were tightly bent up under him and facing to the right side. His left leg was outside of the sheet, excoriations were observed on his lower leg.</p> <p>A second observation was made at 10:53 AM. R13 was in the same position. (Refer to F677)</p> <p>Surveyor made additional observations on 08/10/21 to 08/12/21 throughout the day shift and into the evening shift. Noted that R13 was in his bed in his hospital gown and appeared with the same disheveled hair.</p> <p>On 08/12/21 at 10:06 AM, surveyor interviewed two staff (S)45 and S34 who requested to remain anonymous. Surveyor asked S45 how often are the showers and personal care being done for R13? S45 responded that today we have three certified nurse aides (CNA) assigned to this side and one who floats between the two sides. We try to do personal care when we make our rounds, baths are usually given two to three times a week. This is the heaviest floor; we really need at least four CNA's because the residents are heavier and more dependent. Sometimes we just can't get to everything, and they don't get all the personal care.</p> <p>S34 stated that she would like to have more time to provide more personalized care to the residents like grooming and cleaning nails. We are often short staffed, there's just no time for those things. (Refer to F725)</p> <p>2) An initial observation of R80 was made on 08/09/21 at 10:48 AM. R80 was sitting upright in bed, sleeping with his television set on the</p>	F 550	<p>have been affected by the deficient practice.</p> <ul style="list-style-type: none"> <li>- On 9/10/21 Resident R13 was assessed for appropriate personal care of grooming and appearance by the Director of Nursing (DON). The resident was observed to have had a bed bath, he was neatly groomed with clean gown on, his bedside table was tidied, and the Christmas decoration was removed and stored. Residents comprehensive care plan reflects the resident's preference to wear gown.</li> <li>- On 9/14/21 The Therapeutic Recreation (TR) manager assisted Resident R80 with a crafting activity of the resident's choice.</li> <li>- On 9/15/21 Resident R80 was interviewed by the TR designee regarding the resident's activity preferences and crafting activity schedule.</li> <li>- A personalized activities schedule was created for Resident R80 (refer to attached document); this schedule is subject to change according the resident's preference &amp; identified reasonableness.</li> <li>- Staff has been educated on the Resident Rights of a dignified existence, self-determination, and the right to exercise his or her rights as a resident of the facility - Staff is to provide residents with care in a manner that promotes maintenance of their quality of life to promote their self-worth.</li> </ul>		

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F 550	<p>Continued From page 3</p> <p>channel and program guide. A hand made sign made with wire and numerous other wire craft objects were in his room. His partially eaten breakfast remained on a tray located on his bedside table at the side of his bed.</p> <p>R80 was interviewed on 08/10/21 at 12:00 PM in his room. R80 stated that he created the wire decorative objects in his room by hand with wire hangers. He stated that he had the tools to create his crafts but had been unable to use them. His tools were locked up at the facility because they were considered dangerous and could only be used when he was supervised. He stated that he could use them previously and staff would supervise him but thinks that he was now unable to because "they don't have enough staff."</p> <p>An interview was done with the Therapeutics Recreations Manager (TRM) on 08/12/21 at 09:12 AM in the training room. She stated that the facility had R80's soldering iron, pure alcohol and glue. The therapeutics recreation (TR) staff or social services (SS) would help to supervise R80 while he was utilizing these items to create his craft projects. She further stated, "He takes so long to get ready. We try to allocate the time for him."</p> <p>R80's "TR Routine Roster" report for the dates of 06/12/21 to 08/12/21 was reviewed on 08/12/21 at 11:00 AM. There were no activities documented for the month of August.</p> <p>In a follow-up interview with the TRM at 11:17 AM in the conference room, she stated that activities with the residents are documented when the TR staff does or upon completion of the activity with the resident. (Refer to F679).</p>	F 550	<p>2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <ul style="list-style-type: none"> <li>- The alleged practice has the potential to affect facility residents.</li> <li>- To identify other residents having the potential to be affected by the identified deficient practice, the F-550 Dignity Personal Care Tracking Tool (Grooming, Bedside Table, Activities Participation) has been created (refer to attached document). Comprehensive care plans will be updated as needed to incorporate resident preferences according to the findings.</li> <li>- Furthermore, managers of the interdisciplinary team are to monitor and manage compliance by performing random assessments of compliance during completion of weekly auditing with use of the referenced tool</li> <li>- Completed forms are to be kept in a binder in the Nursing Home Administrator's (NHA's) office or designee.</li> </ul> <p>3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> <li>- To ensure quality assurance and</li> </ul>		

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F 550	Continued From page 4	F 550	<p>effectiveness, staff were in-serviced regarding Residents Rights to a dignified existence, self-determination and care preferences to promoting quality of life. Comprehensive care plans will be updated to incorporate resident preferences.</p> <p>- In-services will be ongoing as needed.</p> <p>4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.</p> <p>- Unit Manager will review Resident R13's personal care activity for four weeks to ensure that the facility is meeting the daily personal care activities and care needs of the resident. Findings will be reviewed with members of the interdisciplinary team (IDT) team, and staff is to be educated as needed.</p> <p>- TR Manager will audit Resident R80's weekly therapeutic activity attendance for four weeks to ensure that the facility is supporting the resident's right to meaningful activities.</p> <p>- To ensure quality assurance and effectiveness of promoting dignity and upholding the residents' rights for</p>		

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F 550	Continued From page 5	F 550	<p>systemic changes, ongoing monitoring and random evaluation with application of the Dignity Personal Care Tracking Tool (Grooming, Bedside Table, Activities Participation) will be completed.</p> <ul style="list-style-type: none"> <li>- Completion of this tool is to occur weekly x 1 month, bimonthly x 1 month and monthly x 1 month for a minimum of 12 weeks to ensure compliance.</li> <li>- Corrective action is to be taken immediately and staff education is to be provided as deemed necessary.</li> <li>- To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved.</li> <li>- If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met.</li> <li>- Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate.</li> </ul> <p>Included dates when corrective action will be completed:</p> <ul style="list-style-type: none"> <li>- Corrective action completion date by Nursing Home Administrator and/or</li> </ul>		

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F 550	Continued From page 6	F 550	designee.		
F 558 SS=D	<p>Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)</p> <p>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to accommodate R88 with services needed to ensure optimal health and safety. R88 was not provided a large enough bed to accommodate his size.</p> <p>Findings include:</p> <p>During an interview with R88 on 08/10/21 at 1:04 PM, R88 stated that he needed a comfortable bed. "I have pain to my lower back that radiates to my legs. The pain medication helps." Surveyor noted the bed looked small for R88, observing that his head was all the way to the top of the mattress and his feet were against the footboard. His overweight stature took up most of the space on the mattress which made it difficult for R88 to turn and reposition. R88 stated that he doesn't think it (his bed) was the right size for a 6-foot-tall man.</p> <p>On 08/11/21 at 3:40 PM surveyor observed the occupational therapist (OT) was conducting left hand exercises with R88 at the bedside. Surveyor asked the OT if she thought the bed was too small for the resident, and pointed out</p>	F 558	<p>F558 Reasonable Accommodations Needs/Preferences</p> <p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility's credible allegation of compliance.</p> <p>1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>- Upon notification of the deficient practice, a message was left for the VA Liaison to request for a larger bed.</p>	9/30/21	

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F 558	Continued From page 7 that his head goes all the way up to the top and his feet touch the foot board. The OT responded that she could mention to the nurse about looking into the concern that the bed may be too small for R88.	F 558	<ul style="list-style-type: none"> <li>- On 8/16/21, upon follow up with the VA Liaison, a request was submitted to the VA for a larger bed and air mattress for Resident R88.</li> <li>- Facility staff were educated on the Residents Rights to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.</li> <li>- Facility inquired with vendors for longer bed to accommodate R88's size, however vendors confirmed they do not have longer bed than what the facility can provide.</li> <li>2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</li> <li>- The alleged practice has the potential to affect facility residents.</li> <li>- A facility-wide audit was conducted to identify potentially affected residents who are equal to or more than 6 ft. tall in height.</li> <li>- A review of all residents on the census was completed to determine which residents may be affected; five other residents were identified to be 6 ft. or taller in height.</li> <li>- These residents were assessed for their</li> </ul>		



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F 558	Continued From page 8	F 558	<p>bed length to accommodate their size; none of these residents were identified as having an inappropriate bed size. All of these five residents stated that they were comfortable in their beds.</p> <p>- To identify other residents having the potential to be affected by the identified deficient practice, the F-558 Reasonable Accommodation Needs/Preferences: Appropriate Bed Length for Residents 6 Feet or Taller audit form has been created</p> <p>- Furthermore, Social Services, Admission's Coordinator, or designee are to monitor and manage compliance by completing and updating the above referenced auditing tool.</p> <p>- Completed forms are to be kept in a binder in the Nursing Home Administrator's (NHA) office or designee.</p> <p>- On 9/27/21, Social Worker, completed the F-558 Reasonable Accommodation Needs/Preferences: Appropriate Bed Length for Residents 6 Feet or Taller form.</p> <p>3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>- To ensure quality assurance and effectiveness, facility staff were educated on the Residents Rights to reside and receive services in the facility with reasonable accommodation of resident</p>		

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F 558	Continued From page 9	F 558	<p>needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This included the right to be provided with a large enough bed to accommodate his/her size.</p> <p>-In-services will be ongoing as needed.</p> <p>4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.</p> <p>- To ensure quality assurance and effectiveness of providing our residents with reasonable accommodation of resident needs and preferences for systemic changes, ongoing monitoring and evaluation with application of the F-558 Reasonable Accommodation Needs/Preferences: Appropriate Bed Length for Residents 6 Feet or Taller form will be completed.</p> <p>- Completion of this tool is to occur with all admissions of residents who are 6 ft. or taller, and with any room change occurrence to ensure resident comfort and compliance.</p> <p>- Corrective action is to be taken be taken immediately and staff education is to be provided as deemed necessary.</p>		

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F 558	Continued From page 10	F 558	<ul style="list-style-type: none"> <li>- To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved.</li> <li>- If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met.</li> <li>- Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and address as deemed appropriate.</li> </ul> <p>Includes dates when corrective action will be completed:</p> <ul style="list-style-type: none"> <li>- Corrective action will be complete by Nursing Home Administrator and/or designee.</li> </ul>		
F 561 SS=D	<p>Self-Determination CFR(s): 483.10(f)(1)-(3)(8)</p> <p>§483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section.</p> <p>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and</p>	F 561		9/30/21	

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NAME OF PROVIDER OR SUPPLIER  <b>ALOHA NURSING &amp; REHAB CENTRE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>45-545 KAMEHAMEHA HIGHWAY KANEHOE, HI 96744</b>		
(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 561	<p>Continued From page 11</p> <p>waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.</p> <p>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.</p> <p>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, interviews and record review, the facility failed to ensure the resident's right to promote and facilitate resident's self-determination through support of resident's choice about aspects of her life that are significant to the resident for one resident in the sample, R103. R103 stated she preferred to wake up prior to breakfast, comb her hair, brush her teeth, and wash her face prior to eating breakfast but the resident's choice was not accommodated. As a result of this deficient practice, the resident is at risk of potential for increased weight loss and potential psychosocial outcomes.</p> <p>Findings include:</p> <p>On 08/09/21 at 08:35 AM, an interview was</p>	F 561	<p>F561 Self Determination</p> <p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility's credible allegation of compliance.</p> <p>1) Address how corrective action will be accomplished for those residents found to</p>		

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F 561	<p>Continued From page 12</p> <p>conducted with R103 in the resident's room. R103 stated at home, she would wake up, get cleaned up (i.e., brush teeth, comb hair, wash face, and change clothes) then eat breakfast. The resident further explained that after waking up with morning breath, the food does not taste good. R103 had made a request with the facility to "clean up and brush my teeth, but I need the staff's help and they aren't able to help me at times." R103 pointed out the breakfast on the resident's bedside table and that the resident had not been helped with brushing her teeth despite asking staff for help.</p> <p>On 08/11/21 at 09:00 AM, an interview was conducted with registered nurse (RN)19. RN19 confirmed, R103 could make her needs known and staff try to assist the resident with all requests made. However, there is only one RN and one certified nurse aide (CNA) assisting residents and although staff try, staff are not always able to assist residents as needed.</p> <p>Conducted a concurrent interview with the Director of Nursing (DON) and review of R103's electronic medical record (EMR) on 08/11/21 at 12:13 PM. An admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/29/21 documented in Section G. Functional Status, R103 required extensive assistance of 2+ person for transferring and extensive assistance with 1-person physical assistance for dressing and eating. Section 04.000 Functional Limitation in Range of Motion documented R103 had impairment on both sides of the upper and lower extremities. Review of R103's care plan documented the resident was autonomous in her daily routine which the DON explained indicated the resident was able to</p>	F 561	<p>have been affected by the deficient practice.</p> <p>-R103 discharged on 9/7/21 prior to receipt of 2567; therefore, the facility was unable to interview the resident and update care preferences and schedule.</p> <p>- To protect residents in similar situations, the facility staff were educated regarding Resident Rights including, but not limited to, the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, which included the residents' right to choice of activities, schedule, health care services and providers. The facilities obligation to support, protect and promote the rights of each resident.</p> <p>2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>- The alleged practice has the potential to affect facility residents.</p> <p>- To identify other residents having the potential to be affected by the identified deficient practice, the Aloha Nursing &amp; Rehab Centre (ANRC) Resident Focus Round was created.</p> <p>- The DON or designee is to monitor and manage compliance by performing random assessments of compliance during weekly completion of the Aloha</p>		

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F 561	Continued From page 13 control what she does from day to day. Shared R103's interview with the DON, and the DON confirmed R103 was unable to perform activities of daily living (ADL) independently and if the resident was requesting help with ADLs prior to breakfast, staff should honor the resident's request. (Refer to F725)	F 561	Nursing & Rehab Centre (ANRC) Resident Focus Round auditing tool.  - Completed forms are to be kept in a binder in the Nursing Home Administrator's (NHA's) office or designee.  3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?  - To ensure quality assurance and effectiveness, and to protect residents in similar situations, the facility staff were educated regarding Resident Rights including, but not limited to, the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, which included the residents' right to choice of activities, schedule, health care services and providers. The facilities obligation to support, protect and promote the rights of each resident.  - The identified care and schedule preferences will be incorporated into the resident's comprehensive care plan.  - To promote individualized care and residents' choices, upon admission and during the initial care plan meeting, the residents and/or responsible party will be interviewed in regards to care and schedule preferences. The identified care and schedule preferences will be		

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F 561	Continued From page 14	F 561	<p>incorporated into resident comprehensive care plan.</p> <ul style="list-style-type: none"> <li>- In-services will be conducted with licensed and non-licensed staff at new hire orientation and, at least, annually by the Director of Nursing (DON) or designee to include supporting the residents' right to a dignified existence, self-determination, and schedule preferences.</li> <li>- In-services will be ongoing as needed.</li> </ul> <p>4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.</p> <ul style="list-style-type: none"> <li>- To ensure quality assurance and effectiveness of promoting the wellbeing of our residents, and upholding the residents' rights for systemic changes, ongoing monitoring and random evaluation with application of the Aloha Nursing &amp; Rehab Centre (ANRC) Resident Focus Round auditing form will be completed.</li> <li>- Completion of this tool is to occur weekly x 1 month, bimonthly for 1 month and monthly x 1 month by the DON or designee for a minimum of 12 weeks to</li> </ul>		

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F 561	Continued From page 15	F 561	<p>ensure compliance.</p> <ul style="list-style-type: none"> <li>- Corrective action is to be taken immediately and staff education is to be provided as deemed necessary.</li> <li>- To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved.</li> <li>- If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met.</li> <li>- Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate.</li> </ul> <p>Included dates when corrective action will be completed:</p> <ul style="list-style-type: none"> <li>- Corrective action completion date by Nursing Home Administrator and/or designee.</li> </ul>		
F 572 SS=E	<p>Notice of Rights and Rules CFR(s): 483.10(g)(1)(16)</p> <p>§483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and</p>	F 572		9/30/21	



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F 572	<p>Continued From page 16</p> <p>responsibilities during his or her stay in the facility.</p> <p>§483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.</p> <p>(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.</p> <p>(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.</p> <p>(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interviews and record reviews, the facility failed to provide R18 education about resident rights (RR). This deficient practice failed to give R18 the capability to protect his rights in the facility and has the potential to affect most of the residents.</p> <p>Findings include:</p> <p>R18's EMR was reviewed on 08/09/21 at 1:14 PM. R18 is a 65-year-old male admitted to the facility on 02/03/17 for the inability to move his legs and lower body. On MDS with ARD of 07/22/21, he scored "15" for his Brief Interview for Mental Status (BIMS), out of a maximum of 15, meaning he is cognitively intact.</p> <p>An interview was conducted with R18 at the front entrance of the facility on 08/10/21 at 10:19 AM. He was reviewing a paper that contained</p>	F 572	<p>F572 Notice of Rights and Rules</p> <p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility's credible allegation of compliance.</p> <p>1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p>		

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F 572	<p>Continued From page 17</p> <p>communication about him to the outpatient physical therapy. While concurrently reading his medical diagnoses, he stated, "What are all these diagnoses?! I don't have these!" R18 was upset. He was queried whether he knew that he had the right to review his medical record at the facility. He stated that he didn't know that he could do so.</p> <p>The resident council (RC) meeting agenda for 07/21/21 was reviewed on 08/10/21 at 3:00 PM. Entry noted, "Resident rights: Handout available (See [TRM])."</p> <p>A follow up interview was done with R18 on 08/12/21 at 08:10 AM in his room. He stated that he doesn't like to attend the RC meetings and staff had not spoken to him about RR. He also stated that he had not seen any other information about RR in the facility.</p> <p>An interview was done with the Quality and Compliance Manager (QCM) in the conference room on 08/12/21 at 10:49 AM. She stated that RR are discussed in the RC meeting and a handout is given. She was queried of the facility's process for providing this information to residents who do not want to or are unable to attend the RC meetings. She stated that the TR department is responsible for providing information about resident rights (RR) to all residents in the facility.</p>	F 572	<p>- On 9/17/21, Resident R18 was provided with education of the Resident Rights, and a handout was provided to Resident R18. The Licensed Social Worker explained to Resident R18 that he has the right to ask the facility for a copy of his medical records.</p> <p>- On 9/17/21, associates of the Therapeutic Recreation Department provided copies of the Residents Rights to each resident. Reasonable accommodations to address language barriers, hearing, and visual difficulties were offered; verbal translation of Resident Rights, printed copy of Residents Rights in various languages, and larger print of the Residents Rights.</p> <p>- On 9/26/21, the activities staff were in-serviced regarding educating the residents on their rights each month during Resident Council Meeting with review of the Residents Rights.</p> <p>- To protect residents in similar situations, the facility staff were educated regarding providing the residents with notice of rights and services to the resident prior to or upon admission and during the resident's stay.</p> <p>- A copy of the Residents Rights document is provided to the resident and/or resident's representative prior to or upon admission to the facility.</p> <p>2) Address how the facility will identify</p>		

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F 572	Continued From page 18	F 572	<p>other residents having the potential to be affected by the same deficient practice.</p> <ul style="list-style-type: none"> <li>- The alleged practice has the potential to affect facility residents.</li> <li>- To identify other residents having the potential to be affected by the identified deficient practice, the Aloha Nursing &amp; Rehab Centre (ANRC) Resident Focus Round was created.</li> <li>- The DON or designee is to monitor and manage compliance by performing random assessments of compliance during weekly completion of the Aloha Nursing &amp; Rehab Centre (ANRC) Resident Focus Round auditing tool.</li> <li>- Completed forms are to be kept in a binder in the Nursing Home Administrator's (NHA's) office or designee.</li> </ul> <p>3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> <li>- To ensure quality assurance and effectiveness, and to protect residents in similar situations, the facility staff were educated regarding Resident Rights including, but not limited to, providing the residents with notice of rights and services to the resident prior to or upon admission and during the resident's stay.</li> </ul>		

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F 572	Continued From page 19	F 572	<ul style="list-style-type: none"> <li>- In-services will be ongoing as needed, and will also be conducted with licensed and non-licensed staff at new hire orientation and, at least, annually by an activities staff or designee.</li> <li>- A designated location in the common area was selected to post Resident Rights information to ensure easy access and visibility to residents and their responsible parties when in the facility.</li> <li>- The facility will continue to provide a copy of Resident Rights and review its contents with the resident and/or responsible party upon admission.</li> <li>- A copy of Resident Rights will be distributed during monthly Resident Council Meetings.</li> <li>- Residents Rights will be reviewed and acknowledged with residents and/or their responsible parties during care plan meetings.</li> </ul> <p>4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.</p> <ul style="list-style-type: none"> <li>- To ensure that correction was achieved, all of the residents currently residing in the</li> </ul>		

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F 572	Continued From page 20	F 572	<p>facility were given a copy their rights and an overview of their rights was completed by an associate of the activities department. - Facility staff were in-serviced on providing Residents' Rights to the resident and their responsible party upon admission and during their stay.</p> <p>- To ensure quality assurance and effectiveness of promoting the wellbeing of our residents, and upholding the residents' rights for systemic changes, ongoing monitoring and random evaluation with application of the Aloha Nursing &amp; Rehab Centre (ANRC) Resident Focus Round auditing form will be completed.</p> <p>- Completion of this tool is to occur weekly x 1 month, bimonthly x 1 month and monthly x 1 month by the DON or designee for a minimum of 12 weeks to ensure compliance.</p> <p>- Corrective action is to be taken immediately and staff education is to be provided as deemed necessary.</p> <p>- Additionally, the facility's Therapeutic Manager will review and audit Resident Council Minutes to ensure that the Residents Rights are covered at every Resident Council Meeting. Corrective measures and education to be taken with any deficient findings.</p> <p>- To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance</p>		

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F 572	Continued From page 21	F 572	<p>Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved.</p> <p>- If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met.</p> <p>- Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate.</p> <p>Included dates when corrective action will be completed:</p> <p>- Corrective action completion date by Nursing Home Administrator and/or designee.</p>		
F 574 SS=E	<p>Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi)</p> <p>§483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:</p> <p>(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -</p> <p>(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;</p> <p>(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of</p>	F 574		9/30/21	

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F 574	Continued From page 22 resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under	F 574			

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F 574	<p>Continued From page 23</p> <p>Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;</p> <p>(v) Contact information for the Medicaid Fraud Control Unit; and</p> <p>(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and interviews, the facility failed to provide contact information of pertinent State agencies that were visible to the residents. The deficient practice rendered the residents incapable of contacting advocacy groups for assistance if the facility failed to protect their rights.</p> <p>Finding includes:</p> <p>On initial observations of the facility on 08/09/21 at 09:30 AM, surveyor was unable to locate posted contact information of the State Survey agency, Long Term Care (LTC) Ombudsman and Adult Protective Services (APS).</p> <p>After continued observations of the facility on 08/09/21, 08/10/21 and 08/11/21, contact information was revealed for the previously mentioned agencies printed on an 8 ½ inch by 11-inch document in the horizontal format. It was posted on the wall next to the elevator approximately five feet and five inches up from the floor.</p>	F 574	<p>F574 Required Notices and Contact Information</p> <p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility's credible allegation of compliance.</p> <p>1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>- On 9/16/21, Resident R86 and Resident R63 were informed by facility staff that</p>		



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F 574	<p>Continued From page 24</p> <p>An RC meeting took place on 08/10/21 at 10:00 AM in the second-floor activities room. R86 and R63 did not know who they could voice their complaints to because their Administrator recently left. They were asked if they knew that complaints about the facility could also be filed with a state agency and they both stated that they didn't know that. R86 stated, "We have a form that we fill out or go to (the former Administrator), but we do not know who to go to now because (the former Administrator) left. R63 stated, "I don't know who to talk to."</p> <p>A review of "COVID 19 Resident Council Satisfaction Survey" from March 3, 2021, to June 30, 2021 was done on 08/10/21 at 3:00 PM. The TRM stated that the facility did these satisfaction surveys in the place of RC meetings because of the COVID-19 pandemic and the inability to do group activities. Question number eight queried the resident, "Are you aware that the ombudsman's contact information is posted? Yes, No." Out of the 36 surveys reviewed, nine circled "Yes," 23 circled "No" and four surveys were not answered, or "N/A" was written.</p> <p>On 08/12/21 at 08:45 AM, an interview was done with RN25 at the unit's nursing station. Surveyor showed RN25 the posted contact information of pertinent State agencies for residents on the wall by the elevator and inquired if residents can read it. RN25 stated that the print was too small, needed to be in bold, was placed too high and that residents would have a hard time seeing the document. RN25 further stated that she previously worked in another nursing home and that the information was provided on a big poster visible to residents.</p>	F 574	<p>Amy Lee is the new Administrator. Both residents were also informed that all issues and concerns may be addressed with the facility Administrator, Social Services Department, or any supervisor or department manager. These residents were also informed that complaints about the facility could also be filed with a state agency.</p> <p>- On 9/26/21, to protect residents in similar situations, facility staff were in-serviced on the facility's responsibility to provide residents with State Agency, Ombudsman, and Adult Protective Services information to submit and file a complaint as needed or as deemed necessary.</p> <p>2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>- The alleged practice has the potential to affect facility residents.</p> <p>- To identify other residents having the potential to be affected by the identified deficient practice, the Aloha Nursing &amp; Rehab Centre (ANRC) Resident Focus Round was created to assess for knowledge deficit of filing complaints with state agencies: Hawaii Dept. of Health Office of Health Care Assurance, Hawaii State Ombudsman, and Adult Protective Services (APS).</p> <p>- The DON or designee is to monitor and</p>		

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F 574	Continued From page 25	F 574	<p>manage compliance by performing random assessments of compliance during weekly completion of the Aloha Nursing &amp; Rehab Centre (ANRC) Resident Focus Round auditing tool.</p> <p>- Completed forms are to be kept in a binder in the Nursing Home Administrator's (NHA's) office or designee.</p> <p>3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>- An informational wall, a designated location in the common area, has been created to allow residents to see and obtain pertinent contact information at wheelchair level to promote resident visibility. The information posted has also been posted in a larger, easy to read, font.</p> <p>- Residents Rights, state regulatory, informational and advocacy agencies' contact numbers will be reviewed with residents during resident council meetings and care plan conferences. If the resident is unable to understand the information, the information will be provided to the resident's responsible party.</p> <p>- Resident Focus Rounds was created to reflect resident interview query regarding their ability to contact the State Agency: Hawaii Department of Health Office of Health Care Assurance - Register of</p>		

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F 574	Continued From page 26	F 574	<p>Complaint Confidential Information, Hawaii State Ombudsman, and APS. Contact information to file a complaint as needed of the referenced state agencies is included on the ANRC Resident Focus Rounds document.</p> <ul style="list-style-type: none"> <li>- To ensure quality assurance and effectiveness, and to protect residents in similar situations, the facility staff were educated regarding the aforementioned Residents Right.</li> <li>- In-services will be ongoing as needed, and will also be conducted with licensed and non-licensed staff at new hire orientation and, at least, annually by an activities staff or designee.</li> </ul> <p>4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.</p> <ul style="list-style-type: none"> <li>- The Therapeutic Manager (TM) will randomly audit 10 resident records monthly to ensure that residents were notified of Residents Rights and advocacy contacts. Audit findings will be reviewed and discussed during the monthly Quality Assurance Performance Improvement (QAPI) meetings.</li> </ul>		

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F 574	Continued From page 27	F 574	<ul style="list-style-type: none"> <li>- To ensure that correction was achieved, all of the residents currently residing in the facility were informed of their rights to file a complaint with the facility Administrator, Social Services Department, or any supervisor or department manager. The residents were also informed that complaints about the facility could also be filed with a state agency.</li> <li>- On 9/26/21, to protect residents in similar situations, facility staff were in-serviced on the facility's responsibility to provide residents with State Agency, Ombudsman, and Adult Protective Services information to submit and file a complaint as needed or as deemed necessary.</li> <li>- To ensure quality assurance and effectiveness of promoting the wellbeing of our residents, and upholding the residents' rights for systemic changes, ongoing monitoring and random evaluation with application of the Aloha Nursing &amp; Rehab Centre (ANRC) Resident Focus Round auditing form will be completed.</li> <li>- Completion of this tool is to occur weekly x 1 month, bimonthly x 1 month and monthly x 1 month by the DON or designee for a minimum of 12 weeks to ensure compliance.</li> <li>- Corrective action is to be taken immediately and staff education is to be provided as deemed necessary.</li> </ul>		

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F 574	Continued From page 28	F 574	<ul style="list-style-type: none"> <li>- To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved.</li> <li>- If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met.</li> <li>- Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate.</li> </ul> <p>Included dates when corrective action will be completed:</p> <ul style="list-style-type: none"> <li>- Corrective action completion date by Nursing Home Administrator and/or designee.</li> </ul>		
F 655 SS=D	<p>Baseline Care Plan CFR(s): 483.21(a)(1)-(3)</p> <p>§483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-</p> <p>(i) Be developed within 48 hours of a resident's</p>	F 655		9/30/21	

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F 655	<p>Continued From page 29 admission.</p> <p>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-</p> <p>(A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.</p> <p>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-</p> <p>(i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).</p> <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <p>(i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure a baseline care plan or comprehensive care plan was developed and implemented for each resident within 48 hours of admission for two residents, R106 and R1. A</p>	F 655	<p>F655 Baseline Care Plan</p> <p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider</p>		

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F 655	<p>Continued From page 30</p> <p>baseline care plan was not developed for: a hospice resident with a history of falls; and a resident with a suprapubic catheter and multiple pressure ulcers. The deficient practice places residents at risk of not receiving quality of care and services which may prevent them from attaining or maintaining their highest practicable physical, mental, and psychosocial well-being.</p> <p>Findings include:</p> <p>1) R1 was discharged from the facility to hospital due to a diagnosis of E. Coli sepsis (bacterial infection in the blood) on 07/30/21 and was readmitted to the facility on 08/03/21. R1 had diagnoses of dementia, diabetes, chronic kidney disease, parkinson's disease, and venous insufficiency.</p> <p>On 08/11/21 at 10:22 AM surveyor conducted a review of R1's EMR. Review of progress notes documented on 08/07/21 at 3:25 PM, R1 had an unwitnessed fall, was found on the ground near the bed by staff, the call light was activated, and the resident did not have a major injury as a result of the fall. Shortly after the fall, a physician's order was written to take R1 to the toilet to void every two hours.</p> <p>On 08/11/21 at 11:35 AM, conducted a concurrent interview with the director of nursing (DON) and record review of R1's EMR. Inquired with the DON regarding R1's care plan related to falls. The DON navigated R1's EMR and confirmed R1 did not have a baseline care plan or a comprehensive care plan. The DON further confirmed the baseline care plan or comprehensive care plan should have been developed within 48 hours after being readmitted</p>	F 655	<p>that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility's credible allegation of compliance.</p> <p>1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <ul style="list-style-type: none"> <li>- Resident R106's comprehensive care plan has been reviewed and updated on 8/6/21.</li> <li>- Resident R1's comprehensive care plan was developed on 8/12/21.</li> <li>- Licensed staff were educated on the facility's responsibility to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of care.</li> </ul> <p>2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <ul style="list-style-type: none"> <li>- The alleged practice has the potential to affect facility residents.</li> </ul>		

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F 655	Continued From page 31 to the facility. A comprehensive care plan was developed on 08/12/21.  2) R106 was readmitted to the facility from the hospital on 8/05/21 with a suprapubic catheter.  On 08/11/21 at 11:50 AM, conducted a concurrent interview with the DON and review of R106's EMR. Requested to view R106's baseline care plan or comprehensive care plan. The DON navigated the resident's EMR and confirmed there was no baseline care plan or comprehensive care plan completed within 48 hours of R106 readmission to the facility.	F 655	- An audit on all new admissions for the months of August 2021 and September 2021 was initiated and conducted by the Director of Nursing (DON) and/or designee to identify residents with missing Baseline Care Plans; comprehensive care plans are to be completed for each deficient finding.  - To identify other residents having the potential to be affected by the identified deficient practice, the Aloha Nursing & Rehab Centre (ANRC) F-655 & F-656 Baseline Care Plan Auditing Tool was created.  - The DON, Minimum Data Set (MDS) Manager and Coordinators, or designee is to monitor and manage compliance by performing random assessments of compliance during weekly completion of the Aloha Nursing & Rehab Centre (ANRC) F-655 & F-656 Baseline Care Plan Auditing Tool.  - Completed forms are to be kept in a binder in the Nursing Home Administrator's (NHA's) office or designee.  3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?  - On 9/24/21, the MDS Manager, MDS Coordinators, and apposite licensed staff were in-serviced on the development of		



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F 655	Continued From page 32	F 655	<p>baseline and comprehensive care plans for each resident.</p> <p>- A baseline or comprehensive care plan will be developed by the MDS Manager, or assigned MDS coordinator, within 48 hours for all newly admitted, or readmitted residents, within 48 hours of the resident's admission or readmission.</p> <p>- In-services will be ongoing as needed, and will also be conducted with MDS Manager, MDS Coordinators, and apposite licensed staff at new hire orientation and, at least, annually.</p> <p>4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.</p> <p>- To ensure quality assurance and effectiveness of the aforementioned systemic changes to promote quality of care and services for our residents to attain or maintain their highest practicable physical, mental, and psychosocial well-being, random monitoring and evaluation with application of the Aloha Nursing &amp; Rehab Centre (ANRC) F-655 &amp; F-656 Baseline Care Plan Auditing Tool.</p>		

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F 655	Continued From page 33	F 655	<ul style="list-style-type: none"> <li>- Completion of this tool is to occur weekly x 1 month, bimonthly x 1 month, and monthly x 1 month by the DON or designee for a minimum of 12 weeks to ensure compliance.</li> <li>- Corrective action is to be taken immediately and staff education is to be provided as deemed necessary.</li> <li>- To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved.</li> <li>- If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met.</li> <li>- Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate.</li> </ul> <p>Included dates when corrective action will be completed:</p> <ul style="list-style-type: none"> <li>- Corrective action completion date by Nursing Home Administrator and/or designee.</li> </ul>		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		9/30/21	

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F 656	Continued From page 34 §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 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	F 656			

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F 656	<p>Continued From page 35</p> <p>requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, interviews and record reviews, the facility failed to ensure a comprehensive person-centered care plan was developed and implemented for each resident to meet resident's medical, nursing, and psychosocial needs for two residents, R60 and R56. This deficient practice enables the potential for these residents to receive sub-optimal care and could affect all residents in the facility.</p> <p>Findings include:</p> <p>1) R60 is a 100 years old and was admitted on 06/14/21 with diagnoses including a urinary tract infection (UTI).</p> <p>On 08/10/21 at 11:34 AM, conducted a review of R60's EMR. R60's admission MDS documented in Section N, Medications, was receiving antibiotic treatment and Section V. Care Area Assessment (CAA) Summary documented Urinary Incontinence and Indwelling Catheter care area was triggered and a decision to care plan this area. Review of R60's care plan did not include a care plan for urinary incontinence or the use of a straight catheter. Progress notes documented a straight catheter was used to obtain a urinary specimen on 08/06/21.</p> <p>On 06/11/21 at 12:15 AM, conducted a concurrent interview with the DON and record review of R60's EMR. Reviewed the resident's care plan. The DON confirmed urinary incontinence/indwelling catheter was identified on the CAA and marked as care planned but a care</p>	F 656	<p>F656 Development/Implement Comprehensive Care Plan</p> <p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility's credible allegation of compliance.</p> <p>1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>- On 8/16/21, Resident R60's comprehensive care plan was reviewed and updated to include a urinary incontinence care plan or the use of a straight catheter.</p> <p>- On 8/16/21, Resident R56's comprehensive care plan was reviewed and updates to the communication care plan have been made.</p> <p>- UM's and MDS staff were educated on the facility's responsibility to develop and</p>		

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F 656	<p>Continued From page 36</p> <p>plan was not developed.</p> <p>2) Observations made on 08/10/21 (01:29 PM), 08/11/21 (08:37 AM, 10:19 AM, 11:48 AM), surveyor noted resident R56 was not wearing hearing aids to left nor right ear.</p> <p>During an interview on 08/12/21 at 09:53 AM, the physical therapist (PT) confirmed hearing aides were not worn to right nor left ear.</p> <p>During an interview on 08/12/21 at 10:00 AM, RN15 verbalized "hearing aides had been on the cart for one and a half years, but they never worked, I think we followed up with the daughter about the broken hearing aids."</p> <p>During an interview on 08/12/21 at 10:05 AM, social worker (SW)2 stated, "I have been onboard 6 months and have not been in contact with the daughter regarding the hearing aid</p>	F 656	<p>implement a comprehensive care plan for each resident to meet resident's medical, nursing, and psychological needs.</p> <p>2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice .</p> <ul style="list-style-type: none"> <li>- The alleged practice has the potential to affect facility residents.</li> <li>- A review of comprehensive care plans for all residents within the facility was initiated by the Director of Nurses (DON), Minimum Data Set (MDS) Manager, and/or designees to identify residents with incomplete or inaccurate comprehensive care plans.</li> <li>- To identify other residents having the potential to be affected by the identified deficient practice, the Aloha Nursing &amp; Rehab Centre (ANRC) F-655 &amp; F-656 Baseline Care Plan Auditing Tool was created.</li> <li>- The DON, Minimum Data Set (MDS) Manager and Coordinators, or designee is to monitor and manage compliance by performing a facility wide assessment of compliance with application of the Aloha Nursing &amp; Rehab Centre (ANRC) F-655 &amp; F-656 Baseline Care Plan Auditing Tool.</li> <li>- Completed forms are to be kept in a binder in the Nursing Home Administrator's (NHA's) office or designee.</li> </ul>		

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F 656	Continued From page 37	F 656	<p>3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> <li>- On 9/24/21, the MDS Manager, MDS coordinators, and licensed staff were in-serviced by the DON on the development, revision, and implementation process of person-centered comprehensive care plans.</li> <li>- A comprehensive person-centered care plan will be developed, implemented, and updated for each resident.</li> <li>- Residents identified with incomplete or inaccurate comprehensive care plans will have their care plans reviewed and updated immediately by the assigned MDS coordinator, or designee, to reflect their current goals, interventions, and appropriate approaches to address their medical and treatment needs.</li> <li>- In-services will be ongoing as needed, and will also be conducted with MDS Manager, MDS Coordinators, and licensed staff at new hire orientation and, at least, annually.</li> </ul> <p>4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must</p>		

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F 656	Continued From page 38	F 656	<p>develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.</p> <ul style="list-style-type: none"> <li>- The DON and the MDS Manager are responsible for maintaining compliance.</li> <li>- To ensure quality assurance and effectiveness of the aforementioned systemic changes to promote quality of care and services for our residents to attain or maintain their highest practicable physical, mental, and psychosocial well-being, the DON, MDS Manager, or designee will perform weekly comprehensive care plan audits coinciding with the MDS assessment calendar to monitor for compliance with application of the Aloha Nursing &amp; Rehab Centre (ANRC) F-655 &amp; F-656 Baseline Care Plan Auditing Tool for all new admissions.</li> <li>- Any or all findings will be reported to the assigned MDS Coordinator or designee for immediate correction.</li> <li>- Completion of this tool is to occur weekly x 1 month, bimonthly x 1 month and monthly x 1 month by the DON or designee for a minimum of 12 weeks to ensure compliance.</li> <li>- For a minimum of 3 months, or until compliance is achieved, audit results will be reviewed, presented, and discussed at</li> </ul>		

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F 656	Continued From page 39	F 656	<p>the monthly Quality Assurance Performance Improvement (QAPI) meeting for analysis, and further recommendations.</p> <p>- If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met.</p> <p>- Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate.</p> <p>Included dates when corrective action will be completed:</p> <p>- Corrective action completion date by Nursing Home Administrator and/or designee.</p>		
F 677 SS=D	<p>ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)</p> <p>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations interview and record review, the facility failed to provide R13 and R16 with the necessary services to maintain good grooming, and personal and oral hygiene. The deficient practice leaves the resident without the highest practicable physical and psychosocial well-being.</p>	F 677	<p>F677 ADL Care Provided for Dependent Residents</p> <p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is</p>	9/30/21	



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F 677	<p>Continued From page 40</p> <p>Findings include:</p> <p>1) Surveyor made observations on 08/09/21 at 08:16 AM, R13 was noted in his bed laying on his back, facing the right side. He was wearing a hospital type gown that was bunched up in a wad on his chest. His hair looked unclean and uncombed. His knees were tightly bent up under him and facing to the right side. His left leg was outside of the sheet, noted excoriations on his lower leg.</p> <p>A second observation was made at 10:53 AM. R13 was in the same position.</p> <p>Surveyor made additional observations on 08/10/21 to 08/12/21 throughout the day shift and into the evening shift. Noted that R13 was in his bed in his hospital gown and appeared with the same disheveled hair.</p> <p>Surveyor reviewed the care plan for R13 on 08/12/21 at 2:00 PM. Problem: R13 is unable to transfer independently and requires two man as needed for ADL's due to limited mobility related to contractures. Approaches: Resident requires active range of motion/ passive range of motion exercises. Oral care after every meal. Encourage resident to be up in wheelchair for 1 meal a day as tolerated. Build up tolerance two to three meals in wheelchair/day. Surveyor noted R13 was in bed during the course of the survey when frequent observations were conducted.</p> <p>2) During an observation on 08/09/21 at 11:00 AM, surveyor noted that R16's hair was uncombed, and unclean. He was lying in bed</p>	F 677	<p>also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility's credible allegation of compliance.</p> <p>1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>- To ensure that the impacted residents were provided with assistance with personal hygiene, they were assessed as follows:</p> <p>- On 9/17/21, R13 was assessed for grooming and appearance. Resident was neatly groomed, with clean gown, and bed linen changed.</p> <p>- On 9/18/21, R16 was neatly groomed, with clean gown, and bed linen changed. Resident's comprehensive care plan reflects preference to wear gown.</p> <p>- Resident R13 was observed to have had a bed bath on 9/1/21, 9/3/21, 9/8/21, 9/10/21, 9/13/21, and 9/17/21; Resident R13 was noted to be neatly groomed, with a clean gown on, and bed linens changed. On 9/6/21 grooming, bathing and changing of clothing were offered; however, the resident refused care. Resident 13's comprehensive care plan</p>		

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F 677	<p>Continued From page 41</p> <p>wearing hospital type gown that was bunched up around neck his neck and revealing a bare chest.</p> <p>On 08/10/21 at 08:29 AM R16 was lying in bed with his gown pulled up on his chest, alert, non-verbal. Hair disheveled, bed in lowest position.</p> <p>Surveyor made a second observation at 12:53 PM and noted R16 laying in his bed on his back, same position, gown pulled up around his neck, restless and waving his hands in the air above his chest.</p> <p>At 04:18 PM during an observation, R16 was lying in his bed, restless and agitated.</p> <p>On 08/11/21 at 10:30 AM R16 observed laying in his bed, moving upper arms, moving head back and forth. Nonverbal, eyes open toward the ceiling. TV on, but volume was down. His hair was uncombed.</p> <p>On 08/12/21 at 09:55 AM surveyor observed a CNA was changing R16 in bed. Surveyor asked if he is getting a shower today, the CNA stated he gets a bath in his bed.</p> <p>Care plan reviewed on 08/12/21 at 2:30 PM. Problem: R16 is on "Comfort care only" status with hospice care. Goal: Maintain dignity and comfort. Approaches: Allow resident to sit up in chair, use bedside commode, or get out of bed as desired and tolerated. Reposition massage, sit and speak with resident...</p> <p>Surveyor noted resident was in bed during the survey when frequent observations were conducted.</p>	F 677	<p>reflects preference to wear gown.</p> <p>- Resident R16 was assessed for grooming and appearance, and observed to have had a bed bath on 9/7/21, 9/11/21, 9/14/21, and 9/18/21, he was neatly groomed, with clean gown, and bed linen changed. On 9/3/21, 9/9/21, and 9/16/21; however, on 9/3/21, 9/9/21, and 9/16/21, Resident R16 was offered bathing, grooming and change of clothing, resident refused care. Resident comprehensive care plan reflects preference to wear gown.</p> <p>- On 9/21/21, direct care staff were in-serviced on activities of daily living (ADL), and on the importance of providing residents with quality personal care and hygiene.</p> <p>- On 9/26/21, to protect residents in similar situations, facility staff were in-serviced on providing necessary services of ADL care for dependent residents, to maintain good grooming and personal hygiene.</p> <p>2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>- The alleged practice has the potential to affect facility residents.</p> <p>3) What measures will be put into place or what systemic changes will you make to</p>		

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F 677	Continued From page 42  On 08/12/21 at 10:06 AM surveyor interviewed two staff (S) 45 and S34 who requested to remain anonymous. Surveyor asked S45 how often are the showers and personal care being done for R13 and R16? S45 responded that today we have three CNAs assigned to this side and one who floats between the two sides. We try to do personal care when we make our rounds, baths are usually given two to three times a week. This is the heaviest floor; we really need at least four CNA's because the residents are heavier and more dependent. Sometimes we just can't get to everything, and they don't get all the personal care. S34 stated that she would like to have more time to provide more personalized care to the residents like grooming and cleaning nails. We are often short staffed, there's just no time for those things. (Refer to F725).	F 677	<p>ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> <li>- Direct care staff were in-serviced on activities of daily living (ADL), and on the importance of providing residents with quality personal care and hygiene.</li> <li>- Facility staff were in-serviced on providing necessary services of ADL care for dependent residents, to maintain good grooming and personal hygiene.</li> <li>- In-service education will be provided to all licensed staff and non-licensed staff at new hire orientation and at least annually by the Director of Nursing, or designee, regarding providing ADL care for dependent residents.</li> <li>- The facility's Unit Managers, or designee, will conduct daily walking rounds, and monitor through observation, to ensure that dependent residents receive person-centered ADL care; education and corrective measures to be taken as deemed necessary.</li> <li>- The Aloha Nursing &amp; Rehab Centre Resident Focus Rounds was created to promote respect, dignity, and care for each resident in a manner and environment that promotes maintenance or enhancement of each resident's quality of life. This auditing tool is for monitoring through resident interview query and observation.</li> <li>- In-services will be ongoing as needed,</li> </ul>		

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F 677	Continued From page 43	F 677	<p>and will also be conducted with licensed and non-licensed staff at new hire orientation and, at least, annually.</p> <p>4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.</p> <ul style="list-style-type: none"> <li>- To protect residents in similar situations, facility staff were in-serviced on the facility's responsibility to provide dependent residents with necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</li> <li>- To ensure quality assurance and effectiveness of promoting the wellbeing of our residents, and upholding the residents' rights for systemic changes, ongoing monitoring and random evaluation with application of the Aloha Nursing &amp; Rehab Centre (ANRC) Resident Focus Round auditing form will be completed.</li> <li>- Completion of above mentioned tool is to occur weekly x 1 month, bimonthly x 1 month and monthly x 1 month by the DON or designee for a minimum of 12 weeks to ensure compliance.</li> <li>- Corrective action is to be taken</li> </ul>		

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F 677	Continued From page 44	F 677	<p>immediately and staff education is to be provided as deemed necessary.</p> <ul style="list-style-type: none"> <li>- To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved.</li> <li>- If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met.</li> <li>- Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate.</li> </ul> <p>Included dates when corrective action will be completed:</p> <ul style="list-style-type: none"> <li>- Corrective action completion date by Nursing Home Administrator and/or designee.</li> </ul>		
F 679 SS=D	<p>Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)</p> <p>§483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the</p>	F 679		9/30/21	

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F 679	<p>Continued From page 45</p> <p>physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, interviews and record reviews, the facility failed to provide activities that meet the interests of two residents, R80 and R314. This deficient practice does not support the physical, mental, and psychosocial well-being of these residents and could render psychosocial harm. This has the potential to affect most residents in the facility.</p> <p>Findings include:</p> <p>1) An initial observation of R80 was made on 08/09/21 at 10:48 AM. R80 was sitting upright in bed, sleeping with his television set on the channel and program guide. A hand made sign made with wire and numerous other wire craft objects were in his room. His partially eaten breakfast remained on a tray located on his bedside table at the side of his bed.</p> <p>R80 was interviewed on 08/10/21 at 12:00 PM in his room. R80 stated that he created the wire decorative objects in his room by hand with wire hangers. He stated that he had the tools to create his crafts but had been unable to use them. His tools were locked up at the facility because they were considered dangerous and could only be used when he was supervised. He stated that he could use them previously and staff would supervise him but thinks that he was now unable to because "they don't have enough staff."</p> <p>R80's EMR was reviewed on 08/10/21 at 3:00 PM. He is a 74-year-old male admitted to the</p>	F 679	<p>F679 Activities Meet Interest/Needs Each Resident</p> <p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility's credible allegation of compliance.</p> <p>1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>- On 9/14/21, the Therapeutic Recreation Manager (TRM) assisted Resident R80 with a crafting activity of the resident's choice.</p> <p>- On 9/16/21, the TRM ensured that Resident R314's television station was set to Resident's R134's favorite news station. A sign was also posted on Resident R134's communication board to remind the care team to turn the</p>		

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F 679	<p>Continued From page 46</p> <p>facility with Parkinson's disease (a progressive nervous system disorder that affects movement). His care plan updated on 06/30/21 stated for activities, "...preferences include...working on/creating new art."</p> <p>An interview was done with the TRM on 08/12/21 at 09:12 AM in the training room. She stated that the facility had R80's soldering iron, pure alcohol and glue. The TR staff or SS would help to supervise R80 while he was utilizing these items to create his craft projects. She further stated, "He takes so long to get ready. We try to allocate the time for him."</p> <p>R80's "TR Routine Roster" report for the dates of 06/12/21 to 08/12/21 was reviewed on 08/12/21 at 11:00 AM. There were no activities documented for the month of August.</p> <p>In a follow-up interview with the TRM at 11:17 AM in the conference room, she stated that activities with the residents are documented when the TR staff does or upon completion of the activity with the resident.</p> <p>2) An initial observation was made of R314 on 08/09/21 at 10:40 AM in his room. R314 was wearing a hospital gown, lying in bed with his head of bed (HOB) raised. His eyes remained closed, and he was slow to respond to the surveyor's salutation.</p> <p>R314 was observed at 12:13 PM the same day still lying in bed. His television was off. His roommate had a staff member helping him do range of motion (ROM) exercises of his legs.</p> <p>On 08/10/21 at 09:51 AM, R314 was alone in his</p>	F 679	<p>television (TV) on to the news station of the resident's preference.</p> <p>-Since admission R134 cognitive status has improved, R134 is now capable of self-manipulating television, to the station of his choice. R134 is also able to independently utilize iPad due to increase cognitive abilities.</p> <p>- The resident's care plan reflects Resident R314's aforementioned TV preference.</p> <p>- Facility staff were educated on the providing residents with activities that are designed to meet their interests and support the physical, mental, and psychosocial well-being of each resident.</p> <p>- Facility staff were educated on implementation of residents' activity plan and proper documentation of participation / refusal to participate.</p> <p>2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>- The alleged practice has the potential to affect facility residents.</p> <p>3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p>		

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F 679	<p>Continued From page 47</p> <p>room. He was wearing a hospital gown lying in bed tilted to the right side. His television was not on.</p> <p>At 10:46 AM of the same day, RN22 was wearing personal protective equipment (PPE) in R314's room. His television was off.</p> <p>R314's EMR was reviewed on 08/10/21 at 2:50 PM. R314 is a 73-year-old male admitted to the facility on 07/21/21 for an infection. His activity care plan dated 07/26/21 stated, "...preferences include having his family involved in discussions about his care, receiving pet visits, and participating in religious services/practices..."</p> <p>Another entry for his activity care plan stated, "It is very important to (R314) to (sic) with the news via television..."</p> <p>In an interview with the TRM on 08/12/21 at 09:26 AM in the training room, she stated that activities have not been done with R314 because he was sleeping or in therapy.</p> <p>R314's "TR Summary Roster" report for 06/12/20 to 08/12/21 was reviewed on 08/12/21 at 10:00 AM. There was only a 20 minute one to one visit documented on 07/31/21.</p>	F 679	<ul style="list-style-type: none"> <li>- The TRM, or designee, will provide annual in-service training and new hire training of the importance of providing residents with activities that are designed to meet the residents' interests and support the physical, mental, and psychosocial well-being of each resident.</li> <li>- The resident's preference interview will be conducted upon admission and reviewed and updated quarterly and annually during the care plan meeting.</li> <li>- The TRM will review, through observation, activity attendance, and, on a weekly basis, audit resident participation records for all residents; this audit will identify trends regarding activities provided to meet the interests and needs of our residents.</li> <li>- Deficient findings will be followed up upon as deemed necessary; these findings and follow up measures will be reported at the monthly Quality Assurance Performance Improvement (QAPI) meetings.</li> <li>- The Aloha Nursing &amp; Rehab Centre Resident Focus Rounds auditing tool was created to promote respect, dignity, and care for each resident in a manner and environment that promotes maintenance or enhancement of each resident's quality of life. This auditing tool is for monitoring through resident interview query and observation.</li> <li>- In-services will be ongoing as needed</li> </ul>		



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F 679	Continued From page 48	F 679	<p>4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.</p> <ul style="list-style-type: none"> <li>- To protect residents in similar situations, facility staff were in-serviced on providing residents with activities that are designed to meet their interests and support the physical, mental, and psychosocial well-being of each resident.</li> <li>- Facility staff were also educated on implementation of residents' activity plan and proper documentation of participation / refusal to participate.</li> <li>- To ensure quality assurance and effectiveness of promoting the wellbeing of our residents, and upholding the residents' rights for systemic changes, ongoing monitoring and random evaluation with application of the Aloha Nursing &amp; Rehab Centre (ANRC) Resident Focus Round auditing form will be completed.</li> <li>- Completion of this tool is to occur weekly x 1 month, bimonthly x 1 month and monthly x 1 month by the DON or designee for a minimum of 12 weeks to ensure compliance.</li> </ul>		

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F 679	Continued From page 49	F 679	<ul style="list-style-type: none"> <li>- Corrective action is to be taken immediately and staff education is to be provided as deemed necessary.</li> <li>- Weekly auditing of facility residents <input type="checkbox"/> activity attendance by the TRM will is to be reported at the monthly Quality Assurance Performance Improvement (QAPI) meetings.</li> <li>- To ensure compliance, audit results completed by the TRM, and auditing with application of the Aloha Nursing &amp; Rehab Centre (ANRC) Resident Focus Round auditing form, will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved.</li> <li>- If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met.</li> <li>- Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate.</li> </ul> <p>Included dates when corrective action will be completed:</p> <ul style="list-style-type: none"> <li>- Corrective action completion date by Nursing Home Administrator and/or designee.</li> </ul>		

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F 684 F 684 SS=D	Continued From page 50 Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure three residents, R13, R16, R162, in the sample received care and treatment in accordance with professional standards of practice. The deficient practice left the residents without the highest practicable physical and psychosocial well-being, at a greater risk for decline in ADLs, and infectious disease.  Findings include:  1) Surveyor made observations on 08/09/21 at 08:16 AM, R13 was noted in his bed laying on his back, facing the right side. Noted a Christmas decoration on his bedside table with a few other items with dust and in disarray. He was wearing a hospital type gown that was bunched up in a wad on his chest. His hair looked unclean and uncombed. His knees were tightly bent up under him and facing to the right side. His left leg was outside of the sheet, noted excoriations on his lower leg.  A second observation was made at 10:53 AM.	F 684 F 684	F684 Quality of Care  Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility's credible allegation of compliance.  1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.  - Resident R162 was discharged from the facility  - To ensure that the impacted residents were provided with assistance with	9/30/21	

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F 684	<p>Continued From page 51</p> <p>R13 was in the same position. (Refer to F677).</p> <p>Surveyor made additional observations on 08/10/21 to 08/12/21 throughout the day shift and into the evening shift. Noted that R13 was in his bed in his hospital gown and appeared with the same disheveled hair.</p> <p>2) During an observation on 08/09/21 at 11:00 AM, surveyor noted that R16's hair looked uncombed, and unclear. He was lying in bed wearing hospital type gown that was bunched up around neck his neck and revealing a bare chest.</p> <p>On 08/10/21 at 08:29 AM R16 was lying in bed with his gown pulled up on his chest, alert, non-verbal. hair looks disheveled, bed in lowest position.</p> <p>Surveyor made a second observation at 12:53 PM and noted R16 laying in his bed on his back, same position, gown pulled up around his neck, restless and waving his hands in the air above his chest.</p> <p>At 04:18 PM during an observation, R16 was laying in his bed, appeared restless and agitated (Refer to F677).</p> <p>On 08/11/21 at 10:30 AM R16 observed laying in his bed, moving upper arms, moving head back and forth. Nonverbal, eyes open toward the ceiling. TV on, but volume was down. His hair looked uncombed.</p> <p>Care plan reviewed on 08/12/21 at 02:30 PM. Problem: R16 is on "Comfort care only" status with hospice care. Goal: Maintain dignity and comfort. Approaches: Allow resident to sit up in</p>	F 684	<p>personal hygiene and psychosocial wellbeing, they were assessed as follows:</p> <ul style="list-style-type: none"> <li>- On 9/10/21 Resident R13 was assessed for appropriate personal care of grooming and appearance by the Director of Nursing (DON). The resident was observed to have had a bed bath, he was neatly groomed with clean gown on, his bedside table was tidied, and the Christmas decoration was removed and stored. Residents comprehensive care plan reflects the resident's preference to wear gown.</li> <li>- On 9/17/21, Resident R13 was assessed for grooming and appearance. Resident was neatly groomed, with clean gown, and bed linen changed.</li> <li>- On 9/18/21, Resident R16 was neatly groomed, with clean gown, and bed linen changed. Resident's comprehensive care plan reflects preference to wear gown.</li> <li>- Resident R13 was observed to have had a bed bath on 9/1/21, 9/3/21, 9/8/21, 9/10/21, 9/13/21, and 9/17/21; Resident R13 was noted to be neatly groomed, with a clean gown on, and bed linens changed. On 9/6/21 grooming, bathing and changing of clothing were offered; however, the resident refused care. Resident 13's comprehensive care plan reflects preference to wear gown.</li> <li>- Resident R16 was assessed for grooming and appearance, and observed to have had a bed bath on 9/7/21, 9/11/21,</li> </ul>		

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F 684	<p>Continued From page 52</p> <p>chair, use bedside commode, or get out of bed as desired and tolerated. Reposition massage, sit and speak with resident...</p> <p>Surveyor noted resident was in bed during the survey when frequent observations were conducted.</p> <p>3) On 08/11/21 at 02:14 PM, surveyor reviewed R162's discharged record from the EMR. Diagnosis: Pneumonitis due to inhalation of food and vomit 11/16/20. Stage four pressure ulcer of sacral region. Osteomyelitis, type two diabetes. Progress note 11/17/20 01:57 AM. R162 readmitted to facility. has large decubitus to sacrum, wound bed granulated tissue. Undermining around the entire wound with 3-6 o'clock the worst, light to moderate yellowish drainage during dressing change (Refer F686).</p> <p>On 08/12/21 at 10:06 AM surveyor interviewed S45 and S34 who requested to remain anonymous. Surveyor asked S45 how often are the showers and personal care being done for R13? S45 responded that today we have three CNAs assigned to this side and one who floats between the two sides. We try to do personal care when we make our rounds, baths are usually given two to three times a week. This is the heaviest floor; we really need at least four CNA's because the residents are heavier and more dependent. Sometimes we just can't get to everything, and they don't get all the personal care. S34 stated that she would like to have more time to provide more personalized care to the residents like grooming and cleaning nails. We are often short staffed, there's just no time for those things. (Refer to F725).</p>	F 684	<p>9/14/21, and 9/18/21, he was neatly groomed, with clean gown, and bed linen changed. On 9/3/21, 9/9/21, and 9/16/21; however, on 9/3/21, 9/9/21, and 9/16/21, Resident R16 was offered bathing, grooming and change of clothing, resident refused care. Resident comprehensive care plan reflects preference to wear gown.</p> <p>- On 9/21/21, direct care staff were in-serviced on activities of daily living (ADL), and on the importance of providing residents with quality personal care and hygiene.</p> <p>- On 9/26/21, to protect residents in similar situations, facility staff were in-serviced on providing necessary services of ADL care for dependent residents, to maintain good grooming and personal hygiene.</p> <p>- On 9/17/21, Resident R13 was assessed for grooming and appearance. Resident was neatly groomed, with clean gown, and bed linen changed.</p> <p>- On 9/18/21, R16 was neatly groomed, with clean gown, and bed linen changed. Resident's comprehensive care plan reflects preference to wear gown.</p> <p>2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>- The alleged practice has the potential to</p>		

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

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F 684	Continued From page 53	F 684	<p>affect facility residents.</p> <p>3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> <li>- Facility staff were in-serviced to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and honor the residents' choices.</li> <li>- Facility staff were educated on the facility's turning and positioning policy and turning wheel. Turning wheel sticker is applied to all direct care providers name tag for ease of reference.</li> <li>- The facility's Unit Manager (UM), or designee, will conduct daily walking rounds, and monitor through observation, to ensure turning and repositioning of residents are being conducted with application of the turning wheel and other daily care treatments according to the residents' person-centered plan of care.</li> <li>- To promote continuity of care, facility staff will be provided with education, as aforementioned, at new hire orientation and at least annually, by the Director of Nursing Services (DON) or designee.</li> <li>- The Aloha Nursing &amp; Rehab Centre Resident Focus Rounds was created to promote respect, dignity, and care for each resident in a manner and</li> </ul>		

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F 684	Continued From page 54	F 684	<p>environment that promotes maintenance or enhancement of each resident's quality of life. This auditing tool is for monitoring through resident interview query and observation.</p> <p>- In-services will be ongoing as needed</p> <p>4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.</p> <p>- To protect residents in similar situations, facility staff were in-serviced on ensuring that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and honor the residents' choices.</p> <p>- To ensure quality assurance and effectiveness of promoting the wellbeing of our residents, and upholding the residents' rights for systemic changes, ongoing monitoring and random evaluation with application of the Aloha Nursing &amp; Rehab Centre (ANRC) Resident Focus Round auditing form will be completed.</p> <p>- Completion of this tool is to occur weekly x 1 month, bimonthly x 1 month and</p>		

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

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OMB NO. 0938-0391

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F 684	Continued From page 55	F 684	<p>monthly x 1 month by the DON or designee for a minimum of 12 weeks to ensure compliance.</p> <ul style="list-style-type: none"> <li>- Corrective action is to be taken immediately and staff education is to be provided as deemed necessary.</li> <li>- To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved.</li> <li>- If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met.</li> <li>- Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate.</li> </ul> <p>Included dates when corrective action will be completed:</p> <ul style="list-style-type: none"> <li>- Corrective action completion date by Nursing Home Administrator and/or designee.</li> </ul>		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)  §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F 686		9/30/21	



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F 686	<p>Continued From page 56</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on family member interview and record review, the facility failed to ensure that one resident, R162, who had a stage four pressure ulcer to the sacral/coccyx received necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent infection. The deficient practice resulted in R162 acquiring a methicillin resistant staphylococcus aureus infection (MRSA) of the sacral wound requiring intravenous antibiotics and a decline in health status.</p> <p>Findings include:</p> <p>1) Surveyor received telephone call from R162's family member (FM) on 02/19/21 at 05:17 PM at the office of health care assurance (OHCA). FM stated that he had concerns regarding R162 care at the facility. FM stated, I didn't see R162 for several months due to the COVID pandemic and the facility was on lock down, before that I went all the time to visit. In late November 2020 I met her at the hospital when she went for a blood transfusion. I saw that her nails were overgrown and were cutting into her hands. There were</p>	F 686	<p>F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer</p> <p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility's credible allegation of compliance.</p> <p>1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>- Resident R162 was discharged from the facility</p>		

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F 686	<p>Continued From page 57</p> <p>sores with puss. I looked at her and almost cried. It was the week before she went to the emergency department (ED), the last week of November. FM stated that R162 went to the ED by ambulance on December 1, 2020 after she stopped breathing at the facility.</p> <p>FM said he talked to the physical therapist and occupational therapist weekly, and they said she was supposed to be getting up in her wheelchair every day. I called once to ask and was told she didn't get up all day, it was already the evening shift. I feel bad for the residents there, they can't speak for themselves. Sometimes when I called to ask the head nurse to ask if she can get R162 up in the wheelchair, they just said we don't have the staff. (Refer to F725).</p> <p>On 08/11/21 at 02:14 PM, surveyor reviewed R162's discharged record from the EMR. Diagnosis: Pneumonitis due to inhalation of food and vomit 11/16/20. Stage four pressure ulcer of sacral region. Osteomyelitis (bone infection), type two diabetes. Progress note 11/17/20 01:57 AM. R162 readmitted to facility. has large decubitus to sacrum, wound bed granulated tissue. Undermining around the entire wound with 3-6 o'clock the worst, light to moderate yellowish drainage during dressing change.</p> <p>On 08/11/21 at 03:55 PM surveyor reviewed the MDS from 01/19/20 through 11/11/20. The review revealed that R162 had stage four pressure ulcer present on the sacral area during the entire time. R162 was also coded as an extensive assistance in her functional abilities and totally dependent in eating. R162's cognitive skills were coded as severely</p>	F 686	<p>- On 9/26/21, to protect residents in similar situations, facility staff were in-serviced on promoting skin integrity and resident care that is consistent with professional standards of practice, to promote healing, prevention of infection, and prevent new ulcers from developing.</p> <p>2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>- The alleged practice has the potential to affect facility residents.</p> <p>3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>- Facility staff were in-serviced to ensure that residents receive treatment and care in accordance with professional standards of practice to promote healing, prevention of infection, and prevent new ulcers from developing.</p> <p>- Facility staff were educated on the facility's turning and positioning policy and turning wheel. Turning wheel sticker is applied to all direct care providers name tag for ease of reference.</p> <p>- The facility's Unit Manager (UM), or designee, will conduct daily walking</p>		

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F 686	<p>Continued From page 58</p> <p>impaired-never/rarely made decisions. Other diagnosis included multidrug resistant organism (MDRO), wound infection, and osteomyelitis.</p> <p>MD orders reviewed: 11/16/20. Sacral wound, cleanse with normal saline, pat dry, pack with calcium alginate and cover with bordered foam. Change every day and as needed.</p> <p>Care plan reviewed. Problem: R162 has stage four noted to coccyx, 3 centimeters (cm) x 4cm x 1.5cm. She is being treated with antibiotics. 01/28/20. Residents area will decrease in size by 50%. Reposition resident every 2 hours and as needed. Resident needs two people to assist with repositioning to avoid skin friction/shearing if needed.</p>	F 686	<p>rounds, and monitor through observation, to ensure turning and repositioning of residents are being conducted with application of the turning wheel and other daily care treatments according to the residents <input type="checkbox"/> person-centered plan of care.</p> <p>- To promote continuity of care, facility staff will be provided with education, as aforementioned, at new hire orientation and at least annually, by the Director of Nursing Services (DON) or designee.</p> <p>- The Aloha Nursing &amp; Rehab Centre Resident Focus Rounds was created to promote respect, dignity, and care for each resident in a manner and environment that promotes maintenance or enhancement of each resident <input type="checkbox"/>s quality of life. This auditing tool is for monitoring through resident interview query and observation.</p> <p>- The Aloha Nursing &amp; Rehab Centre - Weekly Wound Care Report was created for ongoing wound assessment, treatment, and monitoring.</p> <p>- In-services will be ongoing as needed</p> <p>4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective</p>		

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F 686	Continued From page 59	F 686	<p>action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.</p> <ul style="list-style-type: none"> <li>- To protect residents in similar situations, facility staff were in-serviced on ensuring that residents receive treatment and care in accordance with professional standards of practice, and on application of the turning and repositioning wheel.</li> <li>- To ensure quality assurance and effectiveness of promoting the wellbeing of our residents, and upholding the residents' rights for systemic changes, ongoing monitoring and random evaluation with application of the Aloha Nursing &amp; Rehab Centre (ANRC) Resident Focus Round auditing form will be completed.</li> <li>- Completion of this tool is to occur weekly x 1 month, bimonthly x 1 month and monthly x 1 month by the DON or designee for a minimum of 12 weeks to ensure compliance.</li> <li>- To ensure quality assurance and effectiveness of promoting the wellbeing of our residents, and upholding the residents' rights for systemic changes, ongoing monitoring and random evaluation with application of the Aloha Nursing &amp; Rehab Centre - Weekly Wound Report.</li> <li>- Completion of this tool is to occur weekly by the Wound Treatment Nurse or designee for a minimum of 12 weeks to</li> </ul>		

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F 686	Continued From page 60	F 686	<p>ensure compliance.</p> <p>* Corrective action is to be taken immediately and staff education is to be provided as deemed necessary.</p> <p>- To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved.</p> <p>- If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met.</p> <p>- Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate.</p> <p>Included dates when corrective action will be completed:</p> <p>- Corrective action completion date by Nursing Home Administrator and/or designee.</p>		
F 688 SS=D	<p>Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)</p> <p>§483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical</p>	F 688		9/30/21	

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F 688	<p>Continued From page 61</p> <p>condition demonstrates that a reduction in range of motion is unavoidable; and</p> <p>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations interview and record review, the facility failed to ensure two residents, R13 and R16, received routine repositioning to maintain or improve mobility. The deficient practice potentially decreased the residents range of motion and mobility. R13 and R16 were not being repositioned at least every two hours. R13 has a stage four pressure ulcer and extremely contracted legs. R16 was left in his bed throughout the entire day.</p> <p>Findings include:</p> <p>1) Surveyor made observations on 08/09/21 at 08:16 AM, R13 was noted in his bed laying on his back, facing the right side. He was wearing a hospital type gown that was bunched up in a wad on his chest. His hair looked unclean and uncombed. His knees were tightly bent up under him and facing to the right side. His left leg was outside of the sheet, noted excoriations on his lower leg</p> <p>A second observation was made at 10:53 AM. R13 was in the same position (Refer to F677).</p>	F 688	<p>F688 Increase/Prevent Decrease in ROM/Mobility</p> <p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility's credible allegation of compliance.</p> <p>1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>- Resident R162 was discharged from the facility.</p>		

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F 688	<p>Continued From page 62</p> <p>Surveyor made additional observations on 08/10/21 to 08/12/21 throughout the day shift and into the evening shift. Noted that R13 was in his bed in his hospital gown and appeared with the same disheveled hair. The resident was not being repositioned at least every two hours.</p> <p>Surveyor reviewed the care plan for R13 on 08/12/21 at 02:00 PM. Problem: R13 is unable to transfer independently and requires two man as needed for ADL's due to limited mobility related to contractures. Approaches: Resident requires active range of motion/ passive range of motion exercises. Oral care after every meal. Encourage resident to be up in wheelchair for one meal a day as tolerated. Build up tolerance two to three meals in wheelchair/day. Surveyor noted R13 was in bed during the course of the survey when frequent observations were conducted.</p> <p>2) During an observation on 08/09/21 at 11:00 AM, surveyor noted that R16's hair looked uncombed, and unclean. He was lying in bed wearing hospital type gown that was bunched up around neck his neck and revealing a bare chest.</p> <p>On 08/10/21 at 08:29 AM R16 was lying in bed with his gown pulled up on his chest, alert, non-verbal. hair looks disheveled, bed in lowest position.</p> <p>Surveyor made a second observation at 12:53 PM and noted R16 laying in his bed on his back, same position, gown pulled up around his neck, restless and waving his hands in the air above his chest.</p> <p>At 04:18 PM during an observation, R16 was</p>	F 688	<ul style="list-style-type: none"> <li>- On 8/18/21, Resident R13 and Resident R16 were assessed, and their person-centered plans of care were assessed to ensure range of motion (ROM) and mobility to provide routine positioning to maintain and/or improve their mobility.</li> <li>- Both aforementioned residents are receiving restorative services in accordance with their person-centered plan of care.</li> <li>- On 9/26/21, to promote resident care that is consistent with professional standards of practice, and to protect residents in similar situations, facility staff were in-serviced on ensuring that residents receive routine repositioning, at least every two hours, to maintain or improve mobility to prevent a reduction in ROM unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.</li> </ul> <p>2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <ul style="list-style-type: none"> <li>- The alleged practice has the potential to affect facility residents.</li> <li>- Director of Nursing, Minimum Data Set (MDS) Coordinator, or designee, shall apply use of the facility assessment, CASPER report, and MDS assessment information to identify all residents for loss</li> </ul>		

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F 688	<p>Continued From page 63</p> <p>laying in his bed, appeared restless and agitated.</p> <p>On 08/11/21 at 10:30 AM R16 observed laying in his bed, moving upper arms, moving head back and forth. Nonverbal, eyes open toward the ceiling. TV on, but volume was down. His hair looked uncombed.</p> <p>On 08/12/21 at 09:55 AM surveyor observed a CNA was changing R16 in bed. Surveyor asked if he is getting a shower today, the CNA stated he gets a bath in his bed.</p> <p>Care plan reviewed on 08/12/21 at 02:30 PM. Problem: R16 is on "Comfort care only" status with hospice care. Goal: Maintain dignity and comfort. Approaches: Allow resident to sit up in chair, use bedside commode, or get out of bed as desired and tolerated. Reposition massage, sit and speak with resident...</p> <p>Surveyor noted resident was in bed during the survey when frequent observations were conducted. (Refer to F677).</p> <p>On 08/12/21 at 10:06 AM surveyor interviewed two staff, S45 and S34 who requested to remain anonymous. Surveyor asked S45 how often are the showers and personal care being done for R13? S45 responded that today we have three CNA's assigned to this side and one who floats between the two sides. We try to do personal care when we make our rounds, baths are usually given two to three times a week. This is the heaviest floor; we really need at least four CNA's because the residents are heavier and more dependent. Sometimes we just can't get to everything, and they don't get all the personal care. S34 stated that she would like to have</p>	F 688	<p>of function.</p> <ul style="list-style-type: none"> <li>- All residents identified will receive referral for therapy evaluation and treatment as recommended.</li> <li>- The identified residents <input type="checkbox"/> person-centered care plans will be updated to reflect any implemented specialized services and/or treatments specific to each resident <input type="checkbox"/>s care needs.</li> </ul> <p>3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>Review facility <input type="checkbox"/>s protocol to ensure:</p> <ul style="list-style-type: none"> <li>- Nursing will be providing recommendations to the Rehabilitation Department for evaluation.</li> <li>- Review of residents identified of loss of ROM and mobility will be reviewed in the daily interdisciplinary team (IDT) meetings to ensure that follow-up is being done with all parties.</li> <li>- Communication protocol is established to ensure plan of care is communicated to licensed staff and unlicensed nursing staff.</li> <li>- Facility staff were in-serviced to ensure that residents receive treatment and care in accordance with professional standards of practice to promote resident care that is consistent with professional standards of</li> </ul>		



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NAME OF PROVIDER OR SUPPLIER  <b>ALOHA NURSING &amp; REHAB CENTRE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>45-545 KAMEHAMEHA HIGHWAY KANE OHE, HI 96744</b>		
(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 688	Continued From page 64 more time to provide more personalized care to the residents like grooming and cleaning nails. We are often short staffed, there's just no time for those things. (Refer to F725).	F 688	<p>practice, and to protect residents in similar situations, facility staff were in-serviced on ensuring that residents receive routine repositioning at least every two hours to maintain or improve mobility to prevent a reduction in ROM unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.</p> <p>- Facility staff were also in-serviced on the facility's turning and positioning policy and turning wheel. Turning wheel sticker is applied to all direct care providers name tag for ease of reference.</p> <p>- The facility's Unit Manager (UM), or designee, will conduct daily walking rounds, and monitor through observation, to ensure turning and repositioning of residents are being conducted with application of the turning wheel and other daily care treatments according to the resident's person-centered plan of care.</p> <p>- In-service training and education training will be conducted by the Director of Nursing (DON), or designee, at new hire orientation, and at least annually to all licensed staff regarding facility's protocol on identifying residents that are at risk for loss of ROM and mobility.</p> <p>- The Aloha Nursing &amp; Rehab Centre Resident Focus Rounds was created to promote respect, dignity, and care for each resident in a manner and environment that promotes maintenance or enhancement of each resident's</p>		

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F 688	Continued From page 65	F 688	<p>quality of life. This auditing tool is for monitoring through resident interview query and observation.</p> <p>- In-services will be ongoing as needed</p> <p>4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.</p> <p>- To protect residents in similar situations, facility staff were in-serviced on ensuring that residents receive treatment and care in accordance with professional standards of practice, and on application of the turning and repositioning wheel.</p> <p>- To ensure quality assurance and effectiveness of promoting the wellbeing of our residents, and upholding the residents' rights for systemic changes, ongoing monitoring and random evaluation with application of the Aloha Nursing &amp; Rehab Centre (ANRC) Resident Focus Round auditing form will be completed.</p> <p>- Completion of this tool is to occur weekly x 1 month, bimonthly x 1 month and monthly x 1 month by the DON or designee for a minimum of 12 weeks to ensure compliance.</p>		

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F 688	Continued From page 66	F 688	<ul style="list-style-type: none"> <li>- To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved.</li> <li>- If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met.</li> <li>- Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate.</li> </ul> <p>Included dates when corrective action will be completed:</p> <ul style="list-style-type: none"> <li>- Corrective action completion date by Nursing Home Administrator and/or designee.</li> </ul>		
F 698 SS=D	<p>Dialysis CFR(s): 483.25(l)</p> <p>§483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and</p>	F 698	F698 Dialysis	9/30/21	

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F 698	<p>Continued From page 67</p> <p>record review, the facility failed to provide care to a resident who requires dialysis receive such services consistent with professional standards of practice for R78. The deficient practice places the resident at risk of complications which could result in serious illness and/or death.</p> <p>Findings include:</p> <p>R78 was admitted to the facility on 08/02/21 and undergoes dialysis treatment three (3) times a week on Monday, Wednesday, and Friday.</p> <p>On 08/09/21 at 12:43 PM, conducted an interview with R78. The resident stated that she had returned from her hemodialysis appointment at approximately 11:30 AM. Inquired with R78 regarding how staff monitor her access site. The resident stated, "staff usually look at the access site and check my blood pressure, but staff has not been in to check me since I got back from my dialysis appointment."</p> <p>On 08/11/21 at 11:13 AM, conducted a concurrent interview with the DON and record review of R78's EMR. R78's admission MDS documented the resident scored a 14 on the BIMS, indicating the resident is cognitively intact. The DON stated the facility uses a form titled "Dialysis Communication Record" as a tool to communicate with the dialysis treatment facility and should be filled out prior to the resident's appointment. The form provides information regarding the following areas: medication(s) given past six (6) hours prior to dialysis, access site condition, condition changes (i.e., abnormal/changes in labs, vital signs, mental, Medications i.e. antibiotics), and the name staff completing the form. The Dialysis</p>	F 698	<p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility's credible allegation of compliance.</p> <p>1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <ul style="list-style-type: none"> <li>- On 8/13/21, to promote corrective action for the cited deficiency, and to ensure that the deficient practice does not occur, nursing staff were in-serviced on the importance to assess and monitor residents returning from dialysis</li> <li>- On 9/18/21 Director of Nursing (DON) conducted a record review, findings reveal Resident R78 was assessed by licensed nurse.</li> <li>- Resident R78 endured no harm from the cited deficiency and care was provided for the resident by facility staff.</li> </ul> <p>2) Address how the facility will identify other residents having the potential to be</p>		

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F 698	Continued From page 68 Communication Record form dated 8/4/21 was not complete and did not provide information regarding the resident's access site condition, condition changes, or the name of the staff completing the form. The DON confirmed all the areas of the form should be filled out but was not. Inquired with the DON if there was a timeframe during which staff are expected to assess and monitor the resident after returning from a dialysis appointment. The DON stated staff should access the resident immediately upon returning, but if it is not possible then staff should access the resident within the first 30 minutes after returning to the facility. The DON confirmed R78 was not assessed until several hours after returning to the facility. (Refer to F725).	F 698	affected by the same deficient practice .  - The alleged practice has the potential to affect facility residents who receive dialysis care and treatment.  3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?  - Licensed staff were in-serviced on the following information to ensure that residents who require dialysis receive such care and services, consistent with professional standards of practice: " Proper monitoring of all dialysis residents prior to and upon return to facility from dialysis " The purpose of the dialysis communication form, and the importance of completing the form accurately and completely prior to dialysis " When the form needs to be completed " Protocol for pre and post dialysis assessment, and timely documentation " Nurse competency assessment  - To promote continuity of care, and to prevent deficient practice regarding proper protocol/practices for safe care of residents receiving dialysis, licensed staff will be provided with education, as aforementioned, at new hire orientation, and at least annually, by the Director of Nursing Service (DON) or designee.		

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F 698	Continued From page 69	F 698	<p>- Licensed staff will be trained and retrained ongoing as deemed necessary.</p> <p>4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.</p> <p>- To protect residents in similar situations, and to reduce the risk of complications, facility staff were in-serviced on ensuring that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>- The Aloha Nursing &amp; Rehab Centre - Dialysis Auditing Tool was created to aid in monitoring that residents receiving dialysis receive care and services, consistent with professional standards of practice.</p> <p>- Weekly x 1 month, bimonthly x 1 month and monthly x 1 month the Director of Nursing (DON), or designee, will utilize the Aloha Nursing &amp; Rehab Centre - Dialysis Auditing Tool to randomly audit dialysis communication forms, progress notes, vital signs, and nursing post dialysis notes. All findings of concern will</p>		

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F 698	Continued From page 70	F 698	<p>be immediately addressed, and corrective action, and resident assessment, as deemed necessary, is to be taken immediately and staff education is to be provided as deemed necessary.</p> <ul style="list-style-type: none"> <li>- To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved.</li> <li>- If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met.</li> <li>- Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate.</li> </ul> <p>Included dates when corrective action will be completed:</p> <ul style="list-style-type: none"> <li>- Corrective action completion date by Nursing Home Administrator and/or designee.</li> </ul>		
F 725 SS=E	<p>Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)</p> <p>§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</p>	F 725		9/30/21	

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F 725	<p>Continued From page 71</p> <p>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).</p> <p>§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.</p> <p>§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 observations, interviews, and record review, the facility failed to ensure sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by the resident assessments, individual plans of care considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment.</p> <p>Findings include:</p>	F 725	<p>F725 Sufficient Nursing Staff</p> <p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility <input type="checkbox"/>s credible allegation of compliance.</p>		



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F 725	<p>Continued From page 72</p> <p>1) On 08/09/21 at 08:35 AM, conducted an interview with R103 in the resident's room. R103 stated at home, he/she would wake up, get cleaned up (i.e., brush teeth, comb hair, wash face, and change clothes) then eat breakfast. The resident further explained that after waking up with morning breath, the food does not taste good, so R103 has requested to "clean up and brush my teeth, but I need the staff's help and they aren't able to help me at times." R103 pointed out the breakfast on the resident's bedside table and that the resident had not been helped with brushing his/her teeth despite asking staff for help. The resident also stated when she was first admitted she needed help with eating meals and had to wait 35-45 minutes before receiving assistance with meals.</p> <p>On 08/11/21 at 09:00 AM, conducted an interview with RN19. RN19 confirmed, R103 can make needs known and staff try to assist the resident with all requests made. However, there is only one RN and one CNA assisting residents and although staff try, staff are not always able to assist residents as needed.</p> <p>Conducted a concurrent interview with the DON and review of R103's EMR on 08/11/21 at 12:13 PM. An admission MDS with an ARD of 07/29/21 documented in Section G. Functional Status, R103 required extensive assistance of 2+ person for transferring and extensive assistance with 1-person physical assistance for dressing and eating. Section 04.000 Functional Limitation in Range of Motion documented R103 has impairment on both sides of the upper and lower extremities. Review of R103's care plan documented the resident is autonomous in his/her daily routine which the DON explained</p>	F 725	<p>1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>- To ensure and promote the highest practicable physical, mental, and psychosocial well-being of the residents found to have been affected by the deficient practice, the following actions were taken:</p> <p>- On 8/13/21, to address concerns regarding Resident R78, nursing staff were in-serviced on the importance to assess and monitor residents returning from dialysis.</p> <p>- Resident R103 was discharged on 9/07/21.</p> <p>- On 9/10/21 Resident R13 was assessed for appropriate personal care of grooming and appearance by the Director of Nursing (DON). The resident was observed to have had a bed bath, he was neatly groomed with clean gown on, his bedside table was tidied, and the Christmas decoration was removed and stored. Residents comprehensive care plan reflects the resident's preference to wear gown.</p> <p>- On 9/17/21, Resident R13 was assessed for grooming and appearance. Resident was neatly groomed, with clean gown, and bed linen changed.</p>		

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F 725	<p>Continued From page 73</p> <p>indicated the resident is able to control what he/she does from day to day. Shared R103's interview with the DON who confirmed R103 is unable to perform activities of daily living (ADL) independently and if the resident is requesting help with ADLs prior to breakfast, staff should honor the resident's request. (Refer to F561).</p> <p>2) R78 was admitted to the facility on 6/26/21 and receives dialysis treatments three (3) times a week on Monday, Wednesday, and Friday.</p> <p>On 08/09/21 at 12:43 PM, conducted an interview with R78. The resident stated that she had returned from her hemodialysis appointment at approximately 11:30 AM. During the time the resident returned from dialysis treatment, unit staff were delivering lunch and assisting other residents with meals. Inquired with R78 regarding how staff monitor her access site. The resident stated, "staff usually look at the access site and check my blood pressure, but staff has not been in to check me since I got back from my dialysis appointment."</p> <p>On 08/11/21 at 11:13 AM, conducted a concurrent interview and record review of R78's EMR. R78's admission MDS documented the resident scored a 14 on the BIMS, indicating the resident is cognitively intact. The DON stated staff should assess R78's access site, a change in condition, and obtain at least a blood pressure reading within 30 minutes of returning to the facility. The DON confirmed the time during which R78 returns to the facility, staffing numbers are stretched thin due to coinciding with lunch, nursing staff is usually busy with administering lunch time medications, and staff assisting during lunch is not necessarily qualified to assess R78</p>	F 725	<p>- On 9/18/21, the Director of Nursing (DON) conducted a record review; findings reveal Resident R78 was assessed by licensed nurse.</p> <p>- Resident R78 endured no harm from the cited deficiency and care was provided for the resident by facility staff.</p> <p>- To provide nursing and related services to assure resident safety and to attain or maintain the highest practical physical, mental, and psychosocial wellbeing of each resident, Human Resource Specialist (HRS) has applied the following measures and promoted advertising for hiring with application of the following platforms:</p> <p>" Aloha Nursing &amp; Rehab Centre website " Indeed " Realjobshawaii " Careermd " Active recruitment through our partnered schools: Healthcare Training and Career Consultants, Windward Community College, and the University of Hawaii Nursing Department - Human Resource Specialist, or a designated facility staff member, continue to guest speak at their monthly Certified Nurses Aides (CNA) graduation ceremony. " Physical posting of a We're Hiring banner has been posted by the facility sign at the front of the facility property. " The facility has also secured contracted agency workers to promote sufficient nursing staff.</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>ALOHA NURSING &amp; REHAB CENTRE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>45-545 KAMEHAMEHA HIGHWAY KANEHOHE, HI 96744</b>		
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F 725	<p>Continued From page 74 after returning from dialysis.</p> <p>On 08/12/21 at 11:07 AM, conducted an interview with the DON regarding sufficient nurse staffing. Reviewed the 2021 Facility Assessment and the staffing schedule for 08/09/21 with the DON. The staff schedule provided by the facility documented on 08/09/21, the Day shift (6-2:30) six (6) registered nurses and ten (10) certified nurse aides; Evening shift five (5) registered nurses, one (1) licensed practical nurse, and nine (9) certified nurse aides; and the Night shift there were four (4) registered nurses, and six (6) certified nurse aides were scheduled as working. The DON stated during lunch, non-direct care staff assist the direct care staff by delivering lunch trays to the residents. According to the 2021 facility assessment, 35.7% (high frequency relative to benchmark) require one-person assistance with eating. Although more staff are available to deliver trays the number of staff trained and able to assist residents with meals remain unchanged if not less when considering all nurses were observed administering medications as opposed to assisting residents with meals. Queried the DON regarding how the number and acuity of the residents are factored into scheduling of staff. The DON stated the facility staffs according to area, for example on the first floor 3 nurses are scheduled: one on the Plumeria unit, one nurse on the Gardenia unit, and one nurse that has residents on both the Plumeria and Gardenia units and the same model of staffing is applied to the second floor. Inquired if the staff model changes according to the number and/or acuity of the residents. The DON confirmed the number and/or acuity of the residents is not factored in to how the facility staffs the units. (Refer to F698).</p>	F 725	<p>- As a result of efforts put forth by the Nursing Home Administrator (NHA), HRS, and apposite staff, the following positions have been filled with newly hired associates:</p> <ul style="list-style-type: none"> <li>" Altres - Agency Hires</li> <li>" Registered Nurses</li> <li>" Registered Nurses - Per Diem</li> <li>" Nursing Assistants - To support nursing staff</li> <li>" Certified Nurses Aides</li> <li>" Infection Control Preventionist / Wound Care Specialist</li> <li>" Interns - To provide non-direct care to support nursing staff</li> </ul> <p>*New hires are put through an orientation process to promote the delivery of safe resident care</p> <p>- Aloha Nursing &amp; Rehab Centre is committed to operate our facility with superior quality to meet the needs of our residents; our residents are our highest priority, and our associates are our most valuable resource. For this reason, and to promote a collaborative effort amongst members of our facility's health care team, facility staff were educated on the facility's attendance policy, and on the importance of regular work attendance to the work flow, productivity, teamwork, and outcomes for all stakeholders.</p> <p>- The DON, Nurse Managers, and apposite staff were educated on staffing to acuity and resident needs.</p>		

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F 725	<p>Continued From page 75</p> <p>3) Surveyor received telephone call from R162's FM on 02/19/21 at 05:17 PM at OHCA. FM stated that he had concerns regarding R162 care at the facility. FM stated, I didn't see R162 for several months due to the COVID pandemic and the facility was on lock down before that I went all the time to visit. In late November 2020 I met her at the hospital when she went for a blood transfusion. I saw that her nails were overgrown and were cutting into her hands. There were sores with puss. I looked at her and almost cried. It was the week before she went to the ED, the last week of November. FM stated that R162 went to the ED by ambulance on December 1, 2020, after she stopped breathing at the facility (Refer to F686).</p> <p>4) Surveyor made observations on 08/09/21 at 8:16 AM, R13 was noted in his bed laying on his back, facing the right side. Noted a Christmas decoration on his bedside table with a few other items with dust and in disarray. He was wearing a hospital type gown that was bunched up in a wad on his chest. His hair looked unclean and uncombed. His knees were tightly bent up under him and facing to the right side. His left leg was outside of the sheet, noted excoriations on his lower leg.</p> <p>A second observation was made at 10:53 AM. R13 was in the same position. Surveyor made additional observations on 08/10/21 to 08/12/21 throughout the day shift and into the evening shift. Noted that R13 was in his bed in his hospital gown and appeared with the same disheveled hair. (Refer to F677).</p> <p>On 08/12/21 at 10:06 AM surveyor interviewed two staff, S45 and S34, who requested to remain</p>	F 725	<p>2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>- The alleged practice has the potential to affect facility residents.</p> <p>3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>- Ongoing measures set forth to promote systemic changes to ensure sufficient nursing staffing and to support our current staff includes:</p> <ul style="list-style-type: none"> <li>" Advertising for new hires</li> <li>" Offering of union approved incentives to CNAs and licensed nurses - For all shifts; including evening and noc shift to ensure adequate assistance with delivery of meals, resident care needs, and grooming</li> <li>" Staff appreciation and recognition with food, games, and door prizes</li> <li>" Tracking of staff attendance</li> <li>" Providing staff with appropriate support and counseling as deemed necessary</li> </ul> <p>- To promote continuity of care, and to prevent deficient practice regarding insufficient nursing staffing, facility staff were educated on facility's the attendance policy, and on the importance of regular work attendance to the work flow, productivity, teamwork, and</p>		

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F 725	Continued From page 76 anonymous. Surveyor asked S45 how often are the showers and personal care being done for R13? S45 responded that today we have three CNAs assigned to this side and one who floats between the two sides. We try to do personal care when we make our rounds, baths are usually given two to three times a week. This is the heaviest floor; we really need at least four CNA's because the residents are heavier and more dependent. Sometimes we just can't get to everything, and they don't get all the personal care. S34 stated that she would like to have more time to provide more personalized care to the residents like grooming and cleaning nails. We are often short staffed, there's just no time for those things.	F 725	<p>outcomes for all stakeholders.</p> <ul style="list-style-type: none"> <li>- As aforementioned, facility staff will be provided with education on the facility's attendance policy to promote positive outcomes for all stakeholders, at new hire orientation, and at least annually, by the Nursing Home Administrator, Director of Nursing Service (DON), or designee.</li> <li>- Daily nursing staffing and facility census is discussed and reviewed at the daily morning Stand Up meeting.</li> <li>- A staffing chart was created to determine and identify ideal vs. critical staffing levels; staffing levels are reviewed daily by the DON or designee, and auditing of these levels are conducted biweekly by the DON or designee.</li> <li>-The DON, or designee, will utilize the Facility Assessment and facility census to determine resident acuity and nursing staff needs.</li> <li>- When staffing level falls below ideal for all shifts (including evening and noc shifts), based on the DON's assessment, contingency measures will be put in place to ensure resident care are being met: <ul style="list-style-type: none"> <li>" The nursing leadership team, including nurse managers, assist with direct care tasks to ensure that all resident care needs are met</li> <li>" The facility non-nursing managerial team help to provide non-direct support, similar to that of interns, such as answering call lights, emptying trash bins,</li> </ul> </li> </ul>		

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F 725	Continued From page 77	F 725	<p>etc.</p> <p>" Reliant Rehabilitation staff provides assistance in accordance with their skill set.</p> <p>4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.</p> <p>- The DON, or designee, will conduct daily random care rounds to promote sufficient nursing staff compliance with residents <input type="checkbox"/> acuity and daily care needs.</p> <p>- To promote sufficient nursing staffing, collaborative action is to taken as aforementioned, and staff education concerning attendance is ongoing and to be provided as deemed necessary.</p> <p>- The DON, or designee, is to complete weekly x 1 month, bimonthly x 1 month and monthly x1 month audit of the care rounds and staff schedule findings for a minimum of 12 weeks to ensure compliance.</p> <p>- To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or</p>		

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F 725	Continued From page 78	F 725	until compliance is achieved.  - If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met.  - Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate.  Included dates when corrective action will be completed:  - Corrective action completion date by Nursing Home Administrator and/or designee.		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)  §483.45(f) Medication Errors. The facility must ensure that its-  §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure its nursing staff administered medications correctly to one resident, R61. The deficient practice places the residents at an increased risk for illness and/or an adverse event. The Licensed Nurse (LN) failed to follow procedures within professional standards of practice that resulted in missed medications for	F 759	F759 Free of Medication Error RTs 5 Prcnt or More  Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission	9/30/21	

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F 759	<p>Continued From page 79 R61.</p> <p>Findings include:</p> <p>During an observation on 08/11/21 at 08:25 AM, Licensed Practical Nurse (LPN) 10 administered medication to R61. After medications were administered, LPN10 returned to the medication cart and stated, "all my medications are done." Surveyor asked if LPN10 would be signing the medications off as given. LPN 10 stated "I am done." Surveyor asked to see the Medication Administration Record (MAR). LPN10 opened the EMR, and the MAR reflected that LPN had signed all the 08:00 AM medications prior to administering medications. Surveyor asked LPN 10 if she typically signed the medications prior to administering them? LPN 10, smiled and stated, "I know."</p> <p>During record review to reconcile the medications on 08/11/21 at 09:30 AM, surveyor noted two 08:00 AM medications (Ventolin and Aspirin) were not administered during observation with LPN10.</p> <p>During an interview on 08/11/21 at 10:24 AM with LPN 10: Surveyor stated to LPN10 when reconciling the medication administration observation with you for the medication administered to resident R61 with the EHR, physician orders, and the MAR, noted two medications that were not administered and were signed off. The medications were Ventolin and Aspirin" LPN10 stated, "it was an honest mistake. I administered the Ventolin." Surveyor asked when was the medication given? LPN10 paused ... then stated, "I went to give the medication after I administered the medications with you (Surveyor). The aspirin is every other day."</p>	F 759	<p>of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility's credible allegation of compliance.</p> <p>1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <ul style="list-style-type: none"> <li>- On 10/1/21, Resident R61 was physically assessed for the resident's well-being by the Director of Nursing (DON); the resident's vital signs were assessed to be within normal limits specific to the resident</li> <li>- Licensed nurses have been educated on professional standards of practice for medication administration to decrease the risk for illness and/or an adverse event <input type="checkbox"/> Preparation and General Guidelines: Medication Administration- General Guidelines.</li> </ul> <p>2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <ul style="list-style-type: none"> <li>- The alleged practice has the potential to affect facility residents.</li> <li>- On 9/20/21, an associate of the facility's partnered pharmacy completed</li> </ul>		



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F 759	Continued From page 80 Surveyor asked, "Is the aspirin due today?" LPN 10 stated, "No, the aspirin is not due today, it is due tomorrow." The MAR noted that the 08:00 AM dose of Aspirin was administered as representative of LPN 10 having signed the medication off in the EHR prior to administering to R 61. The medication order stated Mon, Wed and Friday.	F 759	a station check of random medication carts and observed a nurse complete a medication pass - preparation and administration of medication.  - To identify other residents having the potential to be affected by the identified deficient practice, the F-759 & F-761 Medication Pass and Storage Audit form was created.  - The DON or designee is to monitor and manage compliance by performing random assessments of compliance during weekly completion of the F-759 & F-761 Medication Pass and Storage Audit form.  - Completed forms are to be kept in a binder in the Nursing Home Administrator's (NHA's) office or designee.  3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?  - To ensure quality assurance and effectiveness, licensed nurses have been in-serviced on professional standards of practice for medication administration (including timeliness, safe administration, and accuracy of documentation) to decrease the risk for illness and/or an adverse event - Preparation and General Guidelines: Medication Administration- General Guidelines.		

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

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F 759	Continued From page 81	F 759	<ul style="list-style-type: none"> <li>- A copy of the referenced document has been provided to the in-serviced licensed nurses.</li> <li>- Upon return from previously schedule time off, Licensed Practical Nurse (LPN), referenced as LPN 10, will be provided with education regarding the importance of adhering to procedures within professional standards of practice for medication administration.</li> <li>- LPN 10 will be in-serviced on not to sign off on medications prior to administering the medication to a resident.</li> <li>- LPN 10 will be in-serviced on the medication rights of administration.</li> <li>- LPN 10 will be in-serviced on adhering to professional standards of practice for medication administration.</li> <li>- A copy of the Preparation and General Guidelines: Medication Administration- General Guidelines will be provided to LPN 10</li> <li>- In-services will be ongoing as needed.</li> </ul> <p>4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The</p>		

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F 759	Continued From page 82	F 759	<p>plan of correction is integrated into the quality assurance system.</p> <ul style="list-style-type: none"> <li>- An associate of the facility's pharmacy partner will continue to conduct a quarterly pharmacy station check of random medication carts, and a monthly observation of a random nurse medication pass - preparation and administration of medication. However, frequency of occurrence may be subject to change as a result of COVID-19 safety rules and regulations set forth in the best interest of all stakeholders.</li> <li>- To ensure quality assurance and effectiveness of promoting the wellbeing of our residents, and upholding the residents' rights for systemic changes, ongoing monitoring and random evaluation with application of the F-759 &amp; F-761 Medication Pass and Storage Audit form will be completed.</li> <li>- Completion of this tool is to occur weekly x 1 month, bimonthly x 1 month and monthly x 1 month by the DON or designee for a minimum of 12 weeks to ensure compliance.</li> <li>- Corrective action is to be taken immediately and staff education is to be provided as deemed necessary.</li> <li>- To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or</li> </ul>		

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F 759	Continued From page 83	F 759	until compliance is achieved.  - If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met.  - Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate.  Included dates when corrective action will be completed:  - Corrective action completion date by Nursing Home Administrator and/or designee.		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)  §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  §483.45(h) Storage of Drugs and Biologicals  §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		9/30/21	

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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 761	<p>Continued From page 84</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to store biologicals (purified protein derivative) in accordance with accepted professional principles within the expiration date.</p> <p>Findings include:</p> <p>On 08/11/21 at 08:52 AM Surveyor inspected the second-floor refrigerator in the medication room on the second floor nursing station. One vial of purified protein derivative (PPD), (used for Tuberculin skin testing) was found with an open date 07/05/21 written on the box. Confirmed with RN16, the vial of PPD expired on 08/05/21. RN16 removed the vial and discarded it into the discard bin.</p>	F 761	<p>F761 Label/Store Drugs and Biologicals</p> <p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility's credible allegation of compliance.</p> <p>1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>- On 8/12/21, to ensure that the facility stored biologicals in accordance with accepted professional principals within the expired date, nursing associates immediately</p>		

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F 761	Continued From page 85	F 761	<p>conducted a facility-wide sweep of medication refrigerators to ensure there were no other instances of expired and/or undated biologicals being stored.</p> <p>- Licensed nurses have been educated on professional standards of practice for storage of drugs and biologicals <input type="checkbox"/> Medication Storage in the Facility.</p> <p>2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents have the potential to be affected by this alleged deficient practice. After the facility medication refrigerators sweep on 8/12/21 it was determined that no residents could be affected by this cited alleged deficiency.</p> <p>- The alleged practice has the potential to affect facility residents.</p> <p>- On 9/20/21, an associate of the facility <input type="checkbox"/>s partnered pharmacy completed a station check of random medication carts to assess for proper label/store of drugs and biologicals.</p> <p>- To identify other residents having the potential to be affected by the identified deficient practice, the F-759 &amp; F-761 Medication Pass and Storage Audit form was created.</p> <p>- The Director of Nursing (DON) or designee is to monitor and manage</p>		

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F 761	Continued From page 86	F 761	<p>compliance by performing random assessments of compliance during weekly completion of the F-759 &amp; F-761 Medication Pass and Storage Audit form.</p> <p>- Completed forms are to be kept in a binder in the Nursing Home Administrator's (NHA's) office or designee.</p> <p>3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>- In-service education will be conducted with licensed staff by the DON or designee upon hire and at least annually regarding the facilities Medication Storage Policy and Procedure.</p> <p>- On 09/12/21, refrigerated medication was assessed and audited by licensed staff to ensure proper labeling and storage of medication and biologicals was in compliance with accepted professional principles within the expiration date.</p> <p>- To ensure quality assurance and effectiveness, licensed nurses have been in-serviced on professional standards of practice for proper storage of drugs and biologicals - Medication Storage in the Facility.</p> <p>- A copy of the referenced document has been provided to the in-serviced licensed nurses.</p>		

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F 761	Continued From page 87	F 761	<p>- In-services will be ongoing as needed</p> <p>4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.</p> <p>- The DON or designee will conduct random audits of medication refrigerators to ensure facility is in compliance. Audit findings will be reviewed at the monthly QA meetings and continued randomly until such time consistent satisfaction is reported.</p> <p>- An associate of the facility's pharmacy partner will continue to conduct a quarterly pharmacy station check of random medication carts. However, the frequency of occurrence may be subject to change as a result of COVID-19 safety rules and regulations set forth in the best interest of all stakeholders.</p> <p>- To ensure quality assurance and effectiveness of promoting the wellbeing of our residents, and upholding the residents' rights for systemic changes, ongoing monitoring and random evaluation with application of the F-759 &amp; F-761 Medication Pass and Storage Audit form will be completed.</p>		



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F 761	Continued From page 88	F 761	<ul style="list-style-type: none"> <li>- Completion of this tool is to occur weekly x 1 month, bimonthly x 1 month and monthly x 1 month by the DON or designee for a minimum of 12 weeks to ensure compliance.</li> <li>- Corrective action is to be taken immediately and staff education is to be provided as deemed necessary.</li> <li>- To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved.</li> <li>- If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met.</li> <li>- Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate.</li> </ul> <p>Included dates when corrective action will be completed:</p> <ul style="list-style-type: none"> <li>- Corrective action completion date by Nursing Home Administrator and/or designee.</li> </ul>		
F 812 SS=F	Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		9/30/21	

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F 812	<p>Continued From page 89</p> <p>§483.60(i) Food safety requirements. The facility must -</p> <p>§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.</p> <p>§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 policy review, the facility failed to follow acceptable sanitation practices in the kitchen. As a result, the facility increased the potential for development of foodborne illnesses.</p> <p>Findings Include:</p> <p>On 08/09/21 at 08:00 AM, during the initial tour of the kitchen, a blanket cloth that appeared wet and dirty was noted under the grill on the floor in a puddle of water. The Kitchen Supervisor (KS) explained to the surveyor the blanket cloth was placed there because the grill was leaking.</p> <p>On 08/11/21 at 10:49 AM during an additional tour of the kitchen, the blanket cloth under the grill</p>	F 812	<p>F812 Food Procurement, Store/Prepare/Serve-Sanitary</p> <p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility's credible allegation of compliance.</p>		

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F 812	<p>Continued From page 90</p> <p>remained in the same place in a puddle of water. The Kitchen Manager (KM) was queried and acknowledged that the blanket cloth appeared dirty and had the potential for the development of foodborne illnesses. KM stated that they would remove the dirty blanket cloth. KM also stated that the facility planned to have the kitchen professionally cleaned in July and/or December.</p> <p>A review of facility policy on sanitation guidelines stated: Policy, it is the policy of this facility that food service areas shall be maintained in a clean and sanitary manner. Procedure, all kitchen, and dining areas shall be kept clean, free from litter and rubbish...</p>	F 812	<p>1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>- It continues to be the practice of the facility to ensure a safe and sanitary food service environment, to promote corrective action for the cited deficiency, on 8/11/21, the Food &amp; Nutritional Services Manager (FNS) removed the identified cloth that was located beneath the grill.</p> <p>- On 9/16/2021, the FNS Manager in-serviced staff members of the Nutritional Services Department/Dietary Department to utilize a catchment container when cleaning the grill, and on the rationale of these applied changes; use of the catchment container is to replace use of the identified cloth.</p> <p>2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>- The alleged practice has the potential to affect facility residents.</p> <p>3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>- On 9/14/21, an Aloha Nursing Rehab</p>		

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F 812	Continued From page 91	F 812	<p>Centre - Grease Catcher Cleaning Log auditing tool was created to promote sanitary food procurement, storage, preparation, and serving.</p> <ul style="list-style-type: none"> <li>- This log is to be completed on a daily basis by the FNS Manager or designee.</li> <li>- Corrective measures are to be taken immediately, and dietary staff will be trained and retrained as deemed necessary.</li> <li>- Weekly auditing of the Aloha Nursing Rehab Centre - Grease Catcher Cleaning Log is to be completed by the FNS Manager or designee</li> <li>- All residents have the potential to be affected by the identified deficient practice. FNS Manager in-serviced the FNS cook staff regarding temporary protocol utilizing the catchment pan when cleaning the grill until a permanent fix is completely.</li> <li>- The FNS staff were in-serviced on proper sanitation and cleaning protocol at new hire orientation, at least annually, and ongoing as deemed necessary.</li> <li>- Employee cleaning schedule and list of duties will be assigned to FNS staff at the beginning of each week.</li> <li>- FNS Manager will review cleaning list at the end of each week.</li> <li>- Frequency of outside professional</li> </ul>		

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F 812	Continued From page 92	F 812	<p>cleaning service will be changed from biannually to quarterly.</p> <p>4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.</p> <ul style="list-style-type: none"> <li>- To ensure quality assurance and effectiveness of promoting sanitary food procurement for the wellbeing of our residents, and upholding the residents' rights for systemic changes, ongoing monitoring and random evaluation with application of the Aloha Nursing Rehab Centre - Grease Catcher Cleaning Log, the auditing tool is to be completed daily by the FNS Manager or designee.</li> <li>- Auditing of this tool is to occur weekly by the FNS Manager, or designee, for a minimum of 12 weeks to ensure compliance.</li> <li>- Corrective action is to be taken immediately and staff education is to be provided as deemed necessary.</li> <li>- To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or</li> </ul>		

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F 812	Continued From page 93	F 812	until compliance is achieved.  - If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met.  - Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate.  Included dates when corrective action will be completed:  - Corrective action completion date by Nursing Home Administrator and/or designee.		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4)  §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.  §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in	F 849		9/30/21	

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F 849	Continued From page 94 paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.	F 849			

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F 849	<p>Continued From page 95</p> <p>(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.</p> <p>(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.</p> <p>(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.</p> <p>(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.</p> <p>(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.</p>	F 849			



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F 849	<p>Continued From page 96</p> <p>§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.</p> <p>The designated interdisciplinary team member is responsible for the following:</p> <ul style="list-style-type: none"> <li>(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.</li> <li>(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.</li> <li>(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.</li> <li>(iv) Obtaining the following information from the hospice: <ul style="list-style-type: none"> <li>(A) The most recent hospice plan of care specific to each patient.</li> <li>(B) Hospice election form.</li> <li>(C) Physician certification and recertification of the terminal illness specific to each patient.</li> <li>(D) Names and contact information for hospice</li> </ul> </li> </ul>	F 849			

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F 849	<p>Continued From page 97</p> <p>personnel involved in hospice care of each patient.</p> <p>(E) Instructions on how to access the hospice's 24-hour on-call system.</p> <p>(F) Hospice medication information specific to each patient.</p> <p>(G) Hospice physician and attending physician (if any) orders specific to each patient.</p> <p>(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.</p> <p>§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to provide coordination of the following services and responsibilities in collaboration with the hospice provider:</p> <p>1) The facility did not designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the facility staff and hospice staff.</p> <p>2) The facility failed to ensure that R16's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the facility coordinated into one joint plan of care.</p> <p>The deficient practice fails to ensure that one</p>	F 849	<p>F849 Hospice Services</p> <p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility <input type="checkbox"/>s credible allegation of compliance.</p>		

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F 849	<p>Continued From page 98</p> <p>resident, R16 will attain the highest practicable physical, mental, and psychosocial well-being while receiving end of life care.</p> <p>Findings include:</p> <p>Surveyor saw R16 on 08/09/21 at 08:45 AM, and noted he was laying in his bed, restless with his gown pulled up on to his neck exposing his full chest. He appeared alert, nonverbal and his hair looked disheveled. Surveyor made additional observations on 08/09/21 at 10:30 AM; 02:00 PM; 08/10/21 at 08:29 AM and 01:52 PM. Surveyor noted R16 was laying in his bed with the same observations, hospital gown bunched up around his neck exposing his torso, fidgeting, and moving his arms around.</p> <p>Surveyor reviewed the EMR on 08/11/21 at 10:38 AM. Care plan stated R16 readmitted with colon cancer and is now receiving hospice care.</p> <ul style="list-style-type: none"> <li>- Provide daily recreational activities and encourage R16 to participate in his chosen activities of interest. It is very important to listen to Hawaiian music, receive pet visits, keep up with the news via television, participate in group activities in his room, please assist him with his preferred activities. 02/28/21 Active. Surveyor did not observe R16 engage in activities during the survey from 08/09/21 to 08/12/21.</li> <li>- In collaboration with Hospice provider, will create an activity care plan based on R16's preferences and interests, and customize the care plan for a routine that fits his current abilities with the goal of R16 enjoying his daily routine and activities of leisure.</li> </ul> <p>Care Plan Description. Receiving Hospice Care. Goal: R16 experiences a peaceful, dignified death 10/20/20 reviewed 01/26/21 Active.</p>	F 849	<p>1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <ul style="list-style-type: none"> <li>-On 8/12/21, the facility reached out to the hospice provider for Resident R16 to ensure that the facility had the most updated hospice care plan.</li> <li>- On 9/17/21, the facility identified that the Unit Manager (UM) will be the designated staff member of the interdisciplinary team (IDT) who will be responsible for collaborating with the hospice representative to coordinate care to the resident by both the facility and hospice health care organization.</li> <li>- On 9/17/21, Resident R16's hospice provider's licensed nurse was contacted to discuss the need for a combined written care plan for Resident R16. This coordinated care plan will include Resident R16's most recent hospice plan of care and the facility's plan of care to promote continuity of care, and to attain the highest practicable physical, mental and psychosocial well-being while receiving end of life care.</li> <li>- Resident R16's person-centered care plan includes most recent hospice plan of care to attain the highest practicable physical, mental and psychosocial well-being while receiving end of life care.</li> <li>- Resident R16's information regarding</li> </ul>		

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F 849	<p>Continued From page 99</p> <p>Interventions: Provide with grief and spiritual counseling if desired. 10/20/20 Active. All Coordinate with the Hospice Team to assure resident experiences as little pain as possible 10/20/20.</p> <p>Coordinate care with Hospice Team. 10/20/20.</p> <p>Reviewed Hospice and Nursing facility services agreement.</p> <p>3.3.1 Development and implementation of the Joint Plan of Care (JPOC). Hospice Plan of Care. All services provided to Hospice Patients under the Agreement must be in accordance with the Joint Plan of Care. ...shall identify the care and services needed and specifically identify whether Hospice or Facility is responsible for performing the respective functions that have been agreed upon and included in the Plan of Care.</p> <p>3.3.8. Documentation of Services. Both Parties shall maintain appropriate documentation of services provided under this Agreement. Surveyor reviewed both the facility and hospice plan of care. Neither document states the coordination of services with the other and responsibility of each provider, the two care plans are separate.</p> <p>Surveyor interviewed RN16 on 08/11/21 at 12:02 PM. Surveyor asked RN16 what services are being provided under hospice? RN16 replied that she wasn't currently aware of the type of services that were being offered and that the hospice nurse (HN) usually comes in on Wednesday. When asked where the surveyor can find the HN notes, replied that they do their own charting in an EMR. She explained that R16 came back from the hospital with a gastrointestinal (GI) bleed.</p>	F 849	<p>hospice care plans was identified and communicated to nursing staff through the shift report</p> <ul style="list-style-type: none"> <li>- To promote continuity of care and collaboration amongst the facility and hospice agencies, UMs and licensed staff were educated regarding the formulation of a coordinated care plan between the facility and hospice agencies for facility residents receiving hospice services.</li> </ul> <p>2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <ul style="list-style-type: none"> <li>- The facility has determined that all residents receiving hospice services have the potential to be affected. For quality assurance, an audit of all residents receiving hospice services was conducted and addressed as deemed necessary.</li> <li>- To identify other residents having the potential to be affected by the identified deficient practice, the Aloha Nursing &amp; Rehab Centre (ANRC) F-655 &amp; F-656 Baseline Care Plan Auditing Tool was created.</li> <li>- The DON, Minimum Data Set (MDS) Manager and Coordinators, or designee is to monitor and manage compliance by performing a facility wide assessment of compliance of coordinated hospice services with application of the Aloha Nursing &amp; Rehab Centre (ANRC) F-655 &amp; F-656 Baseline Care Plan Auditing Tool.</li> </ul>		

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F 849	<p>Continued From page 100</p> <p>Surveyor located the hospice provider binder in the second-floor nursing station on 08/11/21 at 12:10 PM. Surveyor reviewed the Comprehensive Assessment Details. No inter-disciplinary team (IDT) notes were found. Per the snapshot, skilled nursing (SN): Visits two times weekly and two as needed visits every seven days. Hospice aide weekly visits as ordered. The Licensed social worker (LSW) will continue to visit one time per month and one time as needed every 30 days to assess for psychosocial needs.</p> <p>Medical Doctor (MD): Medications reviewed for interactions. Continue current plan of care. Monitor for further decline.</p> <p>Reviewed the face-to-face visit details by the physician dated 03/24/21. Admitted to hospice with primary diagnosis of malignant neoplasm of sigmoid colon. Requires maximum to complete assist with all activities of daily living, (ADL's) including 1:1 feeding assistance.</p> <p>Plan of care effective 04/17/21. Reviewed the Hospice interdisciplinary progress notes.</p> <p>08/12/21 01:04 PM Surveyor interviewed the Social Services Director (SSD). When asked who the designated point of contact in the facility is who collaborates with the Hospice IDT and attends the care plan meetings, the SSD stated there isn't one person who is the liaison, the team members collaborate with the hospice team. Requested the Joint plan of care which describes what each caregiver in the facility and in the hospice is providing to the resident.</p> <p>Surveyor reviewed the hospice plan of care on 08/12/21 at 02:30 PM. Noted "Problem" Potential deficit r/t poor communication between Hospice provider and Facility will coordinate care reflected</p>	F 849	<p>- Completed forms are to be kept in a binder in the Nursing Home Administrator's (NHA's) office or designee.</p> <p>3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>- On 9/24/21, the MDS Manager, MDS coordinators, and licensed staff were in-serviced by the DON on the development, revision, and implementation process of person-centered comprehensive care plans.</p> <p>- In-services will be ongoing as needed, and will also be conducted with the Director of Nursing (DON) or designee at new hire orientation and, at least, annually addressing the continuity of care by combining Hospice and Facility care plans at new hire orientation and at least annually.</p> <p>- Facility staff were regarding the importance of coordinating services and responsibilities in collaboration with participating hospice providers to promote quality of care necessary for the care of resident's terminal illness and related conditions.</p> <p>- The IDT meetings will include documentation of hospice</p>	

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F 849	Continued From page 101 in the collaborative plan of care. Interventions Invite facility representative to inter disciplinary team meetings (IDT). The plan of care listed the services the hospice staff were going to provide and did not include the care and services and who was responsible in the facility.	F 849	<p>communication/collaboration of the identified plan of care.</p> <ul style="list-style-type: none"> <li>- The DON, Admissions Coordinator, or designee will continue to educate and re-educate hospice vendor on the required coordinated person-centered care plan for residents receiving hospice services.</li> <li>- Residents identified with incomplete or inaccurate hospice coordinated care plans updated immediately by the UM, or designee, to reflect their current goals, interventions, and appropriate approaches to address their medical and treatment needs.</li> </ul> <p>4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.</p> <ul style="list-style-type: none"> <li>- To ensure quality assurance and effectiveness of the aforementioned systemic changes to promote quality of care and services for our hospice residents to attain or maintain their highest practicable physical, mental, and psychosocial well-being, random monitoring and evaluation with application of the Aloha Nursing &amp; Rehab Centre (ANRC) F-655 &amp; F-656 Baseline Care</li> </ul>		

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F 849	Continued From page 102	F 849	<p>Plan Auditing Tool.</p> <ul style="list-style-type: none"> <li>- Completion of this tool is to occur weekly x 1 month, bimonthly x 1 month and monthly x 1 month by the DON or designee for a minimum of 12 weeks to ensure compliance.</li> <li>- Corrective action is to be taken immediately and staff/hospice agency education is to be provided as deemed necessary.</li> <li>- To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved.</li> <li>- If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met.</li> <li>- Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate.</li> </ul> <p>Included dates when corrective action will be completed:</p> <ul style="list-style-type: none"> <li>- Corrective action completion date by Nursing Home Administrator and/or designee.</li> </ul>		

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F 880 F 880 SS=E	Continued From page 103 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;  §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;	F 880 F 880		9/30/21	



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F 880	<p>Continued From page 104</p> <p>(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.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. 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 observation, interview and record review, the facility failed to ensure it provided a safe, sanitary environment to prevent the development and transmission of communicable diseases and infections for its residents. The facility staff created a breach in its infection control when staff improperly donned personal protective equipment (PPE) and did not properly isolate residents with infections. The deficient</p>	F 880	<p>F880 Infection Prevention &amp; Control</p> <p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or</p>		

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F 880	<p>Continued From page 105</p> <p>practice jeopardizes the health and safety for its vulnerable residents and staff working in the facility.</p> <p>Findings include:</p> <p>1) On 08/09/21 at 11:05 AM observed one R15 sitting in his wheelchair in the doorway of his room. Noted contact precaution signs outside the door and a PPE cart outside of the room. Per RN17 he is on contact precautions for an abscess of the stoma that tested positive for MRSA. R15's colostomy bag was visible and hanging below the front of his shirt. At 12:09 PM R16 walked out of his room pushing the overbed table and gave his lunch plate to the staff. His colostomy bag was visible hanging out under his shirt. Surveyor noted that another resident's family member was near R15's room visiting in the hallway. At 1:52 PM, R15 was observed sitting up in his wheelchair in the second-floor activity room. Surveyor asked the unit manager if R15 was supposed to be in his room since he is on contact precautions, the unit manager (UM2) replied that the infected area is covered so he can be out of his room, although his bag needs to be covered. Surveyor made additional observations during the survey of R15 outside of his room wheeling around the unit and sitting and speaking with staff in the activity/ dining area on the second floor. Noted the colostomy bag was visibly hanging outside of his shirt.</p> <p>2) PM During an observation in front of room 220 on 08/10/21 at 04:11 PM, noted contact isolation signage at the door. Surveyor observed staff go into the room with a Hoyer lift wearing only a mask. Surveyor asked RN17 why the resident was on contact precautions which she stated was</p>	F 880	<p>may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility's credible allegation of compliance.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.</p> <p>Director of Nursing Services (DON) or designee will infection control compliance. Audit weekly x 1 month, bimonthly x 1 month, and monthly x 1 month. All findings of concern will be immediately addressed with the individual staff member. Audit findings will be reviewed and discussed during the monthly QA meetings until such time consistent satisfaction is reported.</p> <p>Included dates when corrective action will be completed: Corrective action completed on 9/26/21, DPOC due 10/7/21.</p> <p>1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p>		

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F 880	<p>Continued From page 106</p> <p>because he has a wound on his toe with MRSA. When asked if the staff should be gowning and masking before going in, she looked at the sign and said yes. The CNA came out of the room and stated only if we are providing care to the toe we will gown and glove. RN17 stated while pointing at the resident who was sitting in the Geri chair outside the room in the hall, he has his wound covered and he's on antibiotics.</p> <p>3) On 08/09/21 at 10:08 AM noted R12 was laying sideways on his bed sleeping. Urinary catheter bag was laying on the bed next to the resident. Surveyor validated with the UM that the urinary bag should be hanging down to the side, below the resident.</p> <p>Surveyor reviewed the EMR for R12 on 08/10/21 at 01:47 PM. The Care plan stated, R12 is diagnosed with acute bacteremia and on oral antibiotics. Start date 04/23/21, Review Date 09/10/21. Diagnosis Chronic kidney disease, stage four, severe fever unspecified on 04/16/21. On 08/12/21 at 09:00 AM, noted R12 Wheeling his self-down the hallway in his wheelchair, noted the catheter was laying on the seat of the wheelchair.</p> <p>Surveyor reviewed the facility assessment on 08/11/21 at 02:00 PM and noted high rates of infections, wound, UTI, septicemia, and MDRO.</p> <p>Surveyor interviewed the infection preventionist (IP) on 08/12/21 at 10:23 AM. Surveyor asked to discuss the log of identified breaches and what type of breaches were identified. The IP stated that on Monday, there were possibly two breaches, the staff went into an isolation room without wearing any PPE. The second was when a staff went in without a face shield. The IP</p>	F 880	<p>- On 8/10/21, CNA44 was provided remediation in regards to donning and doffing of personal protective equipment (PPE) and proper droplet isolation precautions requirements.</p> <p>-On 8/10/21, regarding Resident R262, appropriate PPE was made available at point of care location required for droplet isolation precautions.</p> <p>-On 8/10/21, Resident R314 received negative PCR COVID test results clearing the resident of isolation precautions.</p> <p>-On 8/11/21, Resident R315 received negative PCR COVID test results clearing the resident of isolation precautions.</p> <p>- On 8/12/21, physician's orders were received for Resident R15 and Resident R32, allowing the residents to be out in common areas as long as the wound is covered.</p> <p>-Resident R15 was encouraged to perform hand hygiene and secure colostomy pouch under waistband prior to exiting room.</p> <p>-On 8/12/21, to promote infection control, Environmental Services (ES) provided additional cleaning in common areas and all high touch surfaces.</p> <p>-On 9/18/21, Resident R12 was discharged from the facility</p> <p>- To promote infection prevention and</p>		

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F 880	<p>Continued From page 107</p> <p>explained that the staff are required to put on (don) PPE according to the sign. When a resident is on contact precautions, they should be wearing gloves and gowns, whenever touching the resident's intact skin or articles near the resident. Staff should remove (doff) their PPE in the room prior to the exit.</p> <p>Surveyor asked if the resident who is on the contact precautions is allowed to be out of the room? the IP responded that if the wound can be managed and contained by dressings. When they are outside of the room, we want to just ensure any areas will be provided for cleaning, including equipment in the vicinity of the resident.</p> <p>4) R262 was newly admitted to the facility on 08/07/21 and was not vaccinated for COVID-19. As a result of the resident's COVID-19 vaccination status and the facility's COVID-19 mitigation plan, the resident was paced in isolation and droplet transmission based precautions was implemented.</p> <p>On 08/10/21 01:24 PM, observed CNA44 enter R262's room with with only a gown and surgical mask (covered nose and mouth only) and assisted the resident with lunch. While this surveyor was observing CNA44 while still in the resident's room, the Assistant Director of Nursing (ADON) approached this surveyor and also observed CNA44 donned in only a gown and a surgical mask in R262's room. Inquired with the ADON regarding the type of PPE CNA44 should have donned. The ADON confirmed CNA44 was not wearing the appropriate PPEs and in addition to the gown and face mask, CNA44 should have been wearing a face shield and gloves. Pointed out to the ADON, the plastic storage bin located outside of R262's room contained only four to five</p>	F 880	<p>control, facility staff were in-serviced on establishing and maintaining infection control measures to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections.</p> <p>2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>- The alleged practice has the potential to affect facility residents.</p> <p>3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>- On 8/16/21, the facility hired an Infection Control Preventionist (IPC) / Wound Care Specialist</p> <p>- Facility-wide review of PPE distribution protocol/guidelines and update to ensure staff have adequate supply of PPE to provide necessary care in a safe manner was conducted; ongoing assessment and review is to continue to promote infection prevention and control</p> <p>- All residents on isolation precautions will require a physician order if care guidelines deviate from said isolation protocol. The facility will use cohorting guidelines set forth by the Centers for Disease Control</p>		

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F 880	<p>Continued From page 108</p> <p>protective gowns. Asked the ADON if there was a designated place for staff to store reusable face shields and what staff should use to sanitize their face shields after use. The ADON stated staff store their face shields in their personal lockers and should wipe their shields down with sanitizing wipes which were stored in the medication cart. The ADON confirmed supplies staff would need to adhere to infection control protocol to mitigate the spread of COVID-19 was not readily available for staff use.</p> <p>5) An initial observation was made of R314 and R315 on 08/09/21 at 10:40 AM in a room they shared. R314 was wearing a hospital gown, lying in bed with his head of bed (HOB) raised. His eyes remained closed, and he was slow to respond to the surveyor's salutation. R315 was also lying in bed wearing a hospital gown with his eyes closed.</p> <p>R315 was observed at 12:13 PM the same day with a staff member performing range of motion (ROM) of his lower extremities.</p> <p>On 08/10/21 at 09:10 AM, a red sign posted on the wall outside of R314 and R315's room stated, "Please see nurse before entering room." Another sign was also posted, "Special droplet/contact precautions." A document from The Centers for Disease Control and Prevention (CDC) outlining the process to don personal protective equipment (PPE) was located on top of a plastic chest located to the left of the doorway. R314 and R315 were noted to be lying in their beds.</p> <p>An interview with the QCM was done in the training room later that day at 4:10 PM. She stated that R314 had a fever yesterday and was tested for COVID-19. She further stated that</p>	F 880	<p>and Prevention (CDC) and Centers for Medicare &amp; Medicaid Services (CMS) in regards to isolating residents suspected of COVID-19 infection.</p> <p>- A required deadline of 10/07/21 was set forth for facility staff to complete specified COVID-19 infection control and prevention measures, to promote infection control measures, and to prevent this deficient practice from occurring:</p> <p>" Facility staff will view training videos on Relias training platform: 1) Use PPE correctly for COVID-19, 2) Keep COVID-19 OUT!, and 3) Closely Monitor Residents for COVID-19.</p> <p>" Facility staff in-serviced on COVID-19 Infection Control and Essentials of Infection Prevention for Nursing Homes, Contact Precautions, Droplet Precautions, and information on PPE location and storage (it is everyone's responsibility to ensure PPE is available at the point of care).</p> <p>" Facility staff was also provided with education on donning/doffing PPEs, appropriate use of PPE, and on adherence to infection control precautionary measures for residents on isolation precaution.</p> <p>- In-services will be ongoing as needed, and will also be conducted with the Director of Nursing (DON), IPC, or designee at new hire orientation and, at least, annually addressing the continuity of care by combining Hospice and Facility care plans at new hire orientation and at least annually.</p>		

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F 880	<p>Continued From page 109</p> <p>R314 should have been isolated and without a roommate.</p> <p>On 08/11/21 at 09:32 AM, R315 was noted to be the only resident in a room across the hall from where he previously resided and the door to his room was open. R314 was also alone in the room with the door open.</p> <p>The CDC's "Interim Infection Prevention and Control Recommendation to Prevent SARS-CoV-2 (COVID-19) Spread in Nursing Homes" updated on March 29, 2021, stated, "Ideally a resident with suspected SARS-CoV-2 infection should be moved to a single-person room with a private bathroom while test results are pending. In general, it is recommended that the door to the room remain closed to reduce transmission of SARS-CoV-2. This is especially important for residents with suspected or confirmed SARS-CoV-2 infection being cared for outside of the COVID-19 care unit."</p> <p>6) R32 is a 90-year-old on hospice care for dysphagia due to a past stroke with left sided weakness. Record Review of R32 EMR on 8/11/2021 showed that per Nurses notes on 7/4/2021 and 7/23/2021, R32 suffered a wound injury to the left 2nd toe after kicking the footrest of the geriatric chair that R32 was laying supine in, and wound care was started thereafter. R32's toe wound progressed to cellulitis (bacterial infection of the skin) and paronychia (an infection of the tissue folds around the nails). The wound was cultured on 7/23/2021 after staff observed pus and was found positive on 8/26/2021 for MRSA (methicillin resistant staphylococcus aureus). Per R32's care plan, nursing diagnosis of Joint infection was identified on 7/23/2021 with treatment of antibiotics, monitoring for signs of</p>	F 880	<p>- Facility staff has been in-serviced on CDC's Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 (COVID-19) Spread in Nursing Homes:</p> <p>" Nursing staff to continue to take daily temperatures of all facility residents every shift as a part of the monitoring process</p> <p>" On a daily basis, and on every shift, nursing staff to continue to assess residents for COVID-19 signs and symptoms</p> <p>" An order is to be obtained for COVID-19 testing</p> <p>" Any resident with assessed COVID-19 signs and symptoms is to be tested for COVID-19 and moved to a single-person room with a private bathroom while test results are pending; the door is to remain closed to reduce the transmission of COVID-19</p> <p>4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.</p> <p>- The IPC, DON, or designee is to continue to perform routine-weekly assessments of proper infection control practices with application of the Log of Identified Breaches in Infection Control to</p>		

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F 880	<p>Continued From page 110</p> <p>infection, and contact precautions for MRSA.</p> <p>On 8/9/2021 at 8:45AM, surveyor observed contact precautions sign and isolation cart outside of R1's room. The isolation gown had a bag of gowns and 2 boxes of gloves. No wipes available in cart. R32 not present in room. Roommate of R32 lying in bed behind curtain. On 8/9/2021 at 11:55AM, S3 observed R32 being fed lunch by staff member in the hibiscus common dining area. Staff member wore gloves but no gown. S3 asked R32's nurse (N)24 if R32 was allowed out of room due to contact precautions posted and if gowns and gloves were needed to be worn by staff. N24 said it's okay to wear no gown if they are not touching the wound and that the wound is covered.</p> <p>08/11/21 at 08:20 AM, S3 observed R32 sitting in geriatric chair with left foam boot on left foot in Hibiscus dining area. CNA10 wearing mask and gloves, and no gown while feeding R32.</p> <p>08/11/21 at 01:58 PM, first floor nursing station in an interview with Physician (P)1, surveyor asked if it was safe for R32 to be outside of room in common areas due to MRSA diagnosis and contact precautions. P1 said that R32 can go outside of room since MRSA infection is localized to the left toe and is covered with a bandage. The infection is not in R32's urine, bowel movements, blood, or lungs so it is okay for R32 to have a roommate. P1 said that staff do not need to wear gown when feeding R32 if they are not directly touching the site that is infected and that wound is covered.</p> <p>Record review in EMR on 08/12/21 09:06 AM, showed no physician orders for contact</p>	F 880	<p>record identified incidents and to apply corrective actions through education and follow up.</p> <ul style="list-style-type: none"> <li>- The Aloha Nursing &amp; Rehab Centre Resident Focus Rounds was created to promote respect, dignity, and care for each resident in a manner and environment that promotes maintenance or enhancement of each resident's quality of life. This auditing tool is for monitoring through resident interview query and observation. This tool includes assessment of infection control measures.</li> <li>- To ensure infection control, quality assurance, and effectiveness of the aforementioned systemic changes random monitoring and evaluation with application of the Log of Identified Breaches in Infection Control and the Aloha Nursing &amp; Rehab Centre Resident Focus Rounds will be applied.</li> <li>- Completion of this tool is to occur weekly x 1 month, bimonthly x 1 month and monthly x 1 month by the DON or designee for a minimum of 12 weeks to ensure compliance.</li> <li>- Corrective action is to be taken immediately and staff education on infection control measures is to be provided as deemed necessary.</li> <li>- To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI)</li> </ul>		

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F 880	<p>Continued From page 111</p> <p>precautions. R32's care plan under Problem Joint Infection listed "Contact precautions + (positive) MRSA" with no specifications on when and how client can go to common areas.</p> <p>Interview with Unit Manager (UM)3 at MDS office on 08/12/21 at 10:06 AM, UM3 acknowledged no physician orders for contact precautions in R32's electronic medical record. UM3 acknowledged that contact precautions, reason for contact precautions, and any other details (such as resident being able to leave room if wound covered) should be documented in both R32's care plan and physician orders. UM3 will contact P1 to input physician orders.</p> <p>On 08/12/21 at 01:30 PM, EMR review of R32 showed under Physician Orders on 8/12/2021 at 11:34AM: OK for resident on contact precautions to enter common meeting areas if wound is covered.</p> <p>On 8/12/21 at 1:00PM, ANRC's Facility Policy effective 6-1-90 for Transmission Based Precautions (Contact) states "wear gown whenever anticipating that clothing will have direct contact with the resident or potentially contaminated environmental surfaces or equipment in close proximity to the resident."</p>	F 880	<p>meeting for a minimum of 3 months or until compliance is achieved.</p> <p>- If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met.</p> <p>- Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate.</p> <p>Included dates when corrective action will be completed:</p> <p>- Corrective action completion date by Nursing Home Administrator (NHA) and/or designee.</p> <p>- Compliance and completion of corrective DPOC by the NHA and/or designee.</p>		



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

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E 000	Initial Comments  The facility was found in compliance with Section 483.73, Requirement for Long Term Care (LTC) Facility Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types, State Operations Manual.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/21/2021

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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K 223 SS=E	<p><b>Doors with Self-Closing Devices</b> CFR(s): NFPA 101</p> <p>Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:</p> <ul style="list-style-type: none"> <li>* Required manual fire alarm system; and</li> <li>* Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</li> <li>* Automatic sprinkler system, if installed; and</li> <li>* Loss of power.</li> </ul> <p>18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by:</p> <p>K-223 Doors with self-closing devices This STANDARD is not met as evidenced by: Based on observation and staff interviews (Quality Assurance Officer and Director of Maintenance), the facility failed to ensure that the hazardous area doors, located at the laundry and kitchen area, would close and latch during an activation of the fire alarm due to a missing self-closing device (kitchen) and a kick down door holder (laundry room). Another door, serving the employee's canteen area which opens into the exit corridor was not equipped with a self-closing device. This citation is a repeat citation from a survey conducted in 2020 where self-closing device was missing from a door serving the maintenance office. This observation of the missing door self-closing device and the kick down door holder is not in accordance with the 2012 edition of the NFPA 101 Life Safety Code, sections 19.2.2.2.7 and 7.2.1.8.2. This deficient</p>	K 223	<p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility's credible allegation of compliance.</p> <p>1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>- To promote corrective action for the cited</p>	11/4/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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(X6) DATE

Electronically Signed

11/04/2021

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K 223	Continued From page 1 practice could affect all residents, staff, and visitors if smoke and fire was to move from these areas into the exit corridor. Findings include: An observation on 10/12/21 at approximately 2:00 pm revealed the kitchen and employee canteen area was not equipped with a self-closing device. The door serving the laundry room had a kick down door holder. This did not meet the requirement of LSC Section 19.2.2.2.7 and 7.2.1.8.2. These findings were verified at the exit conference with the Quality Assurance Officer and Director of Maintenance on 10/12/21 at 3:00 pm.	K 223	deficiency, and to ensure that the deficient practice does not occur, the Director of Maintenance and maintenance staff were in-serviced on the regulation, and on the importance of ensuring that doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are equipped with self-closing devices. 10/26/21  - To ensure facility-wide compliance, and to promote correction measures, of the deficient practice, the Director of Maintenance and designees conducted a facility-wide door audit to identify doors within the facility that are not in accordance with the 2012 edition of the NFPA standard of doors with self-closing devices. 10/26/21  -The deficient findings in the referenced citation were corrected, and directed improvements were made as follows: Door in the laundry area - Kick down holder was removed and a self-closing device was installed. 10/29/21 Door in the kitchen area - Self-closing device was installed. 10/29/21 Door in the employees canteen area - Self-closing device was installed. 11/02/21  2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice.  - The alleged practice has the potential to affect all facility residents, staff, and		

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NAME OF PROVIDER OR SUPPLIER  <b>ALOHA NURSING &amp; REHAB CENTRE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>45-545 KAMEHAMEHA HIGHWAY KANEHOE, HI 96744</b>		
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K 223	Continued From page 2	K 223	<p>visitors. 11/04/21 &amp; ongoing</p> <p>3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>- Maintenance staff were in-serviced on the regulation, and on the importance, and rationale, of ensuring that doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are equipped with self-closing devices. 11/04/21 &amp; ongoing</p> <p>-To ensure that the facility is consistent with professional standards of practice:</p> <p>" The Director of Maintenance and designees conducted a facility-wide door audit to identify doors within the facility that are not in accordance with the 2012 edition of the NFPA standard of doors with self-closing devices. 10/26/21</p> <p>" As a result of the facility-wide door audit, correction to doors that did not meet the safety standard was completed. 11/04/21 door closers ordered, expected delivery date, 11/18/21-11/25/21. Installation will occur upon receiving shipment of door closers. Anticipated final correction completion 11/26/21.</p> <p>- To promote continuity of care, and to prevent deficient practice regarding the above-mentioned citation, facility</p>		

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K 223	Continued From page 3	K 223	<p>maintenance staff will be trained and retrained ongoing as deemed necessary. 11/04/21 &amp; ongoing</p> <p>- In-services will be ongoing, and as needed, and it will also be conducted by the Facilities Manager and Quality &amp; Compliance Officer, or designee, with all licensed and unlicensed staff at new hire orientation, and, at least, annually. 11/04/21 &amp; ongoing</p> <p>4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.</p> <p>- A facility-wide audit will be completed on a quarterly basis by the Director of Maintenance, or designee, to ensure compliance in accordance with the 2012 edition of the NFPA for doors requiring self-closing devices. 10/26/21</p> <p>- All audits and monitoring tools will be presented, reviewed, and discussed at the monthly Safety Meeting and Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved.</p> <p>- If further corrective action is needed, continued education to apposite staff will</p>		

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K 223	Continued From page 4	K 223	<p>be provided until such time that the QAPI committee determines consistent substantial compliance has been met.</p> <p>- Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate.</p> <p>Included dates when corrective action will be completed:</p> <p>- Corrective action completion date by Nursing Home Administrator and/or designee. 11/04/21</p>		

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E 006 SS=C	<p>Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2)</p> <p>§403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2)</p> <p>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:]</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>* [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.</p> <p>*[For LTC facilities at §483.73(a):] Emergency</p>	E 006		11/4/21	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/04/2021

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 006	<p>Continued From page 1</p> <p>Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>*[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>This REQUIREMENT is not met as evidenced by: E-006 Emergency Prep</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interviews (Quality Assurance Officer and Director of Maintenance), the facility failed to produce a complete Emergency Preparedness Plan (EPP) document in accordance with Appendix Z of the State Operations Manual (SOM) and 42 CFR 483.73 for long term care facilities. This deficiency could affect all residents, staff, and visitors during an emergency due to the lack of available policies and procedures to provide guidance and structure.</p>	E 006	<p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility's credible allegation of compliance.</p> <p>1) Address how corrective action will be</p>		



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E 006	Continued From page 2 Findings include: An observation on 10/12/21 at approximately 1:00 pm revealed that the facility's Emergency Preparedness Plan was missing sections such as Testing and Training of the EPP, Communications section, and Policies and Procedures were incomplete and not in accordance with Appendix Z of the SOM and 42 CFR 483.73. These findings were verified at the exit conference with the Quality Assurance Officer and Director of Maintenance on 10/12/21 at 3:00 pm.	E 006	accomplished for those residents found to have been affected by the deficient practice.  - The facility will develop and maintain an Emergency Preparedness Plan (EPP) The development of the EPP will include sections outlined in Appendix Z of the State Operations Manual (SOM) and 42 CFR 483.73 " Risk Assessment and All Hazards approach " Policies and Procedures " Testing and Training of EPP " Communications 11/04/21 and Ongoing  2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice.  - The alleged practice has the potential to affect all facility residents, staff, and visitors during an emergency.  - The Facility Manager and Quality & Compliance Officer are developing an Emergency Preparedness Plan that is compliant with guidelines outlined in Appendix Z of the SOM and 42 CFR 483.73.  - Completed EPP will be provided to all department managers and kept in a binder in the Nursing Home Administrator's (NHA's) office or designee. 11/04/21 and Ongoing		

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E 006	Continued From page 3	E 006	<p>3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> <li>- On 9/13/21, the Facilities Manager and Quality &amp; Compliance Officer initiated the development of Aloha Nursing Rehab Centre's Emergency Preparedness Plan. 9/13/21 &amp; ongoing</li> <li>-On 11/04/21, the Facilities Manager and Quality &amp; Compliance Officer will in-service members of the Management Team, licensed and unlicensed staff of the facilities Emergency Preparedness Plan. 11/04/21 &amp; ongoing</li> <li>- In-services will be ongoing, and as needed, and it will also be conducted by the Facilities Manager and Quality &amp; Compliance Officer, or designee, with all licensed and unlicensed staff at new hire orientation, and, at least, annually. 11/04/21 &amp; ongoing</li> </ul> <p>4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.</p> <ul style="list-style-type: none"> <li>- To ensure quality assurance, and</li> </ul>		

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E 006	Continued From page 4	E 006	<p>effectiveness of the aforementioned systemic changes, to promote safety and services for our residents, staff, and visitors through the development and training of the emergency preparedness plan in the event of a natural or man-made emergency or disaster. By providing initial and ongoing Emergency Preparedness training to all licensed and unlicensed staff will be prepared to effectively and competently handle emergency situation(s) and provide resident with highest practicable physical, mental, and psychosocial well-being. 11/04/21 &amp; ongoing</p> <p>- The facility will conduct reviews of the Emergency Preparedness Plan, and make applicable changes as deemed necessary, at least annually and as needed. 11/04/21 &amp; ongoing</p> <p>- Ongoing development of the facilities Emergency Preparedness Plan insure compliance. 11/04/21 &amp; ongoing</p> <p>- Corrective action is to be taken immediately and staff education is to be provided as deemed necessary. 11/04/21 &amp; ongoing</p> <p>- To ensure compliance, the Emergency Preparedness plan will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance</p>		

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E 006	Continued From page 5	E 006	is achieved.  - If further corrective action is needed, continued education to apposite staff will be provided until such time that the QAPI committee determines consistent substantial compliance has been met.  - Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate.  Included dates when corrective action will be completed:  - Corrective action completion date by Nursing Home Administrator and/or designee. 11/04/21		
E 037 SS=E	EP Training Program CFR(s): 483.73(d)(1)  §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).  *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under	E 037		11/4/21	

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E 037	<p>Continued From page 6</p> <p>arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.</p> <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.</p> <p>(ii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iii) Provide emergency preparedness training at least every 2 years.</p> <p>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.</p> <p>(v) Maintain documentation of all emergency preparedness training.</p> <p>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.</p> <p>*[For PRTFs at §441.184(d):] (1) Training</p>	E 037			

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E 037	<p>Continued From page 7</p> <p>program. The PRTF must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) After initial training, provide emergency preparedness training every 2 years.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iv) Maintain documentation of all emergency preparedness training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.</p> <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.</p> <p>(iv) Maintain documentation of all training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.</p> <p>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the</p>	E 037			

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E 037	<p>Continued From page 8</p> <p>following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:</p> <p>(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.</p> <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:</p>	E 037			

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E 037	<p>Continued From page 9</p> <p>(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.</p> <p>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.</p> <p>This REQUIREMENT is not met as evidenced by: E-037 EPP Training</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interviews (Quality Assurance Officer and Director of Maintenance), the facility failed to demonstrate</p>	E 037	<p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees,</p>		



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E 037	Continued From page 10 staff competency of the facility's Emergency Preparedness Plan's (EPP) Fire and Emergency Evacuation policy and procedures in accordance with Appendix Z of the SOM and 42 CFR 483.73. This deficiency could affect all residents, staff, and visitors during an emergency due to the lack of staff knowledge and performance of policies and procedures during an emergency that would require full evacuation or shelter in place strategies. Findings include: A fire drill was initiated on 10/12/21 at 2:32 pm in the Orchid Wing on the second floor of the facility. Staff member discovered the fire simulator set by maintenance staff and attempted to alert other staff members to sound the fire alarm. At 2:34 pm, no fire alarm signal was initiated and other staff members did not respond to assist the lone staff member. At this time, a housekeeper fell while running to assist the staff member. Due to the accident, the drill was canceled and all efforts were made to address the injured housekeeper. These findings were verified at the exit conference with the Quality Assurance Officer and Director of Maintenance on 10/12/21 at 3:00 pm.	E 037	agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility's credible allegation of compliance.  1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.  - On 10/28/21 the Facilities Manager initiated facility-wide department specific training with all licensed and unlicensed staff. 11/04/21 & Ongoing " Fire emergencies policies and procedures " Roles and responsibilities at departmental level during a fire emergency " Actions to take in the event smoke or fire is found " Actions to take in the event the fire alarm sounds " Communication " Safety actions when responding to announcement of Dr. Red and/or when fire alarm sounds " Actions to take when incident occurs during announcement of Dr. Red and/or when fire alarm sounds " Actions to take when fire location is announced " Fire prevention " Evacuation procedures and methods " Steps to take when All Clear is announced		

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E 037	Continued From page 11	E 037	<p>- On 10/30/21 and 11/03/21 fire drills were conducted on day/ evening, and NOC shifts.</p> <p>- Review of the fire drill evaluation findings were discussed with staff, and staff education was provided as deemed necessary 11/04/21 &amp; Ongoing</p> <p>2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>- The alleged practice has the potential to affect all facility residents, staff, and visitors. 11/04/21 &amp; Ongoing</p> <p>3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>- To ensure quality assurance and effectiveness, and to protect residents, staff and visitors, the facility staff were educated regarding fire emergency policies and procedures, roles and responsibilities, steps to take in the event of smoke and/or fire and/or alarm sounds. 11/04/21 &amp; Ongoing</p> <p>- In-services will be ongoing as needed, and will also be conducted by the Facilities Manager, or designee, with all licensed and unlicensed staff at new hire orientation, and, at least, annually. 11/04/21 &amp; Ongoing</p>		

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E 037	Continued From page 12	E 037	<p>- The facility will conduct unannounced fire drills throughout all shifts evaluating and monitoring for effectiveness, staff knowledge, and staff competency of the facility's fire and emergency evacuation policy and procedures. 11/04/21 &amp; Ongoing</p> <p>4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.</p> <p>- To ensure that correction was achieved, staff who have routine work schedules were provided with a copy their departmental roles and responsibilities in the event of a fire emergency. 11/04/21 &amp; Ongoing</p> <p>- Licensed and unlicensed staff were in-serviced on departmental specific roles and responsibilities; staff training was provided on how to respond effectively in the event of a fire emergency. 11/04/21 &amp; Ongoing</p> <p>-To ensure quality assurance and effectiveness of the aforementioned systemic changes, and to promote safety and services for our residents, staff, and visitors, facility staff will be provided with</p>		

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E 037	Continued From page 13	E 037	<p>ongoing training and further development of the fire emergency policies and procedures in the event of a fire emergency. 11/04/21 &amp; Ongoing</p> <p>-All licensed and unlicensed staff will be provided with initial and ongoing Fire Emergency training. 11/04/21 &amp; Ongoing</p> <p>-Staff will be prepared to effectively and competently handle a fire emergency situation to provide facility residents with highest practicable physical, mental, and psychosocial well-being. 11/04/21 &amp; Ongoing</p> <p>-The facility will conduct unannounced fire drills throughout all shifts on a monthly basis for 3 months or until compliance is achieved, then the facility will conduct one fire drill on a monthly basis thereafter to ensure that all shifts receive a fire drill quarterly.</p> <p>-Fire response by staff will be evaluated using the Fire Drill Evaluation Form, and post-drill debriefing will be conducted to review actions that promoted a safety response and actions that required performance improvement.</p> <p>-Departmental Managers, or designee, to assist in drill evaluations.</p> <p>-Fire Emergency policies and procedures will be reviewed at least annually.</p> <p>- Completion of the initial Fire Emergency in-services by 11/04/21 to insure</p>		

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E 037	Continued From page 14	E 037	<p>compliance.</p> <ul style="list-style-type: none"> <li>- During fire drills corrective action is to be taken immediately and staff education is to be provided as deemed necessary.</li> <li>- To ensure compliance, the Fire Drills evaluations will be presented, reviewed, and discussed at the monthly Safety Meeting and Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved.</li> <li>- If further corrective action is needed, continued education to staff will be provided until such time that the QAPI committee determines consistent substantial compliance has been met.</li> <li>- Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate.</li> </ul> <p>Included dates when corrective action will be completed:</p> <ul style="list-style-type: none"> <li>- Corrective action completion date by Nursing Home Administrator and/or designee. 11/04/21</li> </ul>		