STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125038	A. BUILDING _____ B. WING _____	08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALOHA NURSING & REHAB CENTRE	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744

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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 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §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. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and 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. §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. §483.10(f)(3) The resident has a right to interact with members of the community and participate in	F 561		9/30/21

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

Electronically Signed | 09/21/2021

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F 561	Continued From page 1 community activities both inside and outside the facility. §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. This REQUIREMENT is not met as evidenced by: 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. Findings include: On 08/09/21 at 08:35 AM, an interview was 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	F 561	F561 Self Determination 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. -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. - To protect residents in similar situations, the facility staff were educated regarding Resident Rights including, but not limited	

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F 561	Continued From page 2 not been helped with brushing her teeth despite asking staff for help. 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. 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 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	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. 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 facility residents. - To identify other residents having the potential to be affected by the identified deficient practice, the Aloha Nursing & Rehab Centre (ANRC) Resident Focus Round was created. - The DON or designee is to monitor and manage compliance by performing random assessments of compliance during weekly completion of the Aloha 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	

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F 561	Continued From page 3	F 561	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 incorporated into resident comprehensive care plan. - 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.	

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F 561	Continued From page 4	F 561		

- In-services will be ongoing as needed.

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.

- 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 & Rehab Centre (ANRC) Resident Focus Round auditing form will be completed.

- 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 ensure compliance.

- Corrective action is to be taken immediately and staff education is to be provided as deemed necessary.

- 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

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F 561	Continued From page 5	F 561	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 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §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- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders.	F 655		9/30/21

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F 655	Continued From page 6 (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (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). §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: (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. 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 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	F 655	F655 Baseline Care Plan 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	

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F 655	Continued From page 7 and services which may prevent them from attaining or maintaining their highest practicable physical, mental, and psychosocial well-being. Findings include: 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. 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. 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 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.	F 655	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 R106□s comprehensive care plan has been reviewed and updated on 8/6/21. - Resident R1□s comprehensive care plan was developed on 8/12/21. - 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. 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 facility residents. - 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	

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F 655	Continued From page 8 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	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 baseline and comprehensive care plans for each resident. - A baseline or comprehensive care plan will be developed by the MDS Manager, or	

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F 655	Continued From page 9	F 655	assigned MDS coordinator, within 48 hours for all newly admitted, or readmitted residents, within 48 hours of the resident's admission or readmission. - 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. 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. - 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 & Rehab Centre (ANRC) F-655 & F-656 Baseline Care Plan Auditing Tool. - 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.	

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F 655	Continued From page 10	F 655	- Corrective action is to be taken immediately and staff education is to be provided as deemed necessary. - 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. - 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 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		9/30/21

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F 656	Continued From page 11 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a	F 656	F656 Development/Implement Comprehensive Care Plan	

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F 656	Continued From page 12 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. Findings include: 1) R60 is a 100 years old and was admitted on 06/14/21 with diagnoses including a urinary tract infection (UTI). 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. 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 plan was not developed. 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.	F 656	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. - 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. - On 8/16/21, Resident R56□ comprehensive care plan was reviewed and updates to the communication care plan have been made. - UM□s and MDS staff were educated on the facility□s responsibility to develop and implement a comprehensive care plan for each resident to meet resident□s medical, nursing, and psychological needs. 2) Address how the facility will identify	

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F 656	Continued From page 13 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. 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." 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	F 656	other residents having the potential to be affected by the same deficient practice. - The alleged practice has the potential to affect facility residents. - 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. - 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 a facility wide assessment of compliance with application 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?	

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- 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.

- A comprehensive person-centered care plan will be developed, implemented, and updated for each resident.

- 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.

- 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.

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.

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- The DON and the MDS Manager are responsible for maintaining compliance.

- 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 & Rehab Centre (ANRC) F-655 & F-656 Baseline Care Plan Auditing Tool for all new admissions.

- Any or all findings will be reported to the assigned MDS Coordinator or designee for immediate correction.

- 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.

- For a minimum of 3 months, or until compliance is achieved, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for analysis, and further recommendations.

- If further corrective action is needed, the

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F 656	Continued From page 16	F 656	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 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §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. 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. He was wearing a	F 677	F677 ADL Care Provided for Dependent Residents 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	9/30/21

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F 677	Continued From page 17 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. 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. 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 motioin 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. 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 wearing hospital type gown that was bunched up around neck his neck and revealing a bare chest. 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	F 677	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. - To ensure that the impacted residents were provided with assistance with personal hygiene, they were assessed as follows: - On 9/17/21, R13 was assessed for grooming and appearance. Resident was neatly groomed, with clean gown, and bed linen changed. - 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. - 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. - 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	

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F 677	Continued From page 18 position. 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. At 04:18 PM during an observation, R16 was lying in his bed, restless and agitated. 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. 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. 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... Surveyor noted resident was in bed during the survey when frequent observations were conducted. 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	F 677	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. - 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. - 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. 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 facility residents. 3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? - Direct care staff were in-serviced on activities of daily living (ADL), and on the importance of providing residents with	

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F 677	Continued From page 19 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	quality personal care and hygiene. - Facility staff were in-serviced on providing necessary services of ADL care for dependent residents, to maintain good grooming and personal hygiene. - 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. - 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. - The Aloha Nursing & 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. - 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. 4) Indicate how the facility plans to	

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F 677	Continued From page 20	F 677		

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.

- 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.

- 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 & Rehab Centre (ANRC) Resident Focus Round auditing form will be completed.

- 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.

- Corrective action is to be taken immediately and staff education is to be provided as deemed necessary.

- To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance

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F 677	Continued From page 21	F 677	Performance Improvement (QAPI) meeting for a minimum of 3 months or 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 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §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 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: Based on observations, interviews and record	F 679	F679 Activities Meet Interest/Needs Each	9/30/21

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F 679	Continued From page 22 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. Findings include: 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. 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." R80's EMR was reviewed on 08/10/21 at 3:00 PM. He is a 74-year-old male admitted to the 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."	F 679	Resident 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. - On 9/14/21, the Therapeutic Recreation Manager (TRM) assisted Resident R80 with a crafting activity of the resident□s choice. - 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 television (TV) on to the news station of the resident□s preference. -Since admission R134 cognitive status has improved, R134 is now capable of self- manipulating television, to the station	

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F 679	Continued From page 23 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." 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. 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. 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. 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. On 08/10/21 at 09:51 AM, R314 was alone in his room. He was wearing a hospital gown lying in bed tilted to the right side. His television was not on. At 10:46 AM of the same day, RN22 was wearing personal protective equipment (PPE) in R314's	F 679	of his choice. R134 is also able to independently utilize iPad due to increase cognitive abilities. - The resident□s care plan reflects Resident R314□s aforementioned TV preference. - 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. - Facility staff were educated on implementation of residents□ activity plan and proper documentation of participation / refusal to participate. 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 facility residents. 3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? - 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	

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F 679	Continued From page 24 room. His television was off. 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..." Another entry for his activity care plan stated, "It is very important to (R314) to (sic) with the news via television..." 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. 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.	F 679	psychosocial well-being of each resident. - The resident□s preference interview will be conducted upon admission and reviewed and updated quarterly and annually during the care plan meeting. - 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. - 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. - The Aloha Nursing & 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. - In-services will be ongoing as needed 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	

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F 679	Continued From page 25	F 679		

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.

- 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.
- Facility staff were also educated on implementation of residents activity plan and proper documentation of participation / refusal to participate.

- 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 & Rehab Centre (ANRC) Resident Focus Round auditing form will be completed.

- 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.

- Corrective action is to be taken immediately and staff education is to be provided as deemed necessary.

- Weekly auditing of facility residents activity attendance by the TRM will is to

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F 679	Continued From page 26	F 679	be reported at the monthly Quality Assurance Performance Improvement (QAPI) meetings. - To ensure compliance, audit results completed by the TRM, and auditing with application of the Aloha Nursing & 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. - 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 684 SS=D	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	F 684		9/30/21

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F 684	Continued From page 27 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. R13 was in the same position. (Refer to F677). 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	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 personal hygiene and psychosocial wellbeing, they were assessed as follows: - 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	

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F 684	Continued From page 28 same disheveled hair. 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. 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. 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. At 04:18 PM during an observation, R16 was laying in his bed, appeared restless and agitated (Refer to F677). 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. 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... Surveyor noted resident was in bed during the survey when frequent observations were conducted.	F 684	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. - On 9/17/21, Resident R13 was assessed for grooming and appearance. Resident was neatly groomed, with clean gown, and bed linen changed. - 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. - 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. - 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	

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F 684	Continued From page 29 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). 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).	F 684	refused care. Resident comprehensive care plan reflects preference to wear gown. - 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. - 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. - On 9/17/21, Resident R13 was assessed for grooming and appearance. Resident was neatly groomed, with clean gown, and bed linen changed. - 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. 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 facility residents. 3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?	

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F 684	Continued From page 30	F 684		

- 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.

- 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.

- 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.

- 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.

- The Aloha Nursing & 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.

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F 684	Continued From page 31	F 684	- In-services will be ongoing as needed 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. - 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. - 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 & Rehab Centre (ANRC) Resident Focus Round auditing form will be completed. - 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. - Corrective action is to be taken immediately and staff education is to be	

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F 684	Continued From page 32	F 684	provided as deemed necessary. - 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. - 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 698 SS=D	Dialysis CFR(s): 483.25(l) §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:	F 698		9/30/21

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F 698	Continued From page 33 Based on observations, staff interviews, and 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. Findings include: R78 was admitted to the facility on 08/02/21 and undergoes dialysis treatment three (3) times a week on Monday, Wednesday, and Friday. 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." 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	F 698	F698 Dialysis 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. - 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 - On 9/18/21 Director of Nursing (DON) conducted a record review, findings reveal Resident R78 was assessed by licensed nurse. - Resident R78 endured no harm from the cited deficiency and care was provided for the resident by facility staff. 2) Address how the facility will identify	

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F 698	Continued From page 34 completing the form. The Dialysis 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	other residents having the potential to be 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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(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 698	Continued From page 35	F 698		

- Licensed staff will be trained and retrained ongoing as deemed necessary.

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.

- 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.

- The Aloha Nursing & 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.

- 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 & Rehab Centre - Dialysis Auditing Tool to randomly audit dialysis communication forms, progress notes, vital signs, and nursing post

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	125038	A. BUILDING _____ B. WING _____	08/12/2021

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F 698	Continued From page 36	F 698	dialysis notes. All findings of concern will 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. - 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. - 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 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to	F 725		9/30/21

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F 725	Continued From page 37 provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on 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. Findings include:	F 725	F725 Sufficient Nursing Staff 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	

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F 725	Continued From page 38 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. 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. 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	F 725	compliance. 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. - 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: - 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. - Resident R103 was discharged on 9/07/21. - 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. - On 9/17/21, Resident R13 was assessed for grooming and appearance. Resident was neatly groomed, with clean	

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his/her daily routine which the DON explained 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).

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.

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."

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 gown, and bed linen changed.

- On 9/18/21, the Director of Nursing (DON) conducted a record review; findings reveal Resident R78 was assessed by licensed nurse.

- Resident R78 endured no harm from the cited deficiency and care was provided for the resident by facility staff.

- 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:

" Aloha Nursing & 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

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F 725	Continued From page 40 lunch is not necessarily qualified to assess R78 after returning from dialysis. 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	F 725	sufficient nursing staff. - 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: " Altres - Agency Hires " Registered Nurses " Registered Nurses - Per Diem " Nursing Assistants - To support nursing staff " Certified Nurses Aides " Infection Control Preventionist / Wound Care Specialist " Interns - To provide non-direct care to support nursing staff *New hires are put through an orientation process to promote the delivery of safe resident care - Aloha Nursing & 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. - The DON, Nurse Managers, and apposite staff were educated on staffing to acuity and resident needs.	

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F 725	Continued From page 41 staffs the units. (Refer to F698). 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). 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. 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). On 08/12/21 at 10:06 AM surveyor interviewed	F 725	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 facility residents. 3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? - Ongoing measures set forth to promote systemic changes to ensure sufficient nursing staffing and to support our current staff includes: " Advertising for new hires " 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 " Staff appreciation and recognition with food, games, and door prizes " Tracking of staff attendance " Providing staff with appropriate support and counseling as deemed necessary - 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	

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F 725	Continued From page 42 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 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	flow, productivity, teamwork, and outcomes for all stakeholders. - 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. - Daily nursing staffing and facility census is discussed and reviewed at the daily morning Stand Up meeting. - 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. -The DON, or designee, will utilize the Facility Assessment and facility census to determine resident acuity and nursing staff needs. - 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: " The nursing leadership team, including nurse managers, assist with direct care tasks to ensure that all resident care needs are met " The facility non-nursing managerial team help to provide non-direct support, similar to that of interns, such as	

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F 725	Continued From page 43	F 725	answering call lights, emptying trash bins, etc. " Reliant Rehabilitation staff provides assistance in accordance with their skill set. 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. - The DON, or designee, will conduct daily random care rounds to promote sufficient nursing staff compliance with residents acuity and daily care needs. - 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. - 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. - To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI)	

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F 725	Continued From page 44	F 725	meeting for a minimum of 3 months or 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	F 761		9/30/21

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F 761	Continued From page 45 personnel to have access to the keys. §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. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to store biologicals (purifired protein derivitive) in accordance with accepted professional principles within the expiration date. Findings include: 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 derivitive (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.	F 761	F761 Label/Store Drugs and Biologicals 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. - On 8/12/21, to ensure that the facility stored biologicals in accordance with accepted professional principals within the expired date,	

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nursing associates immediately conducted a facility-wide sweep of medication refrigerators to ensure there were no other instances of expired and/or undated biologicals being stored.

- Licensed nurses have been educated on professional standards of practice for storage of drugs and biologicals Medication Storage in the Facility.

2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

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.

- The alleged practice has the potential to affect facility residents.

- On 9/20/21, an associate of the facility s partnered pharmacy completed a station check of random medication carts to assess for proper label/store of drugs and biologicals.

- 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 Director of Nursing (DON) or

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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
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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?

- 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.

- 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.

- 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.

- A copy of the referenced document has been provided to the in-serviced licensed

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nurses.

- In-services will be ongoing as needed

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.

- 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.

- 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.

- 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 & F-761 Medication Pass and Storage Audit

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F 761	Continued From page 49	F 761	form will be completed. - 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. - Corrective action is to be taken immediately and staff education is to be provided as deemed necessary. - 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. - 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	F 849		9/30/21

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F 849	Continued From page 50 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 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	F 849		

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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.
(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.
(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.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies

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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.
(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.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§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.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the

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F 849	Continued From page 53	F 849		

provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(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.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(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.

§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

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F 849	Continued From page 54 well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: 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: 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. 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. The deficient practice fails to ensure that one resident, R16 will attain the highest practicable physical, mental, and psychosocial well-being while receiving end of life care. Findings include: 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. 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.	F 849	F849 Hospice Services 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. -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. - 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. - On 9/17/21, Resident R16□s hospice	

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F 849	Continued From page 55 - 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. - 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. Care Plan Description. Receiving Hospice Care. Goal: R16 experiences a peaceful, dignified death 10/20/20 reviewed 01/26/21 Active. 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. Coordinate care with Hospice Team. 10/20/20. Reviewed Hospice and Nursing facility services agreement. 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. 3.3.8. Documentation of Services. Both Parties shall maintain appropriate documentation of	F 849	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. - 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. - Resident R16□s information regarding hospice care plans was identified and communicated to nursing staff through the shift report - 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. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice. - The facility has determined that all residents receiving hospice services have the potential to be affected. For quality assurance, an audit of all residents	

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F 849	Continued From page 56 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. 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. 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. Medical Doctor (MD): Medications reviewed for interactions. Continue current plan of care. Monitor for further decline. 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.	F 849	receiving hospice services was conducted and addressed as deemed necessary. - 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 a facility wide assessment of compliance of coordinated hospice services with application 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 licensed staff were in-serviced by the DON on the development, revision, and implementation process of person-centered comprehensive care plans. - In-services will be ongoing as needed,	

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F 849	Continued From page 57 Plan of care effective 04/17/21. Reviewed the Hospice interdisciplinary progress notes. 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. 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 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	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. - 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. - The IDT meetings will include documentation of hospice communication/collaboration of the identified plan of care. - 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. - 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. 4) Indicate how the facility plans to monitor its performance to make sure that	

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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.

- 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 & Rehab Centre (ANRC) F-655 & F-656 Baseline Care Plan Auditing Tool.

- 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.

- Corrective action is to be taken immediately and staff/hospice agency education is to be provided as deemed necessary.

- 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.

- If further corrective action is needed, the

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F 849	Continued From page 59	F 849	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 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		9/30/21

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ALOHA NURSING & REHAB CENTRE	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744

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F 880	Continued From page 60	F 880		

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;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.

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F 880	Continued From page 61 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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 practice jeopardizes the health and safety for its vulnerable residents and staff working in the facility. Findings include: 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	F 880	F880 Infection Prevention & Control 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. 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. 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	

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F 880	Continued From page 62 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. 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 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. 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. 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,	F 880	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. Included dates when corrective action will be completed: Corrective action completed on 9/26/21, DPOC due 10/7/21. 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. - 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. -On 8/10/21, regarding Resident R262, appropriate PPE was made available at point of care location required for droplet isolation precautions. -On 8/10/21, Resident R314 received negative PCR COVID test results clearing the resident of isolation precautions. -On 8/11/21, Resident R315 received negative PCR COVID test results clearing the resident of isolation precautions. - On 8/12/21, physician□s orders were received for Resident R15 and Resident	

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F 880	Continued From page 63 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. Surveyor reviewed the facility assessment on 08/11/21 at 02:00 PM and noted high rates of infections, wound, UTI, septicemia, and MDRO. 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 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. 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. 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	F 880	R32, allowing the residents to be out in common areas as long as the wound is covered. -Resident R15 was encouraged to perform hand hygiene and secure colostomy pouch under waistband prior to exiting room. -On 8/12/21, to promote infection control, Environmental Services (ES) provided additional cleaning in common areas and all high touch surfaces. -On 9/18/21, Resident R12 was discharged from the facility - To promote infection prevention and 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. 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 facility residents. 3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?	

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F 880	Continued From page 64 precautions was implemented. 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 obseving 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 protective gowns. Asked the ADON if there was a designated place for staff to store reusable face shields and what staff shold use to santize their face shields after use. The ADON stated staff store their face shields in their personal lockers and should wipe their shields down with sanitiing 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 avaiable for staff use. 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. R315 was observed at 12:13 PM the same day	F 880	- On 8/16/21, the facility hired an Infection Control Preventionist (IPC) / Wound Care Specialist - 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 - 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 and Prevention (CDC) and Centers for Medicare & Medicaid Services (CMS) in regards to isolating residents suspected of COVID-19 infection. - 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: " 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. " 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	

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with a staff member performing range of motion (ROM) of his lower extremities.

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.

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 R314 should have been isolated and without a roommate.

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.

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

storage (it is everyone□s responsibility to ensure PPE is available at the point of care).
" 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.

- 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.

- 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:
" Nursing staff to continue to take daily temperatures of all facility residents every shift as a part of the monitoring process
" On a daily basis, and on every shift, nursing staff to continue to assess residents for COVID-19 signs and symptoms
" An order is to be obtained for COVID-19 testing
" Any resident with assessed COVID-19 signs and symptoms is to 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

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F 880	Continued From page 66 outside of the COVID-19 care unit." 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 infection, and contact precautions for MRSA. 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. 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	F 880	transmission of COVID-19 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. - 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 record identified incidents and to apply corrective actions through education and follow up. - The Aloha Nursing & 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. - 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	

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F 880	Continued From page 67 gloves, and no gown while feeding R32. 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. Record review in EMR on 08/12/21 09:06 AM, showed no physician orders for contact 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. 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. 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.	F 880	Aloha Nursing & Rehab Centre Resident Focus Rounds will be applied. - 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. - Corrective action is to be taken immediately and staff education on infection control measures is to be provided as deemed necessary. - 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. - 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 (NHA) and/or designee.	

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F 880	Continued From page 68 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."	F 880	- Compliance and completion of corrective DPOC by the NHA and/or designee.	