DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	<u> 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		ONSTRUCTION	· · ·	E SURVEY PLETED
		125038	B. WING			80	/12/2021
NAME OF PI	ROVIDER OR SUPPLIER	I		STR	REET ADDRESS, CITY, STATE, ZIP CODE		
	URSING & REHAB CENT	RE			545 KAMEHAMEHA HIGHWAY		
				KA	NEOHE, HI 96744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00	00			
	Office of Health Care facility was found not compliance with 42 C Complaints from the A System (ACTS) #871 be substantiated; #81 be unsubstantiated.						
	Survey Census: 103	1 00 10 / 10gust 12, 202 1					
	Sample Size: 23						
F 561 SS=D	•	(3)(8)	F 56	51			9/30/21
	promote and facilitate through support of re-	right to and the facility must resident self-determination sident choice, including but ts specified in paragraphs (f)					
	activities, schedules ( waking times), health						
		ident has a right to make s of his or her life in the cant to the resident.					
		ident has a right to interact community and participate in					
LABORATORY	L DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	Ē	- 1	TITLE		(X6) DATE
Electroni	cally Signed						09/21/2021

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

TATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	0. 0938-039 SURVEY DLETED
		125038	B. WING			08/	12/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-
	URSING & REHAB CENT	TRE			5-545 KAMEHAMEHA HIGHWAY		
					ANEOHE, HI 96744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 561	Continued From page	e 1	F	561			
		both inside and outside the		001			
	§483.10(f)(8) The res	sident has a right to ctivities, including social,					
	religious, and commu interfere with the righ	unity activities that do not its of other residents in the					
	facility. This REQUIREMENT by:	□ is not met as evidenced					
	Based on observation review, the facility fai	ons, interviews and record led to ensure the resident's			F561 Self Determination		
	right to promote and self-determination thr choice about aspects	rough support of resident's			Preparation and/or execution of this P of Correction does not constitute admission or agreement by the provid		
		dent for one resident in the			that a deficiency exists. This response		
		stated she preferred to			also not to be construed as an admiss		
		akfast, comb her hair, brush			of fault by the facility, its employees,		
		her face prior to eating			agents or other individuals who drafted		
		ident's choice was not			may be discussed in this response and		
		a result of this deficient			Plan of Correction. This response and Plan of Correction is submitted as the		
		is at risk of potential for sand potential psychosocial			facility s credible allegation of		
	outcomes.				compliance.		
	Findings include:						
	0n 08/00/21 at 00.25	AM an interview was			<ol> <li>Address how corrective action will b accomplished for those residents foun</li> </ol>		
		5 AM, an interview was 5 in the resident's room.			have been affected by the deficient		
		, she would wake up, get			practice.		
		sh teeth, comb hair, wash			F		
		thes) then eat breakfast.			-R103 discharged on 9/7/21 prior to		
	-	explained that after waking			receipt of 2567; therefore, the facility v	vas	
		th, the food does not taste			unable to interview the resident and		
	-	le a request with the facility			update care preferences and schedule	Э.	
		sh my teeth, but I need the					
		aren't able to help me at			- To protect residents in similar situation		
	-	d out the breakfast on the			the facility staff were educated regardi	•	
	resident's bedside tal	ble and that the resident had			Resident Rights including, but not limit	ted	

Facility ID: HI02LTC5038

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		125038	B. WING		08/12/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ALOHA N	URSING & REHAB CEN	IRE		15-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLETION	
F 561	Continued From page	e 2	F 561			
	not been helped with asking staff for help. On 08/11/21 at 09:00 conducted with regist confirmed, R103 cou and staff try to assist requests made. How and one certified nur residents and althoug always able to assist	brushing her teeth despite AM, an interview was tered nurse (RN)19. RN19 Id make her needs known		<ul> <li>to, the right to a dignified exister self-determination, and commun with and access to persons and inside and outside the facility, will included the residents' right to cl activities, schedule, health care and providers. The facilities oblig support, protect and promote the each resident.</li> <li>2) Address how the facility will ic other residents having the potential of the potentia</li></ul>	ication services hich noice of services gation to e rights of	
	electronic medical re 12:13 PM. An admis (MDS) with an Asses	DON) and review of R103's cord (EMR) on 08/11/21 at sion Minimum Data Set sment Reference Date ocumented in Section G.		affected by the same deficient pro- - The alleged practice has the pro- affect facility residents.		
	Functional Status, R assistance of 2+ pers extensive assistance assistance for dressi 04.000 Functional Lir	103 required extensive son for transferring and with 1-person physical ng and eating. Section mitation in Range of Motion ad impairment on both sides		- To identify other residents having potential to be affected by the id deficient practice, the Aloha Nur Rehab Centre (ANRC) Resident Round was created.	entified sing &	
	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)			<ul> <li>The DON or designee is to more manage compliance by performing random assessments of compliance during weekly completion of the Nursing &amp; Rehab Centre (ANRC) Resident Focus Round auditing</li> <li>Completed forms are to be kep binder in the Nursing Home Administrator s (NHAs) office designee.</li> </ul>	ng ince Aloha :) tool. tin a	

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Facility ID: HI02LTC5038

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		D HUMAN SERVICES MEDICAID SERVICES				PRINTED: 01/04/202 FORM APPROVE OMB NO. 0938-039
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		125038	B. WING			08/12/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	
	URSING & REHAB CENT	RE		45	5-545 KAMEHAMEHA HIGHWAY	
				ĸ	ANEOHE, HI 96744	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD ) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 561	Continued From page	3	F	561		
					ensure that the deficient practice does recur?	s not
					<ul> <li>To ensure quality assurance and effectiveness, and to protect residents similar situations, the facility staff were educated regarding Resident Rights including, but not limited to, the right the dignified existence, self-determination and communication with and access the persons and services inside and outsit the facility, which included the resident right to choice of activities, schedule, health care services and providers. The facilities obligation to support, protect promote the rights of each resident.</li> <li>The identified care and schedule preferences will be incorporated into the resident into the resident individualized care and residents choices, upon admission and uring the initial care plan meeting, the services in the resident of the resident of</li></ul>	e o a o o de ts' ne and he and
					<ul> <li>during the initial care plan meeting, the residents and/or responsible party will interviewed in regards to care and schedule preferences. The identified of and schedule preferences will be incorporated into resident comprehensionare plan.</li> <li>In-services will be conducted with licensed and non-licensed staff at new hire orientation and, at least, annually the Director of Nursing (DON) or design to include supporting the residents residents residents residents.</li> </ul>	be care sive y by gnee
L	7(02-99) Previous Versions Obs				preferences.	investion check Dago 4 of 6

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		ND HUMAN SERVICES			FORM APPROVE OMB NO. 0938-039
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		125038	B. WING		08/12/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
ALOHA N	JRSING & REHAB CEN	TRE		45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 561	Continued From pag	je 4	F 561	1	
				- In-services will be ongoing as nee	eded.
				4) Indicate how the facility plans to monitor its performance to make si solutions are sustained. The facilit develop a plan for ensuring that co is achieved and sustained. This pl must be implemented and the corr action evaluated for its effectivenes plan of correction is integrated into quality assurance system.	ure that ry must rrection an ective ss. The
				<ul> <li>To ensure quality assurance and effectiveness of promoting the well of our residents, and upholding the residents rights for systemic char ongoing monitoring and random evaluation with application of the A Nursing &amp; Rehab Centre (ANRC) Resident Focus Round auditing for be completed.</li> </ul>	nges, loha
				- Completion of this tool is to occur x 1 month, bimonthly for 1 month a monthly x 1 month by the DON or designee for a minimum of 12 wee ensure compliance.	ind
				- Corrective action is to be taken immediately and staff education is provided as deemed necessary.	to be
				- To ensure compliance, audit resu be reviewed, presented, and discu the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 month	ssed at

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/04/2022 M APPROVED D. 0938-0391
-	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		CONSTRUCTION	· /	E SURVEY PLETED
		125038	B. WING			08/12/2021	
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ALOHA N	URSING & REHAB CENT	RE		45-545 KAMEHAMEHA HIGHWAY			
		ATEMENT OF DEFICIENCIES		n	ANEOHE, HI 96744		0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 561	§483.21 Comprehens Planning §483.21(a) Baseline ( §483.21(a)(1) The fac implement a baseline that includes the instr effective and person- that meet professiona The baseline care pla	-(3) sive Person-Centered Care Care Plans cility must develop and care plan for each resident uctions needed to provide centered care of the resident al standards of quality care. in must-		655	until compliance is achieved. - If further corrective action is needed, f auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met. - Results of the monthly QAPI meeting be brought to the attention of the quarter QA Committee meetings and addresses as deemed appropriate. Included dates when corrective action of be completed: - Corrective action completion date by Nursing Home Administrator and/or designee.	will erly d	9/30/21
	admission. (ii) Include the minimu necessary to properly including, but not limit						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		125038	B. WING			08/	12/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				45	5-545 KAMEHAMEHA HIGHWAY		
ALOHA N	URSING & REHAB CENT	RE		κ	ANEOHE, HI 96744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 655	§483.21(a)(2) The fac comprehensive care is care plan if the compo- (i) Is developed within admission. (ii) Meets the requirer (b) of this section (exc this section). §483.21(a)(3) The fac resident and their rep of the baseline care po- limited to: (i) The initial goals of (ii) A summary of the dietary instructions. (iii) Any services and administered by the facilit (iv) Any updated infor of the comprehensive This REQUIREMENT by: Based on interviews facility failed to ensur comprehensive care implemented for each admission for two ress baseline care plan wa hospice resident with resident with a suprap pressure ulcers. The	endation, if applicable. cility may develop a plan in place of the baseline rehensive care plan- n 48 hours of the resident's ments set forth in paragraph cepting paragraph (b)(2)(i) of cility must provide the resentative with a summary plan that includes but is not if the resident. resident's medications and I treatments to be acility and personnel acting y. mation based on the details a care plan, as necessary. is not met as evidenced and record review, the e a baseline care plan or plan was developed and n resident within 48 hours of idents, R106 and R1. A as not developed for: a a history of falls; and a public catheter and multiple deficient practice places	F	355	F655 Baseline Care Plan Preparation and/or execution of this Pl of Correction does not constitute admission or agreement by the provide that a deficiency exists. This response also not to be construed as an admissi of fault by the facility, its employees, agents or other individuals who drafted	er e is on I or	
	limited to: (i) The initial goals of (ii) A summary of the dietary instructions. (iii) Any services and administered by the fa- on behalf of the facilit (iv) Any updated infor of the comprehensive This REQUIREMENT by: Based on interviews facility failed to ensur- comprehensive care i implemented for each admission for two ress baseline care plan wa hospice resident with resident with a suprag- pressure ulcers. The	the resident. resident's medications and treatments to be acility and personnel acting y. mation based on the details care plan, as necessary. is not met as evidenced and record review, the e a baseline care plan or plan was developed and n resident within 48 hours of idents, R106 and R1. A as not developed for: a a history of falls; and a public catheter and multiple			Preparation and/or execution of this PL of Correction does not constitute admission or agreement by the provide that a deficiency exists. This response also not to be construed as an admissi of fault by the facility, its employees,	er e is on I or	

Facility ID: HI02LTC5038

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OLITILI	5 FUR MEDICARE &	MEDICAID SERVICES			OMB NO. 09	938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SUR COMPLETE		
		125038	B. WING		08/12/2	08/12/2021	
NAME OF PI	ROVIDER OR SUPPLIER	•	· ·	STREET ADDRESS, CITY, STATE, ZIP C	ODE		
ALOHA N	URSING & REHAB CEN	TRE		45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE CC	(X5) DMPLETIO DATE	
F 655	Continued From pag	e 7	F 65	5			
	and services which n attaining or maintaini	nay prevent them from ng their highest practicable d psychosocial well-being.		Plan of Correction. This res Plan of Correction is submi facility s credible allegation compliance.	tted as the		
	due to a diagnosis of infection in the blood readmitted to the fac diagnoses of dement	d from the facility to hospital E. Coli sepsis (bacterial ) on 07/30/21 and was ility on 08/03/21. R1 had tia, diabetes, chronic kidney disease, and venous		<ul> <li>1) Address how corrective a accomplished for those res have been affected by the opractice.</li> <li>Resident R106 s compreplan has been reviewed an 8/6/21.</li> </ul>	idents found to deficient chensive care		
	review of R1's EMR. documented on 08/0 unwitnessed fall, was	AM surveyor conducted a Review of progress notes 7/21 at 3:25 PM, R1 had an s found on the ground near		- Resident R1⊡s comprehe plan was developed on 8/1	2/21.		
	the resident did not h result of the fall. Sho	s written to take R1 to the		<ul> <li>Licensed staff were education</li> <li>facility s responsibility to d implement a baseline care resident that includes the inneeded to provide effective</li> </ul>	levelop and plan for each istructions		
	interview with the dir record review of R1's	5 AM, conducted a concurrent ector of nursing (DON) and s EMR. Inquired with the		person-centered care of the meet professional standard	e resident that ls of care.		
	The DON navigated did not have a baseli comprehensive care	plan. The DON further		2) Address how the facility other residents having the p affected by the same deficient	potential to be ent practice.		
	developed within 48	ne care plan or plan should have been hours after being readmitted prehensive care plan was		- The alleged practice has t affect facility residents.     - An audit on all new admis			
	developed on 08/12/			months of August 2021 and 2021 was initiated and cond Director of Nursing (DON) a	d September ducted by the		
		vith a suprapubic catheter.		designee to identify resider			

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Statement or benciescies AND PLAN OF CORRECTON       (MI PROVDERSUMPLERLAUM DENTRICATION NUMBER 12603       (PO PLAND       (DO DUNC)       (DD DUNC)       (DD DUNC) </th <th></th> <th></th> <th>ND HUMAN SERVICES MEDICAID SERVICES</th> <th></th> <th></th> <th>PRINTED: 01/04/2022 FORM APPROVED OMB NO. 0938-0391</th>			ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/04/2022 FORM APPROVED OMB NO. 0938-0391
NAME OF PROVIDER OR SUPPLIER         DURING         STREET ADDRESS, CITY, STATE, ZP CODE           ALOHA NURSING & REHAB CENTRE         STREET ADDRESS, CITY, STATE, ZP CODE         45-36 KAMEHAMEIA HIOHMYA KANEOHE, HI 95744         90           Image: Contract of the control	STATEMENT (	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ,		(X3) DATE SURVEY
MALE OF PROVIDER OR SUPPLIER       STREET ADDRESS. CITY. STRITE ZIP CODE         43-35 KAMEHAMEHA HIGHWAY         ALCHA NURSING & REHAB CENTRE         STREET ADDRESS. CITY. STRITE ZIP CODE         43-35 KAMEHAMEHA HIGHWAY         KAND OF CORRECTION         (CALL DEPCIDEMENT OF DEFICIENCIES         PROVIDERS HAN OF CORRECTION         (CALL DEPCIDEMENT OF DEFICIENCIES         (CALL D			125038	B. WING		08/12/2021
ALOHA NURSING & REHAB CENTRE       XANECHE, HI 95744         (M)10 PHEFIX TAG       ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST ET REACEDED BY FULL RECULATORY OR USE IDENTIFYING INFORMATION)       ID PROVIDER SPLAOF CORRECTIVE ACTON SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY       COMPLETIVE CORRECTIVE ACTON SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY       COMPLETIVE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY       COMPLETIVE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY       COMPLETIVE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY       COMPLETIVE CROSS-REFERENCE DEFICIENCY       COMPLETIVE CROSS-REFERENCE DEFICIENCY       COMPLETIVE CROSS-REFERENCE CARE Plans are to be completed for each deficient practice, the Aloha Nursing & Rehab Centre (ANRC) F-655 & F-656 Baseline Care Plan Auditing Tool.       - The DON, Minimum Data Set (MDS) Manager and Coordinators, or designee is to monitor and manage compliance by performing random assessments of 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 AdministratorTis (NHACTIS) office or what systemic changes will you make to ensure that the deficient practice does not recur?       - Om 9/24/21, the MDS Manager, MDS Coordinators, and	NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CANECOME         INFORMATION           CANECOME, HI 96744         SUMMARY STATEMENT OF DEFICIENCES (EACH CORRECTION ACTION SHOULD BE (EACH CORRECTION ACTION SHOULD BE (EACH CORRECTION CANTON CANTON SHOULD BE (EACH CORRECTION CANTON CANTON CANTON CANTON CANTON SHOULD BE (EACH CORRECTION CANTON CANTON CANTON CANTON CANTON CANTON CANTON DEFICIENCY)         COUNTERT (EACH CORRECTION SHOULD BE (EACH CORRECTION CANTON CANTON CANTON DEFICIENCY         COUNTERT (EACH CORRECTION CANTON CANTON CANTON CANTON CANTON CANTON CANTON CANTON CONTRICT CANTON CANTON CANTON CANTON COMPLEXITY CANTON CONTRICT CANTON CANTON CANTON CONTRICT CANTON CANTON CANTON CONTRICT CANTON CANTON CANTON CONTRICT CANTON CANTON CANTON CANTON CONTRICT CANTON CANTON CONTRICT CANTON CANTON CANTON CONTRICT CANTON CANTON CANTON CONTRICT CANTON CANTON CANTON CONTRICT CANTON CANTON CANTON CANTON CONTRICT CANTON CANTON CANTON CONTRICT CANTON CANTON CANTON CANTON CONTRICT CANTON CANTON CANTON CANTON CONTRICT CANTON CANT					45-545 KAMEHAMEHA HIGHWAY	
PREFIX TAG       (EACH DEFICIENCY MIST BE PRECEDED BY FULL REQULATORY OR LSCIDENTIFYING INFORMATION)       PREFIX TAG       (EACH CASH CONFRECTIVE ACTION SHOULD BE CROSS-BERRENCE OT THE APPROPRIATE DEFICIENCY)       COMPLETION DEFICIENCY)         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.       - To identify other residents having the potential to be affected by the identified deficient finding.       - To identify other plans are to 2000 the Allows Name of deficient finding.         - The DON, Minimum Data Set (MDS) Manager and Coordinators, or designee is to monitor and manage compliated by the 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	ALOHA N	JRSING & REHAB CENT	IRE		KANEOHE, HI 96744	
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.       - To identify other residents having the potential to be affected by the identified deficient finding.         - To identify other resident's EMRs       - To identify other resident's EMRs       - To identify other resident's EMRs         - To identify other resident's EMRs       - To identify other resident's EMRs       - To identify other resident's EMRs         - To identify other resident's EMRs       - To identify other resident's EMRs       - To identify other resident's EMRs         - The DON, Minimum Data Set (MDS)       Manager and Coordinators, or designee is to monitor and manage compliatione 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.         - On 9/24/21, the MDS Manager, MDS Coordinators, and appostel licensed staff were in-serviced on the development of baseline and comprehensive care plans	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE COMPLETION
- A baseline or comprehensive care plan will be developed by the MDS Manager, or	F 655	On 08/11/21 at 11:50 interview with the DO EMR. Requested to plan or comprehensivn navigated the resident there was no baseline comprehensive care	AM, conducted a concurrent N and review of R106's view R106's baseline care ve care plan. The DON nt's EMR and confirmed e care plan or plan completed within 48	F 65	<ul> <li>Baseline Care Plans; comprehensive plans are to be completed for each deficient finding.</li> <li>To identify other residents having the potential to be affected by the identic deficient practice, the Aloha Nursing Rehab Centre (ANRC) F-655 &amp; F-69 Baseline Care Plan Auditing Tool was created.</li> <li>The DON, Minimum Data Set (MD Manager and Coordinators, or design to monitor and manage compliance performing random assessments of compliance during weekly completion the Aloha Nursing &amp; Rehab Centre (ANRC) F-655 &amp; F-656 Baseline Care Plan Auditing Tool.</li> <li>Completed forms are to be kept in binder in the Nursing Home Administrator S (NHA S) office or designee.</li> <li>3) What measures will be put into pl what systemic changes will you makensure that the deficient practice do recur?</li> <li>On 9/24/21, the MDS Manager, MI Coordinators, and apposite licensed were in-serviced on the developmer baseline and comprehensive care p for each resident.</li> <li>A baseline or comprehensive care</li> </ul>	he fied g & 56 as S) gnee is by on of are a a a cace or ke to les not DS i staff nt of lans plan

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Facility ID: HI02LTC5038

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/04/2022 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		125038	B. WING			08/	12/2021
NAME OF PF	ROVIDER OR SUPPLIER	l		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ALOHA NI	JRSING & REHAB CENT	RE			5-545 KAMEHAMEHA HIGHWAY		
				K	ANEOHE, HI 96744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 655	Continued From page	9	F	655	<ul> <li>assigned MDS coordinator, within 48 hours for all newly admitted, or readmission or readmission.</li> <li>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.</li> <li>4) Indicate how the facility plans to monitor its performance to make sure solutions are sustained. The facility is develop a plan for ensuring that correct action evaluated for its effectiveness plan of correction is integrated into the quality assurance system.</li> <li>To ensure quality assurance and effectiveness of the aforementioned systemic changes to promote quality care and services for our residents to attain or maintain their highest praction physical, mental, and psychosocial well-being, random monitoring and evaluation with application of the Alol Nursing &amp; Rehab Centre (ANRC) F-6 F-656 Baseline Care Plan Auditing To - Completion of this tool is to occur wix 1 month, bimonthly x 1 month, and monthly x 1 month by the DON or</li> </ul>	nitted dent's ed, ethat must ection tive tive cable na i55 & pol. eekly	
	7(02-99) Previous Versions Obs	nlete Event ID·KT(			designee for a minimum of 12 weeks ensure compliance.		

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		D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/04/2022 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		125038	B. WING		08/12/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ALOHA N	JRSING & REHAB CENT	RE		45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744	
		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 655	Continued From page	10	F 65	5	
				- Corrective action is to be taken immediately and staff education is provided as deemed necessary.	to be
				- To ensure compliance, audit resu be reviewed, presented, and discus the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months until compliance is achieved.	ssed at
				- If further corrective action is need auditing will continue until such tim the QAPI committee determines consistent substantial compliance h been met.	e that
				- Results of the monthly QAPI mee be brought to the attention of the q QA Committee meetings and addre as deemed appropriate.	uarterly
				Included dates when corrective act be completed:	ion will
				- Corrective action completion date Nursing Home Administrator and/o designee.	
F 656 SS=E	Develop/Implement C CFR(s): 483.21(b)(1)	omprehensive Care Plan	F 65	6	9/30/21
	implement a compreh care plan for each res	ensive Care Plans illity must develop and ensive person-centered ident, consistent with the h at §483.10(c)(2) and			

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						IO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		FE SURVEY MPLETED
		125038	B. WING	B. WING		8/12/2021
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
ALOHA NU	JRSING & REHAB CENT	IRE		45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 656	Continued From page	e 11	F 65	56		
			1 00			
	§483.10(c)(3), that in	ames to meet a resident's				
		mental and psychosocial				
		ied in the comprehensive				
		nprehensive care plan must				
	describe the following					
		are to be furnished to attain				
		ent's highest practicable				
		psychosocial well-being as				
		24, §483.25 or §483.40; and				
		would otherwise be required				
		.25 or §483.40 but are not				
		esident's exercise of rights				
	•	ding the right to refuse				
	treatment under §483					
	-	ervices or specialized				
		s the nursing facility will				
	provide as a result of					
	recommendations. If	a facility disagrees with the				
		RR, it must indicate its				
	rationale in the reside	ent's medical record.				
	(iv)In consultation wit	h the resident and the				
	resident's representa	tive(s)-				
	(A) The resident's go	als for admission and				
	desired outcomes.					
		eference and potential for				
		ilities must document				
		s desire to return to the				
		ssed and any referrals to				
	÷	s and/or other appropriate				
	entities, for this purpo					
		n the comprehensive care				
		in accordance with the				
	-	h in paragraph (c) of this				
	section.					
		is not met as evidenced				
	by:					
	Loood on obconvotio					
	reviews, the facility fa	ons, interviews and record		F656 Development/Impleme Comprehensive Care Plan	ent	

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		10. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	· · /	MPLETED
		125038	B. WING		0	8/12/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
ALOHA N	URSING & REHAB CENT	RE		45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 656	Continued From page	e 12	F 6	56		
	developed and implet meet resident's media psychosocial needs for R56. This deficient pr for these residents to and could affect all re Findings include: 1) R60 is a 100 years	or two residents, R60 and actice enables the potential receive sub-optimal care		Preparation and/or execution of Correction does not consti admission or agreement by the that a deficiency exists. This also not to be construed as a of fault by the facility, its emp agents or other individuals w may be discussed in this resp Plan of Correction. This resp Plan of Correction is submitted facility s credible allegation compliance.	tute he provider response is in admission bloyees, ho drafted or ponse and onse and ed as the	
	R60's EMR. R60's ad in Section N, Medicat treatment and Section (CAA) Summary docu Incontinence and Inde was triggered and a c area. Review of R60 care plan for urinary i straight catheter. Pro-	welling Catheter care area lecision to care plan this 's care plan did not include a ncontinence or the use of a ogress notes documented a used to obtain a urinary		<ul> <li>1) Address how corrective ac accomplished for those resid have been affected by the depractice.</li> <li>On 8/16/21, Resident R60 comprehensive care plan wa and updated to include a urin incontinence care plan or the straight catheter.</li> <li>On 8/16/21, Resident R56 </li> </ul>	ents found to ficient s s reviewed hary e use of a	
	review of R60's EMR care plan. The DON incontinence/indwellin the CAA and marked plan was not develop 2) Observations made 08/11/21 (08:37 AM,	with the DON and record . Reviewed the resident's confirmed urinary ng catheter was identified on as care planned but a care ed. e on 08/10/21 (01:29 PM), 10:19 AM, 11:48 AM), ent R56 was not wearing		<ul> <li>Off 8/10/21, Resident RSG comprehensive care plan wa and updates to the communi- plan have been made.</li> <li>UM s and MDS staff were the facility s responsibility to implement a comprehensive each resident to meet reside nursing, and psychological meet</li> </ul>	s reviewed cation care educated on o develop and care plan for nt⊡s medical,	

Facility ID: HI02LTC5038

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DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE &				PRINTED: 01/04/202 FORM APPROVEI OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125038	B. WING		08/12/2021
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ALOHA NURSING & REHAB CEN	TDE		45-545 KAMEHAMEHA HIGHWAY	
ALONA NORSING & RENAD CEN	IRE		KANEOHE, HI 96744	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
physical therapist (P were not worn to righ During an interview RN15 verbalized "he cart for one and a ha worked, I think we fo about the broken he During an interview social worker (SW)2	on 08/12/21 at 09:53 AM, the T) confirmed hearing aides ht nor left ear. on 08/12/21 at 10:00 AM, earing aides had been on the alf years, but they never blowed up with the daughter aring aids." on 08/12/21 at 10:05 AM, stated, "I have been onboard not been in contact with the	F 656	<ul> <li>other residents having the potential affected by the same deficient practice deficient practice has the potential affect facility residents.</li> <li>A review of comprehensive care for all residents within the facility winitiated by the Director of Nurses Minimum Data Set (MDS) Manage and/or designees to identify reside incomplete or inaccurate compreheare plans.</li> <li>To identify other residents having potential to be affected by the ider deficient practice, the Aloha Nursi Rehab Centre (ANRC) F-655 &amp; F-Baseline Care Plan Auditing Tool with the facility wide assessing compliance with application of the Nursing &amp; Rehab Centre (ANRC) F-656 Baseline Care Plan Auditing to the the forming a facility wide assessing compliance with application of the Nursing &amp; Rehab Centre (ANRC) F-656 Baseline Care Plan Auditing</li> <li>Completed forms are to be kept binder in the Nursing Home Administrator (NHA) office of designee.</li> <li>3) What measures will be put into what systemic changes will you mensure that the deficient practice of the fact of</li></ul>	IDS) signee is be by hent of Aloha F-655 & g Tool. in a r

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Facility ID: HI02LTC5038

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/04/2022 FORM APPROVED OMB NO. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		125038	B. WING		08/12/2021
NAME OF PF	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, Z	IP CODE
ALOHA NU	JRSING & REHAB CENT	RE		45-545 KAMEHAMEHA HIGHWAY	r
				KANEOHE, HI 96744	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE ) CROSS-REFERENCED DEFICI	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 656	Continued From page	9 14	F 6	56	
				<ul> <li>On 9/24/21, the MDS I coordinators, and licens in-serviced by the DON development, revision, a implementation process person-centered compreplans.</li> <li>A comprehensive pers plan will be developed, i updated for each reside</li> <li>Residents identified wi inaccurate comprehensis have their care plans reupdated immediately by MDS coordinator, or des their current goals, inter appropriate approaches medical and treatment r</li> <li>In-services will be ong and will also be conduct Manager, MDS Coordin licensed staff at new him at least, annually.</li> <li>A) Indicate how the facil monitor its performance solutions are sustained. develop a plan for ensuri is achieved and sustain must be implemented at action evaluated for its performance</li> </ul>	eed staff were on the and of ehensive care con-centered care implemented, and ent. ith incomplete or ive care plans will viewed and of the assigned signee, to reflect ventions, and to address their needs. oing as needed, ted with MDS ators, and e orientation and, ity plans to to make sure that The facility must ring that correction ed. This plan nd the corrective
		olete Event ID·KT04		plan of correction is inte quality assurance system	-

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Facility ID: HI02LTC5038

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		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 01/04 FORM APPRO OMB NO. 0938-	OVED
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		125038	B. WING	÷		08/12/2021	1
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	JRSING & REHAB CENT	RF		4	5-545 KAMEHAMEHA HIGHWAY		
				l M	ANEOHE, HI 96744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TAG	FIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLE	ETION
F 656	Continued From page	e 15	F	<sup>-</sup> 656			
					- The DON and the MDS Manager an responsible for maintaining complian		
					<ul> <li>To ensure quality assurance and effectiveness of the aforementioned systemic changes to promote quality care and services for our residents to attain or maintain their highest practi physical, mental, and psychosocial well-being, the DON, MDS Manager, designee will perform weekly comprehensive care plan audits coinciding with the MDS assessment calendar to monitor for compliance w application of the Aloha Nursing &amp; Re Centre (ANRC) F-655 &amp; F-656 Basel Care Plan Auditing Tool for all new admissions.</li> <li>Any or all findings will be reported to assigned MDS Coordinator or design for immediate correction.</li> </ul>	o cable or it it hehab line o the	
					<ul> <li>Completion of this tool is to occur w x 1 month, bimonthly x 1 month and monthly x 1 month by the DON or designee for a minimum of 12 weeks ensure compliance.</li> <li>For a minimum of 3 months, or unti compliance is achieved, audit results be reviewed, presented, and discuss the monthly Quality Assurance Performance Improvement (QAPI) meeting for analysis, and further</li> </ul>	to I swill	
					<ul> <li>If further corrective action is needed</li> </ul>	d, the	
ORM CMS-256	7(02-99) Previous Versions Obs	solete Event ID: KTC	0411	Fa	cility ID: HI02LTC5038 If cont	inuation sheet Page 1	6 of

Facility ID: HI02LTC5038

	-	ND HUMAN SERVICES			FORM APPROVE OMB NO. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		125038	B. WING		08/12/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ALOHA N	URSING & REHAB CEN	IRE	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIO	
F 656 F 677 SS=D	CFR(s): 483.24(a)(2) §483.24(a)(2) A resident out activities of daily services to maintain of personal and oral hys This REQUIREMENT by: Based on observation review, the facility fail with the necessary set grooming, and person	or Dependent Residents lent who is unable to carry living receives the necessary good nutrition, grooming, and	F 65	<ul> <li>auditing will continue until such ti the QAPI committee determines consistent substantial compliance been met.</li> <li>Results of the monthly QAPI me be brought to the attention of the QA Committee meetings and add as deemed appropriate.</li> <li>Included dates when corrective a be completed:</li> <li>Corrective action completion da Nursing Home Administrator and designee.</li> </ul>	e has eeting will e quarterly dressed action will ate by //or 9/30/21	
	highest practicable p well-being. Findings include:	hysical and psychosocial		admission or agreement by the p that a deficiency exists. This res also not to be construed as an ac of fault by the facility, its employe agents or other individuals who c	ponse is dmission ees,	
	08:16 AM, R13 was r	servations on 08/09/21 at noted in his bed laying on his side. He was wearing a		may be discussed in this response Plan of Correction. This response Plan of Correction is submitted a	se and e and	

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				F OME	NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	· · ·	DATE SURVEY COMPLETED
		125038	B. WING				08/12/2021
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ALOHA N	URSING & REHAB CENT	IRE			-545 KAMEHAMEHA HIGHWAY ANEOHE, HI 96744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 677	Continued From page	e 17	F 6	77			
	hospital type gown th on his chest. His hai uncombed. His knew	at was bunched up in a wad			facility⊡s credible allegation of compliance.		
	outside of the sheet, lower leg.	noted excoriations on his			1) Address how corrective action will accomplished for those residents four have been affected by the deficient		
	A second observation R13 was in the same	n was made at 10:53 AM. e position.			practice.		
	08/10/21 to 08/12/21 into the evening shift bed in his hospital go same disheveled hair				<ul> <li>To ensure that the impacted residen were provided with assistance with personal hygiene, they were assesse follows:         <ul> <li>On 9/17/21, R13 was assesse grooming and appearance. Resident neatly groomed, with clean gown, and</li> </ul> </li> </ul>	d as d for was	
	08/12/21 at 2:00 PM. transfer independent needed for ADL's due contractures. Approa active range of motio exercises. Oral care	e care plan for R13 on Problem: R13 is unable to ly and requires two man as e to limited mobility related to aches: Resident requires n/ passive range of motioin after every meal. o be up in wheelchair for 1			linen changed. - On 9/18/21, R16 was neatly groomed, with clean gown, and bed li changed. Resident⊡s comprehensive care plan reflects preference to wear gown.		
	meal a day as tolerat to three meals in whe	ed. Build up tolerance two eelchair/day. Surveyor d during the course of the			- Resident R13 was observed to have a bed bath on 9/1/21, 9/3/21, 9/8/21, 9/10/21, 9/13/21, and 9/17/21; Reside R13 was noted to be neatly groomed, a clean gown on, and bed linens char On 9/6/21 grooming, bathing and	ent , with	
	AM, surveyor noted t uncombed, and uncle wearing hospital type	tion on 08/09/21 at 11:00 hat R16's hair was ean. He was lying in bed gown that was bunched up and revealing a bare chest.			changing of clothing were offered; however, the resident refused care. Resident 13 s comprehensive care p reflects preference to wear gown. - Resident R16 was assessed for	blan	
	with his gown pulled	AM R16 was lying in bed up on his chest, alert, neveled, bed in lowest			grooming and appearance, and obser to have had a bed bath on 9/7/21, 9/1 9/14/21, and 9/18/21, he was neatly		

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				IO. 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>·</i>			TE SURVEY MPLETED	
		125038	B. WING		0	8/12/2021	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
ALOHA N	URSING & REHAB CENT	ſRE		45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE CC			
F 677	Continued From page	e 18	F 67	7			
	position. Surveyor made a sec PM and noted R16 la same position, gown restless and waving h chest. At 04:18 PM during a lying in his bed, restle On 08/11/21 at 10:30 his bed, moving uppe and forth. Nonverbal ceiling. TV on, but vo was uncombed. On 08/12/21 at 09:55 CNA was changing R	cond observation at 12:53 aying in his bed on his back, pulled up around his neck, his hands in the air above his an observation, R16 was less and agitated. AM R16 observed laying in the arms, moving head back by eyes open toward the plume was down. His hair AM surveyor observed a R16 in bed. Surveyor asked if ar today, the CNA stated he		<ul> <li>groomed, with clean gown, and l changed. On 9/3/21, 9/9/21, and however, on 9/3/21, 9/9/21, and Resident R16 was offered bathin grooming and change of clothing refused care. Resident compreh care plan reflects preference to v gown.</li> <li>On 9/21/21, direct care staff we in-serviced on activities of daily I (ADL), and on the importance of residents with quality personal c hygiene.</li> <li>On 9/26/21, to protect residents similar situations, facility staff we in-serviced on providing necessa services of ADL care for depend residents, to maintain good groop personal hygiene.</li> </ul>	9/16/21; 9/16/21, ng, o, resident ensive wear ere iving providing are and s in ere ary ent		
	Problem: R16 is on " with hospice care. G comfort. Approaches chair, use bedside co desired and tolerated and speak with reside Surveyor noted reside survey when frequen conducted. On 08/12/21 at 10:06 two staff (S) 45 and S anonymous. Surveyor the showers and pers	ent was in bed during the		<ul> <li>2) Address how the facility will ic other residents having the poten affected by the same deficient poten - The alleged practice has the pot affect facility residents.</li> <li>3) What measures will be put int what systemic changes will you ensure that the deficient practice recur?</li> <li>Direct care staff were in-service activities of daily living (ADL), ar importance of providing resident</li> </ul>	tial to be ractice. otential to o place or make to e does not ed on id on the		

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 01/04/2022 APPROVED . 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	PLE CONSTRUCTION	(X3) DATE COMPI	SURVEY
		125038	B. WING		08/*	2/2021
NAME OF PI	ROVIDER OR SUPPLIER		- <b>-</b>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	
	JRSING & REHAB CENT	rdc		45-545 KAMEHAMEHA HIGHWAY		
	JKSING & KEHAB CEN			KANEOHE, HI 96744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 677	who floats between the personal care when we are usually given two is the heaviest floor; or CNA's because the re- more dependent. So everything, and they care. S34 stated that more time to provide the residents like gro	signed to this side and one he two sides. We try to do we make our rounds, baths to three times a week. This we really need at least four esidents are heavier and metimes we just can't get to don't get all the personal t she would like to have more personalized care to oming and cleaning nails. affed, there's just no time for	F 67		n good led to staff at inually nee, vation, vation, s to be re ed to for hance s for ew eded,	
				orientation and, at least, annually. 4) Indicate how the facility plans to		

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Facility ID: HI02LTC5038

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER       125038       B. WING       08/12/202         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744       45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744         (X4) ID PREFIX       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL       ID PREFIX       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 0' FORM AP OMB NO. 09	PROVED	
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       ALOHA NURSING & REHAB CENTRE     STREET ADDRESS, CITY, STATE, ZIP CODE       45-545 KAMEHAMEHA HIGHWAY     KANEOHE, HI 96744       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION     (component)       YREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     CROSS-REFERENCED TO THE APPROPRIATE     COMP       TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     DEFICIENCY     Deficiency	ATEMENT OF DEFICIE	ENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ,		(X3) DATE SUR	VEY	
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         ALOHA NURSING & REHAB CENTRE       45-545 KAMEHAMEHA HIGHWAY         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL         TAG       PREFIX, REGULATORY OR LSC IDENTIFYING INFORMATION)			125038	B. WING		08/12/2	2021	
ALOHA NURSING & REHAB CENTRE       KANEOHE, HI 96744         (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)       0	AME OF PROVIDER (	OR SUPPLIER	I		STREET ADDRESS, CITY, STATE	•		
KANEOHE, HI 96744         (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)       (2) COMP DA	ALOHA NURSING	& REHAB CENT	ſRE					
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMP DA					KANEOHE, HI 96744			
F 677 Continued From page 20 F 677	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTI CROSS-REFERENCE	VE ACTION SHOULD BE CO ED TO THE APPROPRIATE	(X5) MPLETION DATE	
monitor is performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved 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. Is responsibility to provide dependent residents with necessary services to maintain good nutrition, grooming, and personal and oral hygiene.         - To resure quality assurance and effectiveness of promoting the wellbeing of our residents, and upholding the residents, and upholding the residents and upholding the residents cound with application of the Aloha Nursing & Rehab Centre (ANRC) Resident Focus Round auditing form will be completed.         - Completein of above mentioned tool is to occur weekly x 1 month, bimonthy x 1 month by the DON or designee for a minimum of 12 weeks to ensure compliance.         - To resture compliance, audit results will be reviewed, presented, and discussed at the monthy Quality Assurance	F 677 Contin	ued From page	e 20	F6	<ul> <li>77</li> <li>monitor its performan solutions are sustained develop a plan for en is achieved and sustained develop a plan for en is achieved and sustain must be implemented action evaluated for it plan of correction is ir quality assurance systemed active substantiation of the plan of correction is in quality assurance systemed facility staff were in-set facility staff were in-set facility is responsibilities dependent residents services to maintain of grooming, and person of our residents, and residents is residents of proming from of our residents, and residents is residented in the plan of our residents, and residents is rights for songoing monitoring a evaluation with applice Nursing &amp; Rehab Cerr Resident Focus Rour be completed.</li> <li>Completion of above occur weekly x 1 mor month and monthly x or designee for a min ensure compliance.</li> <li>Corrective action is immediately and staff provided as deemed</li> <li>To ensure compliant be reviewed, present.</li> </ul>	ace to make sure that ed. The facility must suring that correction ained. This plan d and the corrective ts effectiveness. The ntegrated into the stem. in similar situations, erviced on the ty to provide with necessary good nutrition, nal and oral hygiene. surance and noting the wellbeing upholding the systemic changes, nd random cation of the Aloha htre (ANRC) nd auditing form will e mentioned tool is to nth, bimonthly x 1 1 month by the DON imum of 12 weeks to to be taken f education is to be necessary. ce, audit results will ed, and discussed at		

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		MEDICAID SERVICES				M APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		e survey IPleted
		125038	B. WING		08	8/12/2021
NAME OF PF	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO		-
ALOHA NU	JRSING & REHAB CENT	RE		45-545 KAMEHAMEHA HIGHWAY		
				KANEOHE, HI 96744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 677 F 679 SS=D	CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The factory the comprehensive as and the preferences of program to support re- activities, both facility individual activities ar designed to meet the physical, mental, and each resident, encour and interaction in the This REQUIREMENT by:	st/Needs Each Resident sility must provide, based on assessment and care plan of each resident, an ongoing isidents in their choice of -sponsored group and id independent activities, interests of and support the psychosocial well-being of raging both independence	F 6	<ul> <li>Performance Improvement ( meeting for a minimum of 3 r until compliance is achieved.</li> <li>If further corrective action is auditing will continue until su the QAPI committee determi consistent substantial compli- been met.</li> <li>Results of the monthly QAF be brought to the attention of QA Committee meetings and as deemed appropriate.</li> <li>Included dates when corrective be completed:</li> <li>Corrective action completion Nursing Home Administrator designee.</li> </ul>	months or s needed, the ich time that nes iance has PI meeting will f the quarterly d addressed ive action will on date by and/or	9/30/21
	by:			F679 Activities Meet Interes	t/Needs Each	

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Facility ID: HI02LTC5038

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	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				ATE SURVEY OMPLETED
		125038	B. WING				08/12/2021
NAME OF PF	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				4	5-545 KAMEHAMEHA HIGHWAY		
ALOHA NU	IRSING & REHAB CENT	ſRE		к	ANEOHE, HI 96744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 679	Continued From page	- 22		070			
F 0/9	Continued From page		F	679			
		iled to provide activities that			Resident		
		two residents, R80 and					
		practice does not support the			Droporation and/or everything of this !	ممار	
		psychosocial well-being of could render psychosocial			Preparation and/or execution of this I of Correction does not constitute		
	harm. This has the po				admission or agreement by the provid	dor	
	residents in the facilit				that a deficiency exists. This response		
		y.			also not to be construed as an admis		
	Findings include:				of fault by the facility, its employees,	51011	
	r maings moldae.				agents or other individuals who drafte	ed or	
	1) An initial observation	on of R80 was made on			may be discussed in this response a		
	,	1. R80 was sitting upright in			Plan of Correction. This response an		
	bed, sleeping with his				Plan of Correction is submitted as the		
		guide. A hand made sign			facility s credible allegation of	-	
		umerous other wire craft			compliance.		
	objects were in his ro	om. His partially eaten					
		n a tray located on his					
	bedside table at the s				1) Address how corrective action will	be	
					accomplished for those residents fou	nd to	
	R80 was interviewed	on 08/10/21 at 12:00 PM in			have been affected by the deficient		
	his room. R80 stated	that he created the wire			practice.		
	decorative objects in	his room by hand with wire					
	hangers. He stated th	hat he had the tools to create			- On 9/14/21, the Therapeutic Recrea		
		en unable to use them. His			Manager (TRM) assisted Resident R		
		at the facility because they			with a crafting activity of the resident	S	
		gerous and could only be			choice.		
		upervised. He stated that he					
	could use them previo	5			- On 9/16/21, the TRM ensured that		
	-	nks that he was now unable			Resident R314 s television station w		
	to because "they don	t nave enough staff."			set to Resident s R134 s favorite n	ews	
		wed an 00/40/04 -+ 0:00			station. A sign was also posted on	and	
		ewed on 08/10/21 at 3:00			Resident R134 s communication bo	aro	
		old male admitted to the			to remind the care team to turn the talevision $(T_{i})$ on to the power station	of	
	-	l's disease (a progressive			television (TV) on to the news station		
	-	der that affects movement).			the resident s preference.		
	activities,"preference	d on 06/30/21 stated for			-Since admission R134 cognitive stat	ue.	
	on/creating new art."	es includeworking			has improved, R134 is now capable of		

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TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION	(X3) DA	IO. 0938-039 FE SURVEY MPLETED		
		125038	B. WING			08/12/2021		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
			45-545 KAMEHAMEHA HIGHWAY					
ALOHA N	URSING & REHAB CEN	ITRE		KANEOHE, HI 96744				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE		
F 679	An interview was do at 09:12 AM in the tr the facility had R80's and glue. The TR st supervise R80 while to create his craft pr "He takes so long to the time for him." R80's "TR Routine F 06/12/21 to 08/12/22 at 11:00 AM. There documented for the In a follow-up intervit in the conference ro with the residents ar staff does or upon c	Roster" report for the dates of 1 was reviewed on 08/12/21 were no activities	F 6'	<ul> <li>of his choice. R134 is also able independently utilize iPad due cognitive abilities.</li> <li>The resident s care plan refl Resident R314 s aforemention preference.</li> <li>Facility staff were educated o providing residents with activiti designed to meet their interests support the physical, mental, a psychosocial well-being of eac</li> <li>Facility staff were educated o implementation of residents and proper documentation of p/ refusal to participate.</li> </ul>	to increase ects ned TV n the es that are s and nd h resident. n activity plan			
	08/09/21 at 10:40 Al wearing a hospital g head of bed (HOB) r closed, and he was surveyor's salutation R314 was observed still lying in bed. His roommate had a sta range of motion (RC On 08/10/21 at 09:5 room. He was weari bed tilted to the right on.	tion was made of R314 on M in his room. R314 was own, lying in bed with his raised. His eyes remained slow to respond to the n. at 12:13 PM the same day television was off. His ff member helping him do 0M) exercises of his legs. 1 AM, R314 was alone in his ng a hospital gown lying in t side. His television was not		<ul> <li>2) Address how the facility will other residents having the pote affected by the same deficient</li> <li>The alleged practice has the affect facility residents.</li> <li>3) What measures will be put in what systemic changes will you ensure that the deficient practice recur?</li> <li>The TRM, or designee, will prannual in-service training and retraining of the importance of presidents with activities that are to meet the residents interest</li> </ul>	ential to be practice. potential to nto place or a make to ce does not rovide new hire oviding e designed			

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PRINTED: 01/04/2022 FORM APPROVED

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED MB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(3) DATE SURVEY COMPLETED
		125038	B. WING			08/12/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
ALOHA N	URSING & REHAB CENT	RE		45-545 KAMEHAMEHA HIGHWA KANEOHE, HI 96744	Y	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 679	room. His television v R314's EMR was revi PM. R314 is a 73-yea facility on 07/21/21 fo care plan dated 07/26 include having his far about his care, receiv participating in religio Another entry for his a is very important to (F via television" In an interview with th AM in the training roo have not been done v sleeping or in therapy R314's "TR Summary to 08/12/21 was revie	vas off. lewed on 08/10/21 at 2:50 ir-old male admitted to the r an infection. His activity 6/21 stated, "preferences nily involved in discussions ing pet visits, and us services/practices" activity care plan stated, "It R314) to (sic) with the news he TRM on 08/12/21 at 09:26 m, she stated that activities with R314 because he was v. r Roster" report for 06/12/20 wed on 08/12/21 at 10:00 a 20 minute one to one visit	F 6	<ul> <li>79</li> <li>psychosocial well-being</li> <li>The resident s prefer be conducted upon addred annually during the care</li> <li>The TRM will review, observation, activity att weekly basis, audit resirecords for all residents identify trends regardin provided to meet the in of our residents.</li> <li>Deficient findings will upon as deemed necess findings and follow up r reported at the monthly Performance Improvem meetings.</li> <li>The Aloha Nursing &amp; Resident Focus Round created to promote resp care for each resident i environment that promotor enhancement of eact quality of life. This aud monitoring through resi query and observation.</li> <li>In-services will be ong</li> <li>4) Indicate how the fact monitor its performance solutions are sustained develop a plan for ensultance and the solutions are sustained develop a plan for ensultance and the solutions are sustained develop a plan for ensultance and the solutions are sustained develop a plan for ensultance and the solutions are sustained develop a plan for ensultance and the solutions are sustained develop a plan for ensultance and the solutions are sustained and the solutions are sustained develop a plan for ensultance and the solutions are sustained and the solu</li></ul>	rence interview will mission and quarterly and e plan meeting. through tendance, and, on ident participation s; this audit will g activities terests and needs be followed up ssary; these measures will be γ Quality Assurance nent (QAPI) Rehab Centre Is auditing tool was pect, dignity, and in a manner and otes maintenance th resident⊟s liting tool is for ident interview going as needed ility plans to e to make sure tha I. The facility must	a e s

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Facility ID: HI02LTC5038

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOI	ED: 01/04/2022 RM APPROVED IO. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		125038	B. WING		0	8/12/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	•	
	JRSING & REHAB CENT			45-545 KAMEHAMEHA HIGHWAY		
ALOHA N	JRSING & REHAB CENT	RE		KANEOHE, HI 96744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 679	Continued From page	≥ 25	F 6	<ul> <li>is achieved and sustaine must be implemented an action evaluated for its elplan of correction is integ quality assurance system</li> <li>To protect residents in a facility staff were in-servi residents with activities th to meet their interests an physical, mental, and psy well-being of each reside</li> <li>Facility staff were also e implementation of residel and proper documentation / refusal to participate.</li> <li>To ensure quality assurance ffectiveness of promotin of our residents, and uph residents□ rights for syst ongoing monitoring and r evaluation with application. Nursing &amp; Rehab Centre Resident Focus Round a be completed.</li> <li>Completion of this tool i x 1 month, bimonthly x 1 month by the designee for a minimum ensure compliance.</li> <li>Weekly auditing of facility and staff edu provided as deemed nece</li> </ul>	d. This plan d the corrective ffectiveness. The grated into the n. similar situations, ced on providing nat are designed d support the ychosocial ent. educated on nts □ activity plan on of participation ance and g the wellbeing olding the temic changes, andom on of the Aloha (ANRC) uditing form will s to occur weekly month and e DON or of 12 weeks to the taken ucation is to be essary.	
DRM CMS-256	7(02-99) Previous Versions Obs	solete Event ID: KTO	411	- Weekly auditing of facili activity attendance by the Facility ID: HI02LTC5038	-	eet Page 26 of 6

Facility ID: HI02LTC5038

		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROV OMB NO. 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVEY COMPLETED	
		125038	B. WING		08/12/2021	
IAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
	URSING & REHAB CENT	RE		45-545 KAMEHAMEHA HIGHWAY		
				KANEOHE, HI 96744	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIC	
F 679	Continued From page	e 26	F 67	9		
				be reported at the monthly Qualit Assurance Performance Improve (QAPI) meetings.	-	
				<ul> <li>To ensure compliance, audit rescompleted by the TRM, and audit application of the Aloha Nursing &amp; Centre (ANRC) Resident Focus F auditing form, will be reviewed, prand discussed at the monthly Qua Assurance Performance Improve (QAPI) meeting for a minimum of months or until compliance is ach</li> <li>If further corrective action is nee auditing will continue until such the the QAPI committee determines</li> </ul>	ting with & Rehab Round resented, ality ment 3 nieved.	
				consistent substantial compliance been met. - Results of the monthly QAPI me	eeting will	
				be brought to the attention of the QA Committee meetings and add as deemed appropriate.		
				Included dates when corrective a be completed:	ction will	
				- Corrective action completion da Nursing Home Administrator and designee.	/or	
F 684 SS=D	Quality of Care CFR(s): 483.25		F 68	4	9/30/21	
		are ndamental principle that nt and care provided to				

Facility ID: HI02LTC5038

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CENTER	S FOR MEDICARF &	MEDICAID SERVICES			OMB NO. 093	PROVE 38-039	
TATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURV COMPLETED	′EY	
		125038	B. WING		08/12/20	08/12/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
	JRSING & REHAB CEN	ITRE		45-545 KAMEHAMEHA HIGHWAY			
				KANEOHE, HI 96744			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE CON	(X5) MPLETIO DATE	
F 684	Continued From pag	ge 27	F 684	4			
	<ul> <li>Continued From page 27</li> <li>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.</li> <li>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,</li> </ul>			F684 Quality of Care Preparation and/or execution of of Correction does not constitute admission or agreement by the p that a deficiency exists. This res also not to be construed as an a	provider ponse is		
	at a greater risk for o infectious disease. Findings include:	decline in ADLs, and		of fault by the facility, its employed agents or other individuals who do may be discussed in this response Plan of Correction. This response Plan of Correction is submitted a	drafted or se and e and		
	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			<ul> <li>facility s credible allegation of compliance.</li> <li>1) Address how corrective action accomplished for those residents have been affected by the deficient practice.</li> <li>Resident R162 was discharged</li> </ul>	n will be s found to ent		
	-	e right side. His left leg was , noted excoriations on his		- Resident R 162 was discharged facility			
	R13 was in the same	on was made at 10:53 AM. e position. (Refer to F677).		were provided with assistance w personal hygiene and psychosod wellbeing, they were assessed a	ith cial s follows:		
	08/10/21 to 08/12/21 into the evening shift	itional observations on 1 throughout the day shift and t. Noted that R13 was in his own and appeared with the		- On 9/10/21 Resident R13 assessed for appropriate person grooming and appearance by the of Nursing (DON). The resident	al care of e Director		

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	0: 01/04/2022 APPROVED 0: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		125038	B. WING		08/	12/2021
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	JRSING & REHAB CENT	PE	4	5-545 KAMEHAMEHA HIGHWAY		
	JKSING & KEHAB CENT	RE	к	ANEOHE, HI 96744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
TAG F 684	Continued From page same disheveled hair 2) During an observat AM, surveyor noted th uncombed, and uncle wearing hospital type around neck his neck On 08/10/21 at 08:29 with his gown pulled u non-verbal. hair looks position. Surveyor made a sec PM and noted R16 lay same position, gown p restless and waving h chest. At 04:18 PM during at laying in his bed, appe (Refer to F677). On 08/11/21 at 10:30 his bed, moving uppe and forth. Nonverbal, ceiling. TV on, but vo looked uncombed. Care plan reviewed o Problem: R16 is on " with hospice care. Go	e 28 ion on 08/09/21 at 11:00 hat R16's hair looked an. He was lying in bed gown that was bunched up and revealing a bare chest. AM R16 was lying in bed up on his chest, alert, a disheveled, bed in lowest ond observation at 12:53 ying in his bed on his back, pulled up around his neck, is hands in the air above his n observation, R16 was eared restless and agitated AM R16 observed laying in r arms, moving head back eyes open toward the dume was down. His hair n 08/12/21 at 02:30 PM. Comfort care only" status bal: Maintain dignity and	F 684	DEFICIENCY) observed to have had a bed bath, he w neatly groomed with clean gown on, hi bedside table was tidied, and the Christmas decoration was removed an stored. Residents comprehensive card plan reflects the resident □s preference 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 linen changed. Resident □s comprehensive care plan reflects preference to wear gown. - Resident R13 was observed to have 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, a clean gown on, and bed linens chang On 9/6/21 grooming, bathing and changing of clothing were offered; however, the resident refused care. Resident 13 □s comprehensive care pl reflects preference to wear gown. - Resident R16 was assessed for grooming and appearance, and observed.	vas s d e e to e. an bed had ht with ged. an	DATE
	chair, use bedside co desired and tolerated and speak with reside	ent was in bed during the		to have had a bed bath on 9/7/21, 9/1 <sup>2</sup> 9/14/21, and 9/18/21, he was neatly groomed, with clean gown, and bed lin changed. On 9/3/21, 9/9/21, and 9/16/ however, on 9/3/21, 9/9/21, and 9/16/2 Resident R16 was offered bathing, grooming and change of clothing, resid	en 21; :1,	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		125038	B. WING			8/12/2021	
IAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
	JRSING & REHAB CE	NTRE		45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744			
0(0)15	X4) ID SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF		()(5)	
(X4) ID PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 684	Continued From pa	ige 29	F 6	84			
		0		refused care. Resident co	mprehensive		
	3) On 08/11/21 at 0	2:14 PM, surveyor reviewed		care plan reflects preferen	•		
	,	record from the EMR.		gown.			
		onitis due to inhalation of food					
		. Stage four pressure ulcer of		- On 9/21/21, direct care s			
		omyelitis, type two diabetes.		in-serviced on activities of			
	-	7/20 01:57 AM. R162		(ADL), and on the importa			
	sacrum, wound be	y. has large decubitus to		residents with quality pers	onal care and		
		d the entire wound with 3-6		hygiene.			
	-	ght to moderate yellowish		- On 9/26/21, to protect re	sidents in		
		essing change (Refer F686).		similar situations, facility s			
	0 0	с с с ,		in-serviced on providing n			
		06 AM surveyor interviewed		services of ADL care for d	•		
		equested to remain		residents, to maintain goo	d grooming and		
	the showers and pe	eyor asked S45 how often are ersonal care being done for		personal hygiene.			
		led that today we have three		- On 9/17/21, Resident R1			
	0	this side and one who floats		for grooming and appeara			
	care when we mak	des. We try to do personal e our rounds, baths are usually		was neatly groomed, with and bed linen changed.	clean gown,		
	•	imes a week. This is the eally need at least four CNA's		On 0/19/21 D16 was no	atly aroomed		
		nts are heavier and more		- On 9/18/21, R16 was new with clean gown, and bed			
		imes we just can't get to		Resident s comprehensiv	-		
	everything, and the	y don't get all the personal hat she would like to have		reflects preference to wea			
		le more personalized care to					
		rooming and cleaning nails.		2) Address how the facility			
		staffed, there's just no time for		other residents having the	•		
	those things. (Refe	r to F725).		affected by the same defic	cient practice.		
				- The alleged practice has affect facility residents.	the potential to		
				3) What measures will be			
				what systemic changes wi	-		
				ensure that the deficient p	ractice does not		

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ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/04/2022 FORM APPROVED OMB NO. 0938-0391
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
125038	B. WING		08/12/2021
	s	TREET ADDRESS, CITY, STATE, ZIP CODE	
RE	4	5-545 KAMEHAMEHA HIGHWAY	
	к	KANEOHE, HI 96744	
ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SI	HOULD BE COMPLETION
<del>9</del> 30	F 684		
		<ul> <li>that residents receive treatment in accordance with professional of practice, the comprehensive person-centered care plan, and residents □ choices.</li> <li>Facility staff were educated on facility □s turning and positioning and turning wheel. Turning whe is applied to all direct care provitag for ease of reference.</li> <li>The facility □s Unit Manager (L designee, will conduct daily wall rounds, and monitor through ob to ensure turning and reposition residents are being conducted v application of the turning wheel daily care treatments according residents □ person-centered pla</li> <li>To promote continuity of care, staff will be provided with educa aforementioned, at new hire orie and at least annually, by the Dir Nursing Services (DON) or desi</li> <li>The Aloha Nursing &amp; Rehab C Resident Focus Rounds was crepromote respect, dignity, and care each resident in a manner and environment that promotes main or enhancement of each resider under the provide of the during tool monitoring through resident integration.</li> </ul>	and care standards honor the the g policy el sticker ders name JM), or king servation, ing of vith and other to the n of care. facility tion, as entation ector of gnee. entre eated to are for htenance nts for
	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125038 RE ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	MEDICAID SERVICES         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE A. BUILDING         125038       B. WING         125038       B. WING         RE       I         ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)       ID PREFIX TAG	MEDICAID SERVICES         (x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (x2) MULTIPLE CONSTRUCTION A. BUILDING         125038       B. WING         125038       B. WING         RE       STREET ADDRESS, CITY, STATE, ZIP CODE 45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744         ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)       D PREFIX TAG       PROVIDER'S PLAN OF CORR (EACH ORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)         2: 30       F 684       - Facility staff were in-serviced th that residents receive treatment in accordance with professional of practice, the comprehensive person-centered care plan, and residents = choices.         - Facility staff were educated on facility_IS turning and positioning and turning wheel. Turning whe is applied to all direct care provi tag for ease of reference.         - The facility_IS Unit Manager (L designee, will conduct dially wail rounds, and monitor through ob to ensure turning and reposition residents = being conducted vially application of the turning wheel daily care treatments according residents person-centered pla         - To promote continuity of care, staff will be provided with educa aforementioned, at new hire ori and at least annually, by the Dir Nursing Services (DON) or desi         - The Aloha Nursing & Rehab C Resident Focus Rounds was cor promote respect, dignity, and ca

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		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 01/04/202 FORM APPROVED OMB NO. 0938-039
STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		125038	B. WING			08/12/2021
NAME OF PF	OVIDER OR SUPPLIER		I	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	
	IRSING & REHAB CENT	RE		45	5-545 KAMEHAMEHA HIGHWAY	
				K	ANEOHE, HI 96744	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 684	Continued From page	9 31	F	684	- In-services will be ongoing as neede	d
					<ul> <li>4) Indicate how the facility plans to monitor its performance to make sure solutions are sustained. The facility n develop a plan for ensuring that corree is achieved and sustained. This plan must be implemented and the correct action evaluated for its effectiveness. plan of correction is integrated into the quality assurance system.</li> <li>To protect residents in similar situation facility staff were in-serviced on ensure that residents receive treatment and coin accordance with professional stand of practice, the comprehensive person-centered care plan, and honor residents ⊂ choices.</li> <li>To ensure quality assurance and effectiveness of promoting the wellbei of our residents, and upholding the residents ⊂ rights for systemic change ongoing monitoring and random evaluation with application of the Aloh Nursing &amp; Rehab Centre (ANRC) Resident Focus Round auditing form</li> </ul>	nust ction ive The e ons, ing care lards r the ing es, a
					<ul> <li>be completed.</li> <li>Completion of this tool is to occur we x 1 month, bimonthly x 1 month and monthly x 1 month by the DON or designee for a minimum of 12 weeks ensure compliance.</li> <li>Corrective action is to be taken</li> </ul>	
	7(02-99) Previous Versions Obs	olete Event ID: KT			immediately and staff education is to	be

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/04/2022 MAPPROVED O. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		125038	B. WING			08	/12/2021
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRE	SS, CITY, STATE, ZIP CODE		
ALOHA N	URSING & REHAB CENT	RE		45-545 KAMEH KANEOHE, H	AMEHA HIGHWAY I 96744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTIO ACH CORRECTIVE ACTION SHOULD SS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 684	Continued From page	≥ 32	F 68	<ul> <li>provided</li> <li>To ensure be review the month Performa meeting for until come auditing with equal performation of the quality of the performation of the performance of the pe</li></ul>	of the monthly QAPI meetir ht to the attention of the qua nittee meetings and address ed appropriate.	ed at or d, the that s mg will urterly sed	
F 698 SS=D	CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensured require dialysis receive with professional star comprehensive person the residents' goals a	ure that residents who ve such services, consistent adards of practice, the on-centered care plan, and nd preferences.	F 69	be compl - Correcti Nursing F designee	ive action completion date b Home Administrator and/or		9/30/21

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	-	D HUMAN SERVICES MEDICAID SERVICES	-			FOR	D: 01/04/2022 MAPPROVED O. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	· · ·	E SURVEY PLETED
		125038	B. WING			08	8/12/2021
NAME OF PF	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	•	
ΔΙ ΟΗΔ ΝΙ	JRSING & REHAB CENT	RE		45	5-545 KAMEHAMEHA HIGHWAY		
				K	ANEOHE, HI 96744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 698	Continued From page	33	F	598			
		ns, staff interviews, and ility failed to provide care to			F698 Dialysis		
	a resident who require services consistent w practice for R78. The the resident at risk of result in serious illness Findings include: R78 was admitted to funder undergoes dialysis tre week on Monday, We On 08/09/21 at 12:43 with R78. The reside returned from her her approximately 11:30 Å regarding how staff m resident stated, "staff site and check my blo not been in to check r dialysis appointment." On 08/11/21 at 11:13 interview with the DO R78's EMR. R78's ac the resident scored a the resident is cognitiv the facility uses a form Communication Reco communicate with the and should be filled o	es dialysis receive such ith professional standards of e deficient practice places complications which could is and/or death. the facility on 08/02/21 and eatment three (3) times a ednesday, and Friday. PM, conducted an interview nt stated that she had nodialysis appointment at AM. Inquired with R78 ionitor her access site. The usually look at the access od pressure, but staff has me since I got back from my AM, conducted a concurrent N and record review of dmission MDS documented 14 on the BIMS, indicating vely intact. The DON stated in titled "Dialysis			<ul> <li>Preparation and/or execution of this of Correction does not constitute admission or agreement by the provident that a deficiency exists. This responses also not to be construed as an admis of fault by the facility, its employees agents or other individuals who draft may be discussed in this response a Plan of Correction. This response a Plan of Correction is submitted as the facility scredible allegation of compliance.</li> <li>1) Address how corrective action will accomplished for those residents for have been affected by the deficient practice.</li> <li>On 8/13/21, to promote corrective for the cited deficiency, and to ensure the deficient practice does not occur nursing staff were in-serviced on the importance to assess and monitor residents returning from dialysis</li> <li>On 9/18/21 Director of Nursing (Deconducted a record review, findings Resident R78 was assessed by lice nurse.</li> <li>Resident R78 endured no harm from the service on the result of the service on the result of the service on the nurse.</li> </ul>	ider ise is ssion ted or and nd re I be und to action re that c, c DN) reveal nsed	
	regarding the followin past six (6) hours prio condition, condition cl abnormal/changes in	g areas: medication(s) given r to dialysis, access site			cited deficiency and care was provid the resident by facility staff. 2) Address how the facility will ident	led for	

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					OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		125038	B. WING		08/12/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE	DE
ALOHA N	URSING & REHAB CENT	RE		45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE
F 698	not complete and did regarding the residen condition changes, or completing the form. areas of the form sho Inquired with the DOI during which staff are monitor the resident a appointment. The DO access the resident in but if it is not possible the resident within the returning to the facilit	The Dialysis ord form dated 8/4/21 was not provide information it's access site condition, r the name of the staff The DON confirmed all the ould be filled out but was not. N if there was a timeframe e expected to assess and after returning from a dialysis ON stated staff should mmediately upon returning, e then staff should access e first 30 minutes after y. The DON confirmed R78 til several hours after	F 69	<ul> <li>8</li> <li>other residents having the poraffected by the same deficient</li> <li>The alleged practice has the affect facility residents who redialysis care and treatment.</li> <li>3) What measures will be put what systemic changes will y ensure that the deficient practice recur?</li> <li>Licensed staff were in-servit following information to ensure residents who require dialysis such care and services, conse professional standards of pratine proper monitoring of all or residents prior to and upon refacility from dialysis <ul> <li>The purpose of the dialy communication form, and the of completing the form accurate completely prior to dialysis</li> <li>When the form needs to completed</li> <li>Protocol for pre and posiassessment, and timely docuted in Nurse competency asset</li> <li>To promote continuity of care prevent deficient practice register protocol/practices for residents receiving dialysis, I will be provided with education aforementioned, at new hire of and at least annually, by the</li> </ul></li></ul>	at practice. e potential to eceive t into place or ou make to trice does not ced on the re that s receive dialysis eturn to sis a importance ately and be t dialysis umentation ssment re, and to arding safe care of icensed staff on, as orientation,

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/04/202 FORM APPROVEI OMB NO. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		125038	B. WING		08/12/2021
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	
ALOHA NU	JRSING & REHAB CENT	RE		45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE
F 698	Continued From page	35	F 69	98	
				- Licensed staff will be trained retrained ongoing as deemed	
				<ul> <li>4) Indicate how the facility pla monitor its performance to m solutions are sustained. The develop a plan for ensuring ti is achieved and sustained. T must be implemented and the action evaluated for its effect plan of correction is integrate quality assurance system.</li> <li>To protect residents in simil and to reduce the risk of com facility staff were in-serviced that residents who require dia such services, consistent witt professional standards of pra comprehensive person-cente plan, and the residents goa preferences.</li> <li>The Aloha Nursing &amp; Rehat Dialysis Auditing Tool was created aid in monitoring that resident dialysis receive care and services.</li> <li>Weekly x 1 month, bimonth and monthly x 1 month the D Nursing (DON), or designee, the Aloha Nursing &amp; Rehab O</li> </ul>	ake sure that facility must hat correction This plan e corrective iveness. The d into the ar situations, on ensuring alysis receive h actice, the ered care Is and o Centre - eated to ts receiving vices, standards of by x 1 month irector of will utilize
				Dialysis Auditing Tool to rand dialysis communication forms notes, vital signs, and nursing	s, progress

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CENTER	S FOR MEDICARE &	D HUMAN SERVICES MEDICAID SERVICES			FORM APPRO OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		125038	B. WING		08/12/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (	
	URSING & REHAB CENT	RE		45-545 KAMEHAMEHA HIGHWAY	
				KANEOHE, HI 96744	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE COMPLETI THE APPROPRIATE DATE
F 698	Continued From page	9 36	F 69	98	
	Continued From page 50			dialysis notes. All findings be immediately addressed action, and resident asses deemed necessary, is to b immediately and staff educ provided as deemed neces	, and corrective sment, as e taken cation is to be
				- To ensure compliance, at be reviewed, presented, at the monthly Quality Assura Performance Improvement meeting for a minimum of until compliance is achieve	nd discussed at ance t (QAPI) 3 months or
				- If further corrective action auditing will continue until the QAPI committee detern consistent substantial com been met.	such time that mines
				- Results of the monthly Q be brought to the attention QA Committee meetings a as deemed appropriate.	of the quarterly
				Included dates when corre be completed:	ective action will
				<ul> <li>Corrective action comple</li> <li>Nursing Home Administrat designee.</li> </ul>	-
F 725 SS=E	Sufficient Nursing Sta CFR(s): 483.35(a)(1)(		F 72	25	9/30/21
		Staff. sufficient nursing staff with etencies and skills sets to			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		125038	B. WING			08/	12/2021
NAME OF P	ROVIDER OR SUPPLIER		<b>I</b>	s	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
ALOHA N	URSING & REHAB CENT	RE			15-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 725	provide nursing and r resident safety and al practicable physical, r well-being of each res resident assessments and considering the n diagnoses of the facil accordance with the f at §483.70(e). §483.35(a)(1) The fac by sufficient numbers types of personnel on nursing care to all res resident care plans: (i) Except when waive this section, licensed (ii) Other nursing pers limited to nurse aides §483.35(a)(2) Except paragraph (e) of this designate a licensed nurse on each tour of This REQUIREMENT by: Based on observatio review, the facility fail nursing staff to provid services to assure res maintain the highest p and psychosocial wel determined by the res individual plans of car	elated services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by a and individual plans of care number, acuity and ity's resident population in acility assessment required clity must provide services of each of the following a 24-hour basis to provide idents in accordance with ed under paragraph (e) of nurses; and sonnel, including but not when waived under section, the facility must nurse to serve as a charge duty. is not met as evidenced ms, interviews, and record ed to ensure sufficient le nursing and related sident safety and attain or practicable physical, mental, l-being of each resident, as sident assessments, re considering the number, s of the facility's resident	F	725	F725 Sufficient Nursing Staff Preparation and/or execution of this Pl of Correction does not constitute admission or agreement by the provide that a deficiency exists. This response also not to be construed as an admiss of fault by the facility, its employees, agents or other individuals who drafted 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	er e is ion d or d	

Facility ID: HI02LTC5038

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 01/04/2022 1 APPROVED 0. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DATE	
		125038	B. WING			08/	12/2021
NAME OF PR	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
		25		45	5-545 KAMEHAMEHA HIGHWAY		
ALOHA NU	JRSING & REHAB CENT	RE		ĸ	ANEOHE, HI 96744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 725	Continued From page 38		F	725			
		:35 AM, conducted an			compliance.		
		the resident's room. R103					
	stated at home, he/sh				1) Address how corrective action will b		
		n teeth, comb hair, wash hes) then eat breakfast.			accomplished for those residents found have been affected by the deficient	1 10	
		xplained that after waking			practice.		
		h, the food does not taste					
		quested to "clean up and			- To ensure and promote the highest		
	brush my teeth, but I	need the staff's help and			practicable physical, mental, and		
	they aren't able to hel				psychosocial well-being of the resident	s	
	pointed out the break				found to have been affected by the		
		t the resident had not been his/her teeth despite asking			deficient practice, the following actions were taken:		
		sident also stated when she					
	-	e needed help with eating			- On 8/13/21, to address concern	s	
		t 35-45 minutes before			regarding Resident R78, nursing staff	_	
	receiving assistance v	with meals.			were in-serviced on the importance to assess and monitor residents returning	1	
		AM, conducted an interview			from dialysis.		
		nfirmed, R103 can make					
		ff try to assist the resident			- Resident R103 was discharged	on	
		e. However, there is only assisting residents and			9/07/21.		
		f are not always able to			- On 9/10/21 Resident R13 was		
	assist residents as ne	-			assessed for appropriate personal care	eof	
					grooming and appearance by the Direc		
	Conducted a concurre	ent interview with the DON			of Nursing (DON). The resident was		
	and review of R103's	EMR on 08/11/21 at 12:13			observed to have had a bed bath, he v		
		DS with an ARD of 07/29/21			neatly groomed with clean gown on, hi	s	
		n G. Functional Status,			bedside table was tidied, and the	-	
		ive assistance of 2+ person			Christmas decoration was removed an		
		tensive assistance with sistance for dressing and			stored. Residents comprehensive care plan reflects the resident s preference		
		0 Functional Limitation in			wear gown.	0	
	Range of Motion docu						
	-	des of the upper and lower			- On 9/17/21, Resident R13 was		
	extremities. Review of	-			assessed for grooming and appearance		
	documented the resid	ent is autonomous in			Resident was neatly groomed, with cle	an	

Facility ID: HI02LTC5038

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MILLI TI	LE CONSTRUC	אחודי		E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				· · ·	PLETED
		125038	B. WING			08	8/12/2021
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDF	RESS, CITY, STATE, ZIP CODE	1 00	
				45-545 KAME	EHAMEHA HIGHWAY		
ALUHA N	URSING & REHAB CENT	KE		KANEOHE,	HI 96744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD E ROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	3E	(X5) COMPLETION DATE
F 725	Continued From page	<u>a</u> 39	F 72	5			
		which the DON explained	1 1 2		and bed linen changed.		
		t is able to control what		gown, a	and bed inten changed.		
		/ to day. Shared R103's		- (	On 9/18/21, the Director of Nurs	sina	
	-	N who confirmed R103 is			conducted a record review;		
	unable to perform act	ivities of daily living (ADL)			s reveal Resident R78 was		
	independently and if t	the resident is requesting		assesse	ed by licensed nurse.		
	help with ADLs prior t	o breakfast, staff should					
	honor the resident's r	equest. (Refer to F561).		-	Resident R78 endured no harm		
					e cited deficiency and care was		
	-	to the facility on 6/26/21 and		provide	d for the resident by facility stat	ff.	
		tments three (3) times a					
	week on Monday, We	ednesday, and Friday.			ovide nursing and related servic		
	0 00/00/04 -+ 40-40				re resident safety and to attain		
		PM, conducted an interview			n the highest practical physical		
		nt stated that she had nodialysis appointment at			and psychosocial wellbeing of sident, Human Resource		
		AM. During the time the			ist (HRS) has applied the follow	vina	
		n dialysis treatment, unit			es and promoted advertising fo		
		unch and assisting other			vith application of the following	//	
	residents with meals.			platform			
		nonitor her access site. The			bha Nursing & Rehab Centre		
		usually look at the access		website	-		
		ood pressure, but staff has		" Ind	leed		
	-	me since I got back from my			aljobshawaii		
	dialysis appointment.	11		" Ca	reermd		
				" Act	tive recruitment through our		
		AM, conducted a concurrent		partnere	ed schools: Healthcare Training	9	
		review of R78's EMR. R78's			reer Consultants, Windward		
		mented the resident scored			unity College, and the University	y of	
		licating the resident is			Nursing Department - Human		
		e DON stated staff should			ce Specialist, or a designated		
		site, a change in condition,		-	staff member, continue to guest		
		blood pressure reading			at their monthly Certified Nurses	5	
	DON confirmed the ti	returning to the facility. The			CNA) graduation ceremony. ysical posting of a We⊡re Hirin	a	
	returns to the facility,	-			has been posted by the facility		
	stretched thin due to				the front of the facility property.		
		y busy with administering		-	e facility has also secured		
		ns, and staff assisting during			ted agency workers to promote		

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				O. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	· · ·	E SURVEY IPLETED
		125038	B. WING		08	3/12/2021
NAME OF PI	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
ALOHA N	URSING & REHAB CEN	TRE		45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 725	Continued From pag	e 40	F 725	5		
		rily qualified to assess R78		sufficient nursing staff.		
	On 08/12/21 at 11:07 with the DON regard Reviewed the 2021 of staffing schedule for staff schedule provid on 08/09/21, the Day registered nurses an aides; Evening shift one (1) licensed prace certified nurse aides were four (4) registe certified nurse aides The DON stated dur staff assist the direct trays to the residents facility assessment, relative to benchman assistance with eatin	7 AM, conducted an interview ing sufficient nurse staffing. Facility Assessment and the 08/09/21 with the DON. The ed by the facility documented v shift (6-2:30) six (6) d ten (10) certified nurse five (5) registered nurses, ctical nurse, and nine (9) g and the Night shift there red nurses, and six (6) were scheduled as working. ing lunch, non-direct care care staff by delivering lunch a. According to the 2021 35.7% (high frequency k) require one-person ug. Although more staff are		<ul> <li>As a result of efforts put forth by Nursing Home Administrator (NH/ and apposite staff, the following p have been filled with newly hired associates:</li> <li>" Altres - Agency Hires</li> <li>" Registered Nurses</li> <li>" Registered Nurses - Per Dien</li> <li>" Nursing Assistants - To support nursing staff</li> <li>" Certified Nurses Aides</li> <li>" Infection Control Preventionis</li> <li>Wound Care Specialist</li> <li>" Interns - To provide non-direct support nursing staff</li> <li>*New hires are put through an oried process to promote the delivery or resident care</li> </ul>	A), HRS, ositions n ort st / ct care to entation	
	trained and able to a remain unchanged if all nurses were obse medications as oppo with meals. Queried number and acuity o into scheduling of sta facility staffs accordii the first floor 3 nurse Plumeria unit, one nu and one nurse that h Plumeria and Garde of staffing is applied if the staff model cha	sed to assisting residents the DON regarding how the f the residents are factored aff. The DON stated the ng to area, for example on s are scheduled: one on the urse on the Gardenia unit, has residents on both the nia units and the same model to the second floor. Inquired inges according to the y of the residents. The DON		<ul> <li>Aloha Nursing &amp; Rehab Centre i committed to operate our facility w superior quality to meet the needs residents; our residents are our hi priority, and our associates are ou valuable resource. For this reaso promote a collaborative effort amorembers of our facility is health of team, facility staff were educated facility attendance policy, and our importance of regular work attend the work flow, productivity, teamw outcomes for all stakeholders.</li> <li>The DON, Nurse Managers, and apposite staff were educated on s</li> </ul>	vith s of our ghest ir most n, and to ongst care on the ance to ork, and	

Facility ID: HI02LTC5038

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ND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:     125038      E E E E E E E E E E E E E E E E E	· ,	STREET ADDRESS, CITY, STATE, ZIP ( 45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744 PROVIDER'S PLAN OF		E SURVEY IPLETED 8/12/2021
ALOHA NURSING & REHAB CENTRE (X4) ID SUMMARY STATE PREFIX (EACH DEFICIENCY M	E EMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL	ID PREFIX	STREET ADDRESS, CITY, STATE, ZIP ( 45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744 PROVIDER'S PLAN OF	CODE	8/12/2021
ALOHA NURSING & REHAB CENTRE (X4) ID SUMMARY STATE PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL	PREFIX	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744 PROVIDER'S PLAN OF		
(X4) ID SUMMARY STATE PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL	PREFIX	KANEOHE, HI 96744 PROVIDER'S PLAN OF		
PREFIX (EACH DEFICIENCY M	IUST BE PRECEDED BY FULL	PREFIX		CORRECTION	
				THE APPROPRIATE	(X5) COMPLETIO DATE
F 725 Continued From page 4	1	F 7	725		
<ul> <li>staffs the units. (Refer 1 3) Surveyor received tel FM on 02/19/21 at 05:11 stated that he had conc at the facility. FM stated several months due to t the facility was on lock of the time to visit. In late at the hospital when she transfusion. I saw that I and were cutting into he sores with puss. I looke It was the week before st last week of November. went to the ED by ambu 2020, after she stopped (Refer to F686).</li> <li>4) Surveyor made obse 8:16 AM, R13 was note back, facing the right sid decoration on his bedsid items with dust and in d a hospital type gown that wad on his chest. His h uncombed. His knees him and facing to the rig outside of the sheet, no lower leg.</li> <li>A second observation w R13 was in the same po additional observations</li> </ul>	to F698). lephone call from R162's 7 PM at OHCA. FM erns regarding R162 care d, I didn't see R162 for he COVID pandemic and down before that I went all November 2020 I met her e went for a blood her nails were overgrown er hands. There were ed at her and almost cried. she went to the ED, the FM stated that R162 ulance on December 1, I breathing at the facility rvations on 08/09/21 at d in his bed laying on his de. Noted a Christmas de table with a few other isarray. He was wearing at was bunched up in a hair looked unclean and were tightly bent up under ght side. His left leg was ted excoriations on his vas made at 10:53 AM. position. Surveyor made on 08/10/21 to 08/12/21 and into the evening shift. his bed in his hospital h the same disheveled		<ul> <li>2) Address how the facility other residents having the affected by the same defice.</li> <li>The alleged practice has affect facility residents.</li> <li>3) What measures will be what systemic changes will ensure that the deficient precur?</li> <li>Ongoing measures set for systemic changes to ensure that the deficient precur?</li> <li>Ongoing measures to ensure that fine deficient precur?</li> <li>Ongoing measures to ensure that the deficient precur?</li> <li>Ongoing measures to ensure the deficient of the systemic changes to ensure attemption of the system of union appretion of the system of union appretion of the system of the system</li></ul>	potential to be cient practice. the potential to put into place or ill you make to ractice does not orth to promote re sufficient oport our current ires roved incentives ses - For all nd noc shift to ce with delivery eds, and d recognition with zes idance opropriate a deemed care, and to regarding g, facility staff is the the importance	

Facility ID: HI02LTC5038

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 01/04/2022 APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		125038	B. WING			08/	12/2021
NAME OF PI	ROVIDER OR SUPPLIER		1	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
ALOHA N	URSING & REHAB CENT	RE					
				ĸ	ANEOHE, HI 96744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 725	anonymous. Surveyor the showers and pers R13? S45 responded CNAs assigned to this between the two sides care when we make or given two to three tim heaviest floor; we rea because the residents dependent. Sometim everything, and they or care. S34 stated that more time to provide the residents like groot	4, who requested to remain or asked S45 how often are conal care being done for d that today we have three s side and one who floats s. We try to do personal our rounds, baths are usually es a week. This is the Ily need at least four CNA's s are heavier and more	F	725	<ul> <li>flow, productivity, teamwork, and outcomes for all stakeholders.</li> <li>As aforementioned, facility staff will b provided with education on the facility attendance policy to promote positive outcomes for all stakeholders, at new h orientation, and at least annually, by th Nursing Home Administrator, Director on Nursing Service (DON), or designee.</li> <li>Daily nursing staffing and facility censis discussed and reviewed at the daily morning Stand Up meeting.</li> <li>A staffing chart was created to determ and identify ideal vs. critical staffing levels are reviewed daily by the staffing levels are re</li></ul>	Is nire e of sus nine vels;	
					<ul> <li>DON or designee, and auditing of thes levels are conducted biweekly by the D or designee.</li> <li>The DON, or designee, will utilize the Facility Assessment and facility census determine resident acuity and nursing staff needs.</li> <li>When staffing level falls below ideal fa all shifts (including evening and noc shifts), based on the DON □s assessm contingency measures will be put in plato ensure resident care are being met: <ul> <li>The nursing leadership team, including nurse managers, assist with direct care tasks to ensure that all resident care needs are met</li> <li>The facility non-nursing manageria team help to provide non-direct suppor similar to that of interns, such as</li> </ul> </li> </ul>	e DON s to or ent, ace	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/04/2022 APPROVED . 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE S COMPL	SURVEY	
		125038	B. WING			08/12/2021		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1		
	JRSING & REHAB CENT	RE		45	5-545 KAMEHAMEHA HIGHWAY			
				K	ANEOHE, HI 96744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	H CORRECTIVE ACTION SHOULD BE COM -REFERENCED TO THE APPROPRIATE		
F 725	Continued From page	2 43	F	725	<ul> <li>answering call lights, emptying trash betc.</li> <li>" Reliant Rehabilitation staff provid assistance in accordance with their skest.</li> <li>4) Indicate how the facility plans to monitor its performance to make sure solutions are sustained. The facility in develop a plan for ensuring that correct is achieved and sustained. This plan must be implemented and the correct action evaluated for its effectiveness. plan of correction is integrated into the quality assurance system.</li> <li>The DON, or designee, will conduct random care rounds to promote sufficient nursing staff compliance with resident acuity and daily care needs.</li> <li>To promote sufficient nursing staffing collaborative action is to taken as aforementioned, and staff education concerning attendance is ongoing and be provided as deemed necessary.</li> <li>The DON, or designee, is to complet weekly x 1 month, bimonthly x 1 mont and monthly x1 month audit of the carrounds and staff schedule findings for minimum of 12 weeks to ensure</li> </ul>	es ill that bust ction ve The daily ient s l, l, l to e h e		
	7(02-99) Previous Versions Obs	olete Event ID: KTC			compliance. - To ensure compliance, audit results be reviewed, presented, and discusse the monthly Quality Assurance Performance Improvement (QAPI)	d at		

Event ID: KTO411

Facility ID: HI02LTC5038

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/04/2022 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		125038	B. WING			08	/12/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1	
ALOHA N	URSING & REHAB CENT	RE			5-545 KAMEHAMEHA HIGHWAY ANEOHE, HI 96744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 725 F 761 SS=D	CFR(s): 483.45(g)(h)( §483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the of applicable. §483.45(h) Storage of §483.45(h)(1) In according Federal laws, the faci- biologicals in locked of	d Biologicals (1)(2) of Drugs and Biologicals s used in the facility must be e with currently accepted s, and include the y and cautionary		725	meeting for a minimum of 3 months or until compliance is achieved. - If further corrective action is needed, auditing will continue until such time the the QAPI committee determines consistent substantial compliance has been met. - Results of the monthly QAPI meeting be brought to the attention of the quart QA Committee meetings and addresses as deemed appropriate. Included dates when corrective action be completed: - Corrective action completion date by Nursing Home Administrator and/or designee.	the lat will terly ed	9/30/21

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		D HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		125038	B. WING		08/12/2021
	ROVIDER OR SUPPLIER	RE		STREET ADDRESS, CITY, STATE, ZIP CODE 45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 761	locked, permanently a storage of controlled of the Comprehensive D Control Act of 1976 and abuse, except when t package drug distribut quantity stored is min be readily detected. This REQUIREMENT by: Based on observation failed to store biologic derivitive) in accordar professional principles Findings include: On 08/11/21 at 08:52 second-floor refrigera on the second floor ne purified protein derivit Tuberculin skin testing date 07/05/21 written RN16, the vial of PPD	cess to the keys. cliity must provide separately affixed compartments for drugs listed in Schedule II of orug Abuse Prevention and nd other drugs subject to he facility uses single unit tion systems in which the imal and a missing dose can " is not met as evidenced in and interview, the facility cals (purifired protein nee with accepted is within the expiration date. AM Surveyor inspected the tor in the medication room ursing station. One vial of tive (PPD), (used for g) was found with an open on the box. Confirmed with	F 76	<ul> <li>F761 Label/Store Drugs and Biological</li> <li>Preparation and/or execution of this P of Correction does not constitute admission or agreement by the provid that a deficiency exists. This response also not to be construed as an admiss of fault by the facility, its employees, agents or other individuals who drafted 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.</li> <li>1) Address how corrective action will the accomplished for those residents four have been affected by the deficient practice.</li> <li>On 8/12/21, to ensure that the facility stored biologicals in accordance with accepted professional principals within expired date,</li> </ul>	lan er e is ion d or d

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Facility ID: HI02LTC5038

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/04/2022 MAPPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		125038	B. WING	i		08	/12/2021
NAME OF P	ROVIDER OR SUPPLIER		<b>I</b>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ALOHA N	URSING & REHAB CENT	RE		4	5-545 KAMEHAMEHA HIGHWAY		
				K	ANEOHE, HI 96744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 761	Continued From page	e 46	F	761	<ul> <li>nursing associates immediately conducted a facility-wide sweep of medication refrigerators to ensure the were no other instances of expired undated biologicals being stored.</li> <li>Licensed nurses have been educate professional standards of practice of storage of drugs and biologicals and biologicals and biologicals affected by the same deficient practice of the facility medication refriger sweep on 8/12/21 it was determine no residents could be affected by the same deficient practice of alleged deficiency.</li> <li>The alleged practice has the potential affect facility residents.</li> <li>On 9/20/21, an associate of the facility as station check of random medicatic carts to assess for proper label/stor drugs and biologicals.</li> <li>To identify other residents having potential to be affected by the ident deficient practice, the F-759 &amp; F-76 Medication Pass and Storage Audit was created.</li> </ul>	and/or ated on or tify to be tice. e actice. ators d that his ntial to pleted on re of the ified 1	
					- The Director of Nursing (DON) or		
ORM CMS-256	7(02-99) Previous Versions Obs	solete Event ID: KTC	9411	Fac	cility ID: HI02LTC5038 If co	ntinuation she	et Page 47 of 69

Facility ID: HI02LTC5038

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/04/2022 MAPPROVED O. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED	
		125038	B. WING			08/12/2021		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0		
ALOHA N	URSING & REHAB CENT	RE			5-545 KAMEHAMEHA HIGHWAY			
	l			K	ANEOHE, HI 96744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 761	Continued From page	e 47	F	761	<ul> <li>designee is to monitor and manage compliance by performing random assessments of compliance during w completion of the F-759 &amp; F-761 Medication Pass and Storage Audit for - Completed forms are to be kept in a binder in the Nursing Home Administrator s (NHA s) office or designee.</li> <li>3) What measures will be put into plawhat systemic changes will you make ensure that the deficient practice doe recur?</li> <li>In-service education will be conduct with licensed staff by the DON or designee upon hire and at least annuregarding the facilities Medication Storage of medication and biologicals in compliance with accepted professi principles within the expiration date.</li> <li>To ensure quality assurance and effectiveness, licensed nurses have to in-serviced on professional standards practice for proper storage of drugs a biologicals - Medication Storage in the Facility.</li> </ul>	a a a a a a a a a a a a a a a a a a a		
	7(02-99) Previous Versions Obs	solete Event ID: KT0			- A copy of the referenced document been provided to the in-serviced licer     CHID2LTC5038     If continues	nsed	et Page 48 of 69	

Facility ID: HI02LTC5038

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CENTER	S FOR MEDICARE &	& MEDICAID SERVICES				. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		125038	B. WING		08/	12/2021
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, Z	ZIP CODE	
ALOHA N	URSING & REHAB CEN	NTRE		45-545 KAMEHAMEHA HIGHWA` KANEOHE, HI 96744	Y	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETION DATE
F 761	Continued From page 48		F 761			
				nurses.		
				- In-services will be ong	oing as needed	
				<ul> <li>4) Indicate how the facili monitor its performance solutions are sustained. develop a plan for ensuris achieved and sustain must be implemented a action evaluated for its oplan of correction is interquality assurance syste</li> <li>The DON or designee random audits of medic to ensure facility is in compared to the system of the system.</li> </ul>	e to make sure that . The facility must ring that correction ed. This plan nd the corrective effectiveness. The egrated into the m. will conduct ation refrigerators	
				findings will be reviewed QA meetings and contir such time consistent sa reported.	nued randomly until	
				- An associate of the fact partner will continue to pharmacy station check medication carts. Howe of occurrence may be s as a result of COVID-19 regulations set forth in t all stakeholders.	conduct a quarterly c of random ever, the frequency ubject to change e safety rules and	
				<ul> <li>To ensure quality assure ffectiveness of promotion of our residents, and up residents rights for systematic ongoing monitoring and evaluation with applicat</li> </ul>	ing the wellbeing bholding the stemic changes, I random	

Event ID: KTO411

Facility ID: HI02LTC5038

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		125038	B. WING		08/12/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	JRSING & REHAB CE	NTRE		45-545 KAMEHAMEHA HIGHWAY	
				KANEOHE, HI 96744	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 761	Continued From page 49		F 761	form will be completed.	
				- Completion of this tool is to occur wee 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.	e
				- To ensure compliance, audit results w be reviewed, presented, and discussed 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, auditing will continue until such time the the QAPI committee determines consistent substantial compliance has been met.	
				- Results of the monthly QAPI meeting be brought to the attention of the quart QA Committee meetings and addresse as deemed appropriate.	erly
				Included dates when corrective action be completed:	will
				- Corrective action completion date by Nursing Home Administrator and/or designee.	
F 849	Hospice Services		F 849	9	9/30/21

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 01/04/2022 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE	
		125038	B. WING			_	08/	12/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ALOHA N	URSING & REHAB CENT	RE			5-545 KAMEHAMEHA HIG ANEOHE, HI 96744	HWAY		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 849	CFR(s): 483.70(o)(1)- §483.70(o) Hospice s §483.70(o)(1) A long- do either of the follow (i) Arrange for the pro through an agreemen Medicare-certified hos (ii) Not arrange for the pro services at the facility a Medicare-certified h resident in transferring arrange for the provis when a resident reque §483.70(o)(2) If hospi LTC facility through an paragraph (o)(1)(i) of the LTC facility must r requirements: (i) Ensure that the hos professional standard to individuals providin to the timeliness of th- (ii) Have a written agr that is signed by an a the hospice and an au the LTC facility before any resident. The wri at least the following: (A) The services the the (B) The hospice's resi the appropriate hospic in §418.112 (d) of this (C) The services the I provide based on eac (D) A communication	(4) ervices. term care (LTC) facility may ing: vision of hospice services t with one or more spices. e provision of hospice through an agreement with ospice and assist the g to a facility that will ion of hospice services ests a transfer. ce care is furnished in an n agreement as specified in this section with a hospice, meet the following spice services meet s and principles that apply g services in the facility, and e services. eement with the hospice uthorized representative of thospice care is furnished to tten agreement must set out nospice will provide. ponsibilities for determining ce plan of care as specified	F	849				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/04/2022 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE S COMPL	SURVEY
		125038	B. WING			08/1	12/2021
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE	, ZIP CODE		
	URSING & REHAB CENT	RE		5-545 KAMEHAMEHA HIGHW	AY		
-			P	CANEOHE, HI 96744			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 849	LTC facility and the ho that the needs of the r met 24 hours per day. (E) A provision that the notifies the hospice al (1) A significant change mental, social, or emo (2) Clinical complication alter the plan of care. (3) A need to transfer for any condition. (4) The resident's dea (F) A provision stating responsibility for deter course of hospice care determination to chan provided. (G) An agreement that responsibility to furnist care, meet the resident nursing needs in coor representative, and en provided is appropriat resident's needs. (H) A delineation of the including but not limited direction and manage counseling (including bereavement); social supplies, durable meet nucessary for the pall associated with the te conditions; and all oth necessary for the care illness and related cor (I) A provision that we personnel are response	ospice provider, to ensure resident are addressed and e LTC facility immediately bout the following: ge in the resident's physical, otional status. ons that suggest a need to the resident from the facility ath. g that the hospice assumes rmining the appropriate re, including the age the level of services at it is the LTC facility's sh 24-hour room and board nt's personal care and rdination with the hospice nsure that the level of care tely based on the individual the hospice's responsibilities, ed to, providing medical ement of the patient; nursing; spiritual, dietary, and work; providing medical dical equipment, and drugs iation of pain and symptoms erminal illness and related her hospice services that are e of the resident's terminal nditions.	F 849				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/04/2022 M APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		125038	B. WING			08	/12/2021
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	JRSING & REHAB CENT	BE		4	5-545 KAMEHAMEHA HIGHWAY		
	JKSING & KERAD CENT	RE		к	KANEOHE, HI 96744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 849	facility personnel may where permitted by S the LTC facility. (J) A provision stating report all alleged viola mistreatment, neglect and physical abuse, in source, and misappro by hospice personnel administrator immedia becomes aware of the (K) A delineation of th hospice and the LTC f bereavement services §483.70(o)(3) Each L provision of hospice of agreement must desig facility's interdisciplina for working with hospic coordinate care to the LTC facility staff and h interdisciplinary team clinical background, fu scope of practice act, assess the resident o that has the skills and resident. The designated intero responsible for the fol (i) Collaborating with and coordinating LTC the hospice care plan residents receiving th	te by the hospice and bice plan of care, the LTC administer the therapies tate law and as specified by g that the LTC facility must ations involving , or verbal, mental, sexual, heluding injuries of unknown priation of patient property , to the hospice ately when the LTC facility e alleged violation. he responsibilities of the facility to provide s to LTC facility staff. TC facility arranging for the are under a written gnate a member of the ary team who is responsible fee representatives to e resident provided by the hospice staff. The member must have a unction within their State and have the ability to r have access to someone d capabilities to assess the lisciplinary team member is lowing: hospice representatives facility staff participation in ning process for those ese services.	F	849			
	· · · •	th hospice representatives providers participating in the					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/04/2022 APPROVED . 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMPI	SURVEY
		125038	B. WING		_	08/ <sup>,</sup>	12/2021
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ALOHA N	URSING & REHAB CENT	RE		5-545 KAMEHAMEHA HIG (ANEOHE, HI 96744	HWAY		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 849	provision of care for the conditions, and other of care for the patient (iii) Ensuring that the with the hospice medi- attending physician, a participating in the pro- as needed to coordina medical care provided (iv) Obtaining the follo hospice: (A) The most recent to each patient. (B) Hospice election (C) Physician certifica- the terminal illness sp (D) Names and conta personnel involved in patient. (E) Instructions on ho 24-hour on-call system (F) Hospice medicati each patient. (G) Hospice physicia any) orders specific to (v) Ensuring that the I orientation in the polio facility, including patie and record keeping re furnishing care to LTC §483.70(o)(4) Each L care under a written a each resident's written the most recent hospi description of the serv facility to attain or ma	he terminal illness, related conditions, to ensure quality and family. LTC facility communicates ical director, the patient's and other practitioners ovision of care to the patient ate the hospice care with the d by other physicians. owing information from the hospice plan of care specific form. ation and recertification of pecific to each patient. act information for hospice hospice care of each ow to access the hospice's m. on information specific to an and attending physician (if peach patient. LTC facility staff provides cies and procedures of the ent rights, appropriate forms, equirements, to hospice staff C residents. TC facility providing hospice agreement must ensure that n plan of care includes both	F 849				

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED . 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		125038	B. WING		08/	12/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00		
ALOHA N	URSING & REHAB CENT	RE		45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 849	well-being, as require This REQUIREMENT by: Based on observation review the facility failed the following services collaboration with the 1) The facility did not facility's interdisciplina for working with hospi coordinate care to the facility staff and hospi 2) The facility failed to plan of care includes hospice plan of care a services furnished by one joint plan of care. The deficient practice resident, R16 will atta physical, mental, and while receiving end of Findings include: Surveyor saw R16 on noted he was laying in gown pulled up on to chest. He appeared a looked disheveled. S observations on 08/09 08/10/21 at 08:29 AM noted R16 was laying observations, hospita his neck exposing his moving his arms arou	d at §483.24. is not met as evidenced h, interview and record ed to provide coordination of and responsibilities in hospice provider: designate a member of the ary team who is responsible ice representatives to resident provided by the ce staff. o ensure that R16's written both the most recent and a description of the the facility coordinated into fails to ensure that one in the highest practicable psychosocial well-being f life care. 08/09/21 at 08:45 AM, and h his bed, restless with his his neck exposing his full alert, nonverbal and his hair urveyor made additional 0/21 at 10:30 AM; 02:00 PM; and 01:52 PM. Surveyor in his bed with the same I gown bunched up around torso, fidgeting, and nd. e EMR on 08/11/21 at 10:38 I R16 readmitted with colon	F 849	<ul> <li>F849 Hospice Services</li> <li>Preparation and/or execution of this Plof Correction does not constitute admission or agreement by the provid that a deficiency exists. This response also not to be construed as an admiss of fault by the facility, its employees, agents or other individuals who drafted 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.</li> <li>1) Address how corrective action will be accomplished for those residents foun have been affected by the deficient practice.</li> <li>On 8/12/21, the facility reached out to hospice provider for Resident R16 to ensure that the facility had the most updated hospice care plan.</li> <li>On 9/17/21, the facility identified that Unit Manager (UM) will be the designal staff member of the interdisciplinary terms (IDT) who will be responsible for collaborating with the hospice representative to coordinate care to the resident by both the facility and hospic health care organization.</li> </ul>	er e is ion d or d d to e the tted am e e		
	noted R16 was laying observations, hospita his neck exposing his moving his arms arou Surveyor reviewed the	in his bed with the same I gown bunched up around torso, fidgeting, and nd. e EMR on 08/11/21 at 10:38 I R16 readmitted with colon		staff member of the interdisciplinary te (IDT) who will be responsible for collaborating with the hospice representative to coordinate care to th resident by both the facility and hospic	am e e		

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TATE!			0.00		OMB NO. 0938-0
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		125038	B. WING		08/12/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE
ALOHA N	URSING & REHAB CENT	IRE		45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COMPLETI O THE APPROPRIATE DATE
F 849	Continued From page	e 55	F 84	19	
	- Provide daily recrea			provider is licensed nurs	se was contacted
		rticipate in his chosen		to discuss the need for a	
		It is very important to listen		care plan for Resident R	
		eceive pet visits, keep up		coordinated care plan wi	
		evision, participate in group		Resident R16□s most re	
		please assist him with his		of care and the facility s	
	-	02/28/21 Active. Surveyor		promote continuity of car	
		engage in activities during		the highest practicable p	<b>3</b>
	the survey from 08/09			and psychosocial well-be	
		Hospice provider, will		receiving end of life care	
	-	e plan based on R16's rests, and customize the		- Resident R16⊡s persor	a contored care
	-	e that fits his current abilities		plan includes most recer	
		enjoying his daily routine and		care to attain the highest	
	activities of leisure.			physical, mental and psy	
		n. Receiving Hospice Care.		well-being while receiving	
		es a peaceful, dignified			
	death 10/20/20 review			- Resident R16□s inform	ation regarding
	Interventions: Provide	e with grief and spiritual		hospice care plans was i	
	counseling if desired.			communicated to nursing	g staff through the
		lospice Team to assure		shift report	
		as little pain as possible			
	10/20/20.	11		- To promote continuity o	
	Coordinate care with	Hospice Team. 10/20/20.		collaboration amongst th hospice agencies, UMs a	
	Reviewed Hospice ar	nd Nursing facility services		were educated regarding	
	agreement.	Ta reasing racinty services		of a coordinated care pla	
		nd implementation of the		facility and hospice agen	
	Joint Plan of Care (JF			residents receiving hospi	-
		e. All services provided to			
	-	ler the Agreement must be in			
		Joint Plan of Careshall		2) Address how the facili	
	identify the care and			other residents having th	
		hether Hospice or Facility is		affected by the same def	icient practice.
	responsible for perfor				
		een agreed upon and		- The facility has determi	
	included in the Plan of			residents receiving hospi	
		n of Services. Both Parties		the potential to be affected	
	snall maintain approp	priate documentation of		assurance, an audit of al	residents

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TI		CONSTRUCTION		IO. 0938-03	
	CORRECTION	IDENTIFICATION NUMBER:	, <i>'</i>			1 Y	PLETED	
		125038	B. WING			0	8/12/2021	
NAME OF P	ROVIDER OR SUPPLIER	•		ST	IREET ADDRESS, CITY, STATE, ZIP CODE			
ALOHA N	URSING & REHAB CENT	RE	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE	
F 849	Continued From page	e 56	F 84	49				
	services provided und				receiving hospice services was conduc	cted		
		oth the facility and hospice			and addressed as deemed necessary.			
	plan of care. Neither							
	coordination of servic				- To identify other residents having the			
		provider, the two care plans			potential to be affected by the identified deficient practice, the Aloha Nursing &			
	are separate.				Rehab Centre (ANRC) F-655 & F-656			
	Survevor interviewed	RN16 on 08/11/21 at 12:02			Baseline Care Plan Auditing Tool was			
		RN16 what services are			created.			
		hospice? RN16 replied that						
		aware of the type of services			- The DON, Minimum Data Set (MDS)			
	-	ed and that the hospice			Manager and Coordinators, or designe			
		omes in on Wednesday. ne surveyor can find the HN			to monitor and manage compliance by performing a facility wide assessment of			
		ey do their own charting in an			compliance of coordinated hospice	01		
	-	that R16 came back from			services with application of the Aloha			
		strointestinal (GI) bleed.			Nursing & Rehab Centre (ANRC) F-65 F-656 Baseline Care Plan Auditing Toc			
		hospice provider binder in						
	12:10 PM. Surveyor	ing station on 08/11/21 at			- Completed forms are to be kept in a binder in the Nursing Home			
	Comprehensive Asse				Administrator s (NHA s) office or			
		n (IDT) notes were found.			designee.			
		lled nursing (SN): Visits two			<b>3 1 1</b>			
		as needed visits every						
		aide weekly visits as			3) What measures will be put into place			
		ed social worker (LSW) will			what systemic changes will you make the			
	as needed every 30 c	ime per month and one time			ensure that the deficient practice does recur?	not		
	psychosocial needs.	ays 10 assess 101						
		Medications reviewed for			- On 9/24/21, the MDS Manager, MDS			
		e current plan of care.			coordinators, and licensed staff were			
	Monitor for further de				in-serviced by the DON on the			
		-face visit details by the			development, revision, and			
		4/21. Admitted to hospice			implementation process of			
		s of malignant neoplasm of res maximum to complete			person-centered comprehensive care plans.			
		es of daily living, (ADL's)			piano.			
	including 1:1 feeding				- In-services will be ongoing as needed	4		

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DEFICIENCIES ORRECTION WIDER OR SUPPLIER	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125038	. ,		(X3) DATE SURVEY COMPLETED
VIDER OR SUPPLIER	125038			
VIDER OR SUPPLIER		B. WING		08/12/2021
		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
SING & REHAB CENT	RE	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744		
(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLET
Plan of care effective Hospice interdiscipline 08/12/21 01:04 PM St Social Services Direct who the designated p s who collaborates w attends the care plan here isn't one person nembers collaborate Requested the Joint p	04/17/21. Reviewed the ary progress notes. urveyor interviewed the tor (SSD). When asked oint of contact in the facility ith the Hospice IDT and meetings, the SSD stated who is the liaison, the team with the hospice team. olan of care which describes	F 849	<ul> <li>and will also be conducted with the Director of Nursing (DON) or designed new hire orientation and, at least, an addressing the continuity of care by combining Hospice and Facility care at new hire orientation and at least annually.</li> <li>Facility staff were regarding the importance of coordinating services responsibilities in collaboration with</li> </ul>	nually plans and
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.		<ul> <li>participating hospice providers to proquality of care necessary for the care resident s terminal illness and relate conditions.</li> <li>The IDT meetings will include documentation of hospice communication/collaboration of the identified plan of care.</li> <li>The DON, Admissions Coordinator designee will continue to educate an re-educate hospice vendor on the required coordinated person-centere care plan for residents receiving hos services.</li> <li>Residents identified with incomplete inaccurate hospice coordinated care updated immediately by the UM, or designee, to reflect their current goa interventions, and appropriate approto to address their medical and treatmen needs.</li> </ul>	e of ed , or nd ed spice e or e plans uls, paches	
	Continued From page lan of care effective lospice interdisciplina 8/12/21 01:04 PM St cocial Services Direct who the designated p who collaborates w ttends the care plan here isn't one person hembers collaborate lequested the Joint p what each caregiver in ospice is providing to surveyor reviewed the 8/12/21 at 02:30 PM eficit r/t poor commu rovider and Facility w the collaborative plan wite facility represen eam meetings (IDT). ervices the hospice s and did not include th	what each caregiver in the facility and in the ospice is providing to the resident. Aurveyor reviewed the hospice plan of care on 8/12/21 at 02:30 PM. Noted "Problem" Potential eficit r/t poor communication between Hospice rovider and Facility will coordinate care reflected in the collaborative plan of care. Interventions hvite facility representative to inter disciplinary eam meetings (IDT). The plan of care listed the ervices the hospice staff were going to provide and did not include the care and services and	Continued From page 57       F 849         Plan of care effective 04/17/21. Reviewed the lospice interdisciplinary progress notes.       8/12/21 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 ttends the care plan meetings, the SSD stated here isn't one person who is the liaison, the team hembers collaborate with the hospice team.         Requested the Joint plan of care which describes what each caregiver in the facility and in the ospice is providing to the resident.         Purveyor reviewed the hospice plan of care on 8/12/21 at 02:30 PM. Noted "Problem" Potential eficit r/t poor communication between Hospice rovider and Facility will coordinate care reflected in the collaborative plan of care. Interventions hvite facility representative to inter disciplinary eam meetings (IDT). The plan of care listed the ervices the hospice staff were going to provide nd did not include the care and services and	<ul> <li>DEFICIENCY)</li> <li>Continued From page 57</li> <li>Itan of care effective 04/17/21. Reviewed the lospice interdisciplinary progress notes.</li> <li>8/12/21 01:04 PM Surveyor interviewed the occial Services Director (SSD). When asked the the designated point of contact in the facility is who collaborates with the Hospice IDT and ttends the care plan meetings, the SSD stated tere isn't one person who is the liaison, the team members collaborate with the hospice team.</li> <li>Lequested the Joint plan of care which describes that each caregiver in the facility and in the ospice is providing to the resident.</li> <li>Uurveyor reviewed the hospice plan of care on 8/12/21 a 02:30 PM. Noted "Problem" Potential efficit r/t poor communication between Hospice rovider and Facility will coordinate care reflected to the collaborative plan of care.</li> <li>The IDT meetings will include documentation of the identified plan of care.</li> <li>The DON, Admissions Coordinator of the identified plan of care.</li> <li>The DON, Admissions Coordinator designee will continue to educate an re-educate hospice vendor on the required coordinated person-centere care plan for residents receiving hos services.</li> <li>Residents identified with incomplet inaccurate hospice coordinated care updated immediately by the UM, or designee, to reflect their current goa interventions, and appropriate approprinte additional and restint appropriate appropriate approprina</li></ul>

Event ID: KTO411

Facility ID: HI02LTC5038

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 01/04/2022 1 APPROVEE 0. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		125038	B. WING			08/	12/2021
NAME OF PI	ROVIDER OR SUPPLIER	L		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00	
	JRSING & REHAB CENT	RE			-545 KAMEHAMEHA HIGHWAY		
				K/	ANEOHE, HI 96744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 849	Continued From page	e 58	F	349	<ul> <li>solutions are sustained. The facility develop a plan for ensuring that correct is achieved and sustained. This plan must be implemented and the correct action evaluated for its effectiveness plan of correction is integrated into the quality assurance system.</li> <li>To ensure quality assurance and effectiveness of the aforementioned systemic changes to promote quality care and services for our hospice residents to attain or maintain their highest practicable physical, mental, psychosocial well-being, random monitoring and evaluation with applic of the Aloha Nursing &amp; Rehab Centre (ANRC) F-655 &amp; F-656 Baseline Car Plan Auditing Tool.</li> <li>Completion of this tool is to occur w x 1 month, bimonthly x 1 month and monthly x 1 month by the DON or designee for a minimum of 12 weeks ensure compliance.</li> <li>Corrective action is to be taken immediately and staff/hospice agence education is to be provided as deeminecessary.</li> <li>To ensure compliance, audit results be reviewed, presented, and discuss</li> </ul>	ection tive . The ne of and cation e veekly sekly sto	
					the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months of until compliance is achieved. - If further corrective action is needed		
DM CMS 256	7(02-99) Previous Versions Obs	solete Event ID: KTO	411	Faci	ility ID: HI02LTC5038 If cont	inuation shee	Dogo 50 of

Event ID: KTO411

Facility ID: HI02LTC5038

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 01/04/2022 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY PLETED
		125038	B. WING			08	/12/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
ALOHA N	URSING & REHAB CENT	RE		5-545 KAMEHAMEHA HIGHWAY			
				K	ANEOHE, HI 96744		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 849 F 880 SS=E	Infection Prevention a CFR(s): 483.80(a)(1) §483.80 Infection Co The facility must esta infection prevention a designed to provide a comfortable environm development and tran diseases and infection §483.80(a) Infection p program. The facility must esta and control program a minimum, the follow §483.80(a)(1) A syste reporting, investigatir and communicable d	& Control (2)(4)(e)(f) ntrol blish and maintain an and control program a safe, sanitary and nent and to help prevent the nsmission of communicable ns. prevention and control blish an infection prevention (IPCP) that must include, at		849	auditing will continue until such time the the QAPI committee determines consistent substantial compliance has been met. - Results of the monthly QAPI meeting be brought to the attention of the quart QA Committee meetings and addresses as deemed appropriate. Included dates when corrective action be completed: - Corrective action completion date by Nursing Home Administrator and/or designee.	will erly :d	9/30/21

Facility ID: HI02LTC5038

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 01/04/2022 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		125038	B. WING				08/	12/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
ALOHA NURSING & REHAB CENTRE					45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744			
(X4) ID PREFIX TAG			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			ULD BE		(X5) COMPLETION DATE
F 880	conducted according accepted national sta §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicabi infections before they persons in the facility; (ii) When and to whor communicable disease reported; (iii) Standard and tran- to be followed to prev (iv)When and how iso resident; including bu (A) The type and dura- depending upon the in involved, and (B) A requirement that least restrictive possil circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit th (vi)The hand hygiene by staff involved in dir	der a contractual pon the facility assessment to §483.70(e) and following ndards; standards, policies, and ogram, which must include, lance designed to identify ble diseases or can spread to other can spread to other can spread to other can spread to other smission-based precautions ent spread of infections; blation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the ble for the resident under the s under which the facility ees with a communicable cin lesions from direct or their food, if direct he disease; and procedures to be followed rect resident contact.	F	880				

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TATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
		125038	B. WING				08/42/2024	
NAME OF P	ROVIDER OR SUPPLIER	120000			IREET ADDRESS, CITY, STATE, ZIP CODE		08/12/2021	
					5-545 KAMEHAMEHA HIGHWAY			
ALOHA N	URSING & REHAB CENT	RE			ANEOHE, HI 96744			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION SHOULD BE		
F 880	Personnel must hand	e 61 lle, store, process, and s to prevent the spread of	F	880				
	IPCP and update the This REQUIREMENT by: Based on observatio review, the facility fail safe, sanitary environ development and tran diseases and infectio facility staff created a control when staff imp protective equipment isolate residents with practice jeopardizes to vulnerable residents a facility. Findings include:	act an annual review of its ir program, as necessary. is not met as evidenced in, interview and record led to ensure it provided a iment to prevent the nsmission of communicable ns for its residents. The breach in its infection properly donned personal (PPE) and did not properly infections. The deficient the health and safety for its and staff working in the			F880 Infection Prevention & Control Preparation and/or execution of this of Correction does not constitute admission or agreement by the pro- that a deficiency exists. This respo also not to be construed as an adm of fault by the facility, its employees agents or other individuals who drai may be discussed in this response Plan of Correction. This response a Plan of Correction is submitted as t facility □ s credible allegation of compliance.	Plan vider nse is ission , ted or and nd		
	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				Indicate how the facility plans to mo its performance to make sure that solutions are sustained. The facility develop a plan for ensuring that cor is achieved and sustained. This pla must be implemented and the corre action evaluated for its effectivenes plan of correction is integrated into quality assurance system. Director of Nursing Services (DON) designee will infection control comp Audit weekly x 1 month, bimonthly x month, and monthly x 1 month. All	or must rection in ctive s. The the or liance.		

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB	NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		NSTRUCTION	` '	OATE SURVEY COMPLETED
125038		B. WING			08/12/2021		
NAME OF PI	ROVIDER OR SUPPLIER		· [	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
ALOHA NURSING & REHAB CENTRE					45 KAMEHAMEHA HIGHWAY IEOHE, HI 96744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 880	Continued From page	e 62	F 8	80			
	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.			f a r s s l t	indings of concern will be immedia addressed with the individual staff nember. Audit findings will be revi and discussed during the monthly ( neetings until such time consistent satisfaction is reported. Included dates when corrective act be completed: Corrective action completed on 9/2 DPOC due 10/7/21.	ewed QA ion will	
	on 08/10/21 at 04:11 signage at the door. into the room with a l mask. Surveyor aske	ervation in front of room 220 PM, noted contact isolation Surveyor observed staff go Hoyer lift wearing only a ed RN17 why the resident autions which she stated was		a l	) Address how corrective action waccomplished for those residents for ave been affected by the deficient practice.	ound to	
	When asked if the sta masking before going and said yes. The C and stated only if we	ound on his toe with MRSA. aff should be gowning and g in, she looked at the sign NA came out of the room are providing care to the toe ve. RN17 stated while		r c	On 8/10/21, CNA44 was provided emediation in regards to donning a doffing of personal protective equip PPE) and proper droplet isolation precautions requirements.	and	
	pointing at the reside chair outside the roor wound covered and h	nt who was sitting in the Geri m in the hall, he has his		a p	On 8/10/21, regarding Resident R appropriate PPE was made availab point of care location required for d solation precautions.	ole at	
	laying sideways on h catheter bag was lay resident. Surveyor v urinary bag should be	is bed sleeping. Urinary ing on the bed next to the alidated with the UM that the e hanging down to the side,		rt	On 8/10/21, Resident R314 receiv legative PCR COVID test results of he resident of isolation precautions	learing S.	
	at 01:47 PM. The Ca diagnosed with acute	e EMR for R12 on 08/10/21 are plan stated, R12 is bacteremia and on oral		r t	On 8/11/21, Resident R315 receiv negative PCR COVID test results of he resident of isolation precautions	learing S.	
		04/23/21, Review Date Chronic kidney disease,			On 8/12/21, physician⊡s orders w eceived for Resident R15 and Res		

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TATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>、</b> ,		(X3) DATE SURVEY COMPLETED		
		125038	B. WING		30	3/12/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
	URSING & REHAB CEN	TRE		45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744			
						0(5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 880	Continued From pag	e 63	F 88				
		ver unspecified on 04/16/21.		R32, allowing the residents to be	out in		
		0 AM, noted R12 Wheeling		common areas as long as the wor			
		lway in his wheelchair, noted		covered.			
		ing on the seat of the					
	wheelchair.			-Resident R15 was encouraged to	)		
				perform hand hygiene and secure			
		ne facility assessment on		colostomy pouch under waistband	l prior to		
		A and noted high rates of		exiting room.			
	infections, wound, U	TI, septicemia, and MDRO.					
	Surveyor interviewe	the infection proventionist		-On 8/12/21, to promote infection Environmental Services (ES) prov			
		the infection preventionist 0:23 AM. Surveyor asked to		additional cleaning in common are			
		entified breaches and what		all high touch surfaces.			
		re identified. The IP stated					
	that on Monday, ther			-On 9/18/21, Resident R12 was			
		vent into an isolation room		discharged from the facility			
		PPE. The second was when		To some the infection second in a	I		
		ut a face shield. The IP aff are required to put on		- To promote infection prevention control, facility staff were in-service			
		to the sign. When a		establishing and maintaining infect			
		t precautions, they should be		control measures to provide a safe			
		gowns, whenever touching		sanitary, and comfortable environ			
		skin or articles near the		and to help prevent the developm			
		d remove (doff) their PPE in		transmission of communicable dis	ease		
	the room prior to the	exit.		and infections.			
		e resident who is on the					
		is allowed to be out of the		2) Address how the facility will ide			
		nded that if the wound can be		other residents having the potentia			
		ned by dressings. When ne room, we want to just		affected by the same deficient pra			
		Il be provided for cleaning,		- The alleged practice has the pot	ential to		
	-	in the vicinity of the resident.		affect facility residents.			
		admitted to the facility on					
		ot vaccinated for COVID-19.					
	As a result of the res			3) What measures will be put into	place or		
		nd the facility's COVID-19		what systemic changes will you m	ake to		
		esident was paced in		ensure that the deficient practice of	does not		
	isolation and droplet	transmission based	1	recur?		1	

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PRINTED: 01/04/2022 FORM APPROVED

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	LE CONSTRUCTION		O. 0938-03		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	· · ·	3	CON	COMPLETED		
125038		B. WING		0	3/12/2021			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
ALOHA NURSING & REHAB CENTRE				45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)		
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETIO		
F 880	Continued From page	e 64	F 88	0				
	precautions was impl	emented.						
				- On 8/16/21, the facility hired a	an Infection			
		M, observed CNA44 enter		Control Preventionist (IPC) / W	ound Care			
		h only a gown and surgical		Specialist				
	mask (covered nose assisted the resident	with lunch. While this		- Facility-wide review of PPE d	stribution			
		ng CNA44 while still in the		protocol/guidelines and update				
		Assistant Director of Nursing		staff have adequate supply of I				
		this surveyor and also		provide necessary care in a sa				
	observed CNA44 dor	nned in only a gown and a		was conducted; ongoing asses				
		2's room. Inquired with the		review is to continue to promot	e infection			
		type of PPE CNA44 should		prevention and control				
		DON confirmed CNA44 was		All residents on isolation proc	outiono will			
		opriate PPEs and in addition mask, CNA44 should have		<ul> <li>All residents on isolation prec require a physician order if car</li> </ul>				
		shield and gloves. Pointed		deviate from said isolation prot				
		plastic storage bin located		facility will use cohorting guide				
		m contained only four to five		forth by the Centers for Diseas				
	protective gowns. As	ked the ADON if there was		and Prevention (CDC) and Cer				
	- · ·	or staff to store reusable face		Medicare & Medicaid Services				
		f shold use to santize their		regards to isolating residents s	uspected of			
		. The ADON stated staff		COVID-19 infection.				
		ls in their personal lockers shields down with sanitiing		- A required deadline of 10/07/	21 was set			
	-	red in the medication cart.		forth for facility staff to complet				
		I supplies staff would need		COVID-19 infection control and				
		control protocol to mitigate		prevention measures, to promo				
	the spread of COVID-	-19 was not readily avaiable		control measures, and to preve	ent this			
	for staff use.			deficient practice from occurrin				
	· ·	on was made of R314 and		" Facility staff will view train	-			
		10:40 AM in a room they		on Relias training platform: 1)				
		earing a hospital gown, lying of bed (HOB) raised. His		correctly for COVID-19, 2) Kee COVID-19 OUT!, and 3) Close				
		d, and he was slow to		Residents for COVID-19.				
		or's salutation. R315 was		" Facility staff in-serviced or	COVID-19			
		ring a hospital gown with his		Infection Control and Essential				
	eyes closed.			Infection Prevention for Nursing				
				Contact Precautions, Droplet F	recautions,			
	R315 was observed a	at 12:13 PM the same day		and information on PPE location	n and			

Facility ID: HI02LTC5038

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			()(0) 1			OMB NO	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
125038		B. WING			08/12/2021		
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	00/	
ALOHA NURSING & REHAB CENTRE				45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744			
					•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIC DATE
F 880	Continued From page	e 65	F 88	30			
	-	performing range of motion			storage (it is everyone⊡s responsibility	to	
	(ROM) of his lower ex				ensure PPE is available at the point of		
	. ,				care).		
		AM, a red sign posted on			" Facility staff was also provided wit	h	
		314 and R315's room stated,			education on donning/doffing PPEs,		
	"Please see nurse be			appropriate use of PPE, and on			
		, "Special droplet/contact			adherence to infection control		
	·	ment from The Centers for			precautionary measures for residents o	on	
		Prevention (CDC) outlining ersonal protective equipment		1	solation precaution.		
	(PPE) was located or			- In-services will be ongoing as needed			
		he doorway. R314 and			and will also be conducted with the	•,	
	R315 were noted to b			Director of Nursing (DON), IPC, or			
		, ,			designee at new hire orientation and, a	ıt	
	An interview with the	QCM was done in the			east, annually addressing the continuit	ty of	
	training room later that			care by combining Hospice and Facility			
		a fever yesterday and was			care plans at new hire orientation and a	at	
		She further stated that			east annually.		
		en isolated and without a					
	roommate.				- Facility staff has been in-serviced on		
	$O_{2} 0 0 (11/21 + 00.22)$	AM D215 was noted to be			CDC s Interim Infection Prevention an	ia	
		AM, R315 was noted to be room across the hall from			Control Recommendations to Prevent SARS-CoV-2 (COVID-19) Spread in		
		resided and the door to his			Nursing Homes:		
		4 was also alone in the room			" Nursing staff to continue to take da	ailv	
	with the door open.			t	temperatures of all facility residents even	-	
					shift as a part of the monitoring process		
	The CDC's "Interim Ir	nfection Prevention and			" On a daily basis, and on every shi		
	Control Recommenda				nursing staff to continue to assess		
		0-19) Spread in Nursing			residents for COVID-19 signs and		
		March 29, 2021, stated,		1	symptoms		
	-	h suspected SARS-CoV-2			" An order is to be obtained for		
		loved to a single-person			COVID-19 testing		
	-	athroom while test results			" Any resident with assessed COVID-19 signs and symptoms is to		
		ral, it is recommended that remain closed to reduce			tested for COVID-19 and moved to a		
		S-CoV-2. This is especially			single-person room with a private		
	important for resident				bathroom while test results are pending	a:	
		/-2 infection being cared for			the door is to remain closed to reduce t	-	

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		ND HUMAN SERVICES			PRINTED: 01/04/2 FORM APPROV OMB NO. 0938-03	
TATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         ND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	125038		B. WING		08/12/2021	
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ALOHA NI	JRSING & REHAB CENT	IRE		5-545 KAMEHAMEHA HIGHWAY XANEOHE, HI 96744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETIC	
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		F 880	transmission of COVID-19	ta	
	8/11/2021 showed the 7/4/2021 and 7/23/20 injury to the left 2nd to of the geriatric chair to in, and wound care we toe wound progressed infection of the skin) a of the tissue folds are was cultured on 7/23. pus and was found po MRSA (methicillin res	Review of R32 EMR on at per Nurses notes on 021, R32 suffered a wound oe after kicking the footrest that R32 was laying supine vas started thereafter. R32's ad to cellulitis (bacterial and paronychia (an infection bund the nails). The wound /2021 after staff observed ositive on 8/26/2021 for sistant staphylococcus are plan, nursing diagnosis		<ul> <li>4) Indicate how the facility plans monitor its performance to make solutions are sustained. The fac develop a plan for ensuring that is achieved and sustained. This must be implemented and the co action evaluated for its effectiven plan of correction is integrated in quality assurance system.</li> <li>The IPC, DON, or designee is continue to perform routine-wee assessments of proper infection</li> </ul>	e sure that cility must correction plan prrective ness. The nto the to kly control	
	treatment of antibiotic infection, and contact On 8/9/2021 at 8:45A	identified on 7/23/2021 with cs, monitoring for signs of t precautions for MRSA. M, surveyor observed sign and isolation cart		practices with application of the Identified Breaches in Infection ( record identified incidents and to corrective actions through educa follow up.	Control to papply	
	outside of R1's room, bag of gowns and 2 to available in cart. R32 Roommate of R32 lyi 8/9/2021 at 11:55AM lunch by staff member dining area. Staff mer gown. S3 asked R32 allowed out of room of posted and if gowns be worn by staff. N2- gown if they are not to the wound is covered	The isolation gown had a boxes of gloves. No wipes 2 not present in room. ing in bed behind curtain. On , S3 observed R32 being fed er in the hibiscus common ember wore gloves but no 's nurse (N)24 if R32 was due to contact precautions and gloves were needed to 4 said it's okay to wear no ouching the wound and that		<ul> <li>The Aloha Nursing &amp; Rehab Correspect, dignity, and care promote respect, dignity, and care ach resident in a manner and environment that promotes main or enhancement of each resider quality of life. This auditing tool monitoring through resident interquery and observation. This too assessment of infection control, qua assurance, and effectiveness of aforementioned systemic chang random monitoring and evaluation</li> </ul>	eated to are for atenance at s is for rview of includes measures. ality the es	
	geriatric chair with lef	ft foam boot on left foot in CNA10 wearing mask and		application of the Log of Identifie Breaches in Infection Control an	ed	

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-03	
TATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
	125038		B. WING		08/12/2021	
NAME OF P	ROVIDER OR SUPPLIER		- <b>·</b>	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ALOHA NURSING & REHAB CENTRE				45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744		
	SI IMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR		
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETIN	
F 880	Continued From pag	e 67	F 88	D		
	gloves, and no gown	-		Aloha Nursing & Rehab Centre Focus Rounds will be applied.	Resident	
	an interview with Phy if it was safe for R32 common areas due to contact precautions. outside of room since to the left toe and is infection is not in R3 blood, or lungs so it roommate. P1 said gown when feeding to touching the site that is covered. Record review in EM showed no physician precautions. R32's of Joint Infection listed + (positive) MRSA" with when and how client	<i>A</i> , first floor nursing station in ysician (P)1, surveyor asked to be outside of room in o MRSA diagnosis and P1 said that R32 can go e MRSA infection is localized covered with a bandage. The 2's urine, bowel movements, is okay for R32 to have a that staff do not need to wear R32 if they are not directly t is infected and that wound IR on 08/12/21 09:06 AM, orders for contact care plan under Problem "Contact precautions with no specifications on can go to common areas. lanager (UM)3 at MDS office		<ul> <li>Completion of this tool is to oc x 1 month, bimonthly x 1 month monthly x 1 month by the DON designee for a minimum of 12 w ensure compliance.</li> <li>Corrective action is to be taken immediately and staff education infection control measures is to provided as deemed necessary</li> <li>To ensure compliance, audit re be reviewed, presented, and dis the monthly Quality Assurance Performance Improvement (QA meeting for a minimum of 3 mor until compliance is achieved.</li> <li>If further corrective action is ne auditing will continue until such the QAPI committee determines</li> </ul>	and or veeks to n on be esults will scussed at PI) nths or eeded, the time that	
	on 08/12/21 at 10:06 physician orders for electronic medical re- that contact precauti precautions, and any resident being able t covered) should be o	AM, UM3 acknowledged no contact precautions in R32's cord. UM3 acknowledged ons, reason for contact o other details (such as o leave room if wound documented in both R32's cian orders. UM3 will contact		<ul> <li>Results of the monthly QAPI n be brought to the attention of th QA Committee meetings and ac as deemed appropriate.</li> </ul>	ce has neeting will e quarterly	
	On 08/12/21 at 01:30 showed under Physi 11:34AM: OK for res	D PM, EMR review of R32 cian Orders on 8/12/2021 at ident on contact precautions beting areas if wound is		Included dates when corrective be completed: - Corrective action completion d Nursing Home Administrator (N designee.	ate by	

Facility ID: HI02LTC5038

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES						APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				(	OMB NO.	0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			B. WING	NG			08/12/2021		
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE				
				45	-545 KAMEHAMEHA HIGHWAY				
ALOHA N	JRSING & REHAB CENT	ſRE		ĸ	ANEOHE, HI 96744				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE		(X5) COMPLETION DATE	
F 880	Continued From page	e 68	F	880					
	effective 6-1-90 for Tu Precautions (Contact whenever anticipating direct contact with the contaminated environ	) states "wear gown g that clothing will have e resident or potentially			- Compliance and completion of co DPOC by the NHA and/or designed		ive		
FORM CMS-256	7(02-99) Previous Versions Obs	solete Event ID: KT	 [0411	Fac	ility ID: HI02LTC5038 If c	continua	ation sheet I	Page 69 of 69	

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