STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING ______ B. WING ______	06/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE NANI REHABILITATION AND NURSING CENTER	1677 PENSACOLA STREET HONOLULU, HI 96822

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) and the facility was found not to be in substantial compliance with 42 CFR 483 Subpart B. Complaints #8092, #8098, #8803 and #8914 and facility reported incidents (FRI) #8576 and #8655 from the Aspen Complaint Tracking System (ACTS) were investigated. ACTS #8098, #8655 and #8914 were substantiated; ACTS #8092, #8576, #8803 were unsubstantiated. Survey Dates: 06/14/21 to 06/21/21 Survey Census: 263 Sample Size: 35	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550		7/29/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 07/28/2021

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

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F 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interview with residents, the facility failed to promote care for residents with respect and dignity to promote and enhance their quality of life while residing in the facility. These deficient practices have the potential to affect residents' psychosocial well-being. Findings include: 1) On 06/14/21 at 02:45 PM, Resident (R)118 reported she feels sometimes staff get impatient with her as she has to toilet frequently, sometimes she doesn't urinate and staff "grumble" to her that she didn't need to use the toilet. R118 also reported at times she has to wait 15 minutes for staff and they tell her she	F 550	CORRECTIVE ACTION Residents are being treated with respect and dignity as related to: 1)Having toileting needs met timely and being provided adequate time for toileting, 2)Staff listening to residents when they speak, 3)Wearing badges so names can be seen, 4)Speaking in the dominant language of the facility, 5)Timely response to call lights, and 6)Not taking a resident□s wheelchair for other residents.	

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F 550	Continued From page 2 needs to wait to toilet. R118 stated that sometimes she is talking to staff, she has not completed her sentence and they walk away from her. 2) On 06/15/21 at 09:49 AM an interview was done with the Resident Council (RC) members. The members reported at times staff members speak in the non-dominant language of the facility. The members stated they don't mind when staff are speaking to a resident that understands them, but sometimes they speak in non-dominant language while providing care. The RC members shared that this issue has been brought up in their meetings; however, it does not get resolved. RC members also reported they observe staff members, especially the "floaters" wearing their name tags backwards which conceals their names. When staff members are asked for their name, they respond, "don't you know me?" 3) Confidential resident interview conducted on the morning of 06/15/21, resident reported waiting a long time for assistance to toilet. The resident reported at times he will wait for an hour for assistance and this usually occurs during the evening shift after dinner. The resident shared that he tries to wait to prevent from wetting the bed or soiling himself but at times, he is unable to wait, resulting in incontinence. 4) Confidential resident interview conducted on the morning of 06/15/21, resident reported staff members are taking his wheelchair and using it for another resident. He reported staff members take his wheelchair without telling him and when he wants to get out of bed, they have to look for	F 550	IDENTIFICATION OF OTHERS Residents residing in the facility are at risk. SYSTEMIC CHANGES/ DON/designee will re-educate staff beginning on 6/18/21 regarding demonstrating respect for residents to promote dignity and enhance their quality of life. Education will include providing residents with the needed time when toileting, respectful listening when a resident is speaking, timely response to call lights and requests for toileting, wearing name badges so name is visible, speaking in the dominant language of the facility and not taking resident□s wheelchairs. If negative responses are received, staff will be identified and provided one to one education. MONITORING DON/designee will conduct random interviews of 5 residents/week x 4 weeks, then 4 residents/week x 2 months to validate that staff are 1) providing residents adequate time when toileting, 2) being respectful listeners when residents speak, 3) wearing badges so names are visible, 4) responding to call lights timely, 5) speaking in the dominant language of the facility, and 5) not using residents□ wheelchairs for other residents.Findings will be reported to the facility QAPI committee monthly x 3 months and if needs are identified in our audits, then we will start to audit again.	

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F 550	Continued From page 3 his wheelchair or use one that is not fitted for him. The resident reported his name is on the chair, however, staff members still take his chair.	F 550	The administrator is responsible for on-going compliance.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance	F 578		7/29/21

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F 578	Continued From page 4 with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to assist two residents, R184 and R509 the ability to formulate an Advance Healthcare Directive (AHCD). The deficient practice violates the resident's (and/ or representative acting on their behalf) right to accept or refuse any medical treatment. This deficient practice has the potential to affect all residents admitted into the facility. Findings include: 1) Surveyor reviewed the electronic health record (EHR) for R184 on 06/15/21 at 01:35 PM. Further review of the inter disciplinary team (IDT) welcome notes revealed there were no AHCD documentation found. Documentation was not found to indicate information about formulating an AHCD for R184 or the residents representative was provided. Surveyor requested a copy of the AHCD for R184 on 06/16/21 at 10:33 AM. No documentation was provided. 2) An initial review of R509's EHR was done on 06/15/21 at 01:29 PM. Progress notes reveal that R509 is a 63-year-old male admitted on 06/09/21 for a stroke caused by a clot. He is alert and oriented times four (person, place, time, and	F 578	CORRECTIVE ACTION Resident 184 representative was provided education/information related to the right to formulate an Advance Health Care Directive. Documentation in the medical record reflects that education was provided. Resident 509 was educated related to the right to formulate an Advance Health Care Directive (AHCD) on 6/18/2021. The medical record reflects that the education was provided. IDENTIFICATION OF OTHERS Residents residing in the facility are at risk. SYSTEMIC CHANGES The administrator/designee re-educated the Social Services staff on 6/20/21 related to educating the resident/representative regarding the right to formulate an AHCD and documenting the education in the medical record. MONITORING Administrator/designee will audit new admission medical records for documentation related to education provided regarding the right to formulate	

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F 578	Continued From page 5 situation) and can communicate his needs to the staff. No AHCD was found. R509 experienced a fall with minor injury on 06/15/21 at 10:30 AM. R509 did not require extensive or emergent medical care. Further review of R509's EMR was done on 06/16/21 at 10:37 AM. No AHCD was found. No care plan and progress note indicating that education was given or the need to formulate an AHCD with R509 was located. A request for R509's and other residents' AHCDs was made to the RNC at 06/16/21 at 04:30 PM. Surveyor asked the RNC for R509's AHCD again on 06/17/21 at 09:30 AM. She stated that they were "waiting for one more Advance Directive" from the medical records department and she will submit them to the State Agency (SA). SA had not received the requested AHCDs from the facility when requested again from the facility at 01:00 PM. A review on 06/17/21 at 03:08 PM of R509's care plan revealed a focus, goal and interventions for Advance Directive. This entry was not present with previous EHR reviews of R509's care plan. On 06/17/21 at 04:00 PM, a document titled "Admission Supplement" was submitted by the facility. Upon review, this document was signed by R509 and dated 06/17/2021. His initials were present after the statement: "...a. I have been given a copy and educated on Advance Directives."	F 578	an AHCD weekly x 4 week, then bi-monthly x 2 months. Findings will be reported to facility QAPI Committee monthly x 3 or until a lesser frequency is deemed appropriate. Date of Compliance: 7/29/2021 Administrator is responsible for on-going compliance.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment	F 584		7/29/21

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CFR(s): 483.10(i)(1)-(7)

§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

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§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on interviews and observations, the facility failed to provide appropriate hot water to their residents. This deficient practice robs them of a clean, comfortable, and homelike environment and has the potential to affect the entire facility.

Findings include:

1) On 06/14/21 at 12:32 PM, an initial check of the facility's hot water was done in R511's room. The hot water was found to be cool to the touch. The hot water was left running for approximately three more minutes and it remained cool.

The hot water was checked in R211's room of the same unit at 01:06 PM. The findings were the same as in R511's room. R211 stated that the hot water does not come out hot and that it needs to "run for a while before it comes hot."

On 06/16/21 at 12:30 PM, surveyor and the Director of Environmental Services (DES) checked the hot water temperature in R511's bathroom. The hot water was verified by both persons to be initially cool to the touch and the temperature reading was 73 degrees Fahrenheit (F).

DES stated that because the facility experienced a power outage on 06/15/21, the hot water furnace turned off and caused the lack of hot water. Surveyor informed him that a resident complained of the lack of hot water prior to the power outage. He replied that resident's showers

F 584

CORRECTIVE ACTION
Water heater was serviced and fixed.
IDENTIFICATION OF OTHERS
Residents residing on Piikoi 2 are at risk. Temperatures were checked in additional rooms to identify other rooms.

SYSTEMIC CHANGES
Administrator/designee re-educated the Director of Environmental services (DES) on 6/18/21 related to routine monitoring of hot water temperatures in resident room and bathrooms.
DES to monitor temperatures on 5 random rooms on Piikoi 2 weekly and log temperatures.

MONITORING
Although facility received citation for temperature reading of 73 degrees, Administrator/designee will continue to review weekly water temperature logs to verify completion and water temperatures of 71-81 degrees, weekly x 4, then every other week x 2 months.
Finding will be reported to facility QAPI Committee monthly x 3 months or until a lesser frequency is deemed appropriate.
Date of Compliance: 7/29/2021
Administrator is responsible for on-going compliance.

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F 584	Continued From page 8 should be staggered because the lack of water would cause the hot water to be cold. On 06/16/21 at 02:42 PM, CNA2 was interviewed at the nursing station. She stated that in "certain rooms, it takes a while for the water to get hot. You have to run the shower first to get hot water to come faster." At 03:32 PM, a follow up query was made with R511. She stated that the "hot water is still cold and you need to run water long in order to get hot." On 06/17/21 at 11:10 AM, RN4 was interviewed in the nursing unit's day room. She stated that the "hot water does not get hot right away" and that "the hot water faucet needs to be opened and run a long time." "It has been like that for a very long time." She further stated that the staff do not follow the shower schedule because of the lack of hot water. 2) Interview with the RC was done on 06/15/21 at 09:49 AM in the activity room. The council members reported the water is tepid during showers. One resident reported the water was lukewarm on the evening of 06/13/21 and asked staff member to hurry with the shower as it was too cold. Interview with R208 on 06/14/21 at 10:42 AM in her room, R208 reported the water is cold during showers. All residents reside on Piikoi 2.	F 584		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity	F 585		7/29/21

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that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may

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be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation

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F 585	Continued From page 11 of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview with the RC members, the facility failed to ensure residents are aware of how to file a grievance and feel they are unable to complain without fear of discrimination or reprisal. This deficient practice has the potential to affect all residents who are aware of their surroundings. Finding includes: RC interview was conducted on 06/15/21 at 09:49 AM. The RC members reported they do not know how to file a grievance. Further inquired whether they felt they are able to complain without worrying someone will "get back" at them. RC members expressed concern staff members will retaliate by forgetting about you when you ask for help, or you will have to wait extra long, or they will do a "fast job" and not speak to you when providing care.	F 585	CORRECTIVE ACTION Social Services Director validated signs are posted on each unit at the social service board, front desk receptionist area and in key visible locations related to the ability to file grievances and the process to do so. Grievance forms are available at each location. IDENTIFICATION OF OTHERS Residents residing in the facility are at risk. SYSTEMIC CHANGES Administrator/designee re-educated Social Service staff regarding Grievance policy and procedure effective 6/18/21. DON/designee re-educated staff regarding the facility grievance process, including the residents right to file grievances without fear of retaliation. Social Service representative will present in Resident Council quarterly to educate residents regarding the facility grievance process effective 6/18/21. MONITORING	

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F 585	Continued From page 12	F 585	Administrator/designee will conduct random interview of residents to validate that residents are aware of the option to file a grievance and the process to do so. 5 residents/week x 4 weeks, then every other week x 2 months. Findings will be reported to facility QAPI Committee monthly x 3 months or until a lesser frequency is deemed appropriate. Date of Compliance: 07/29/2021 Administrator is responsible for on-going compliance.	
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free	F 604		7/29/21

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F 604	Continued From page 13 from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on review of Facility Reported Incident (FRI), observations, staff interview, and record review, the facility failed to ensure that one R170, of the three residents reviewed, was free from physical restraint. This deficient practice has the potential to affect all vulnerable residents. Finding includes: A review of the FRI sent by the facility to the Department of Health, Office of Health Care Assurance stated the following: On 01/07/21, a gait belt was placed on R170 and tied to a wheelchair to prevent R170 from standing. The incident was witnessed by another staff member and reported to management. R170 was assessed with no injuries noted. The doctor and family were informed, R170 was placed on alert monitoring and the care plan was modified accordingly. Electronic Health Record (EHR) for R170 showed R170 was admitted to the facility on 08/13/19 with a diagnosis of Dementia (progressive cognitive loss), Bipolar Disorder (mental illness with extreme mood swings), Polyneuropathy (damage of peripheral nerves), Atherosclerosis of Aorta (plaque buildup in the aorta), Vitamin D Deficiency, Dysphagia (difficulty swallowing).	F 604	CORRECTIVE ACTION Upon identification of the issue, the gait belt was removed, R170 was assessed, and no injuries were noted. IDENTIFICATION OF OTHERS Residents residing in the facility have the potential to be affected. SYSTEMIC CHANGES DON/designee re-educated staff on 6/18/21 related to restraints, their definition and, if indicated, requirements for use of a restraint. Re-education included definition of abuse, neglect, and mistreatment. Re-education included management of challenging behaviors with an emphasis on residents who are at risk. MONITORING DON/designee will observe 5 residents weekly x 4 weeks, then 4 residents weekly x 2 months to verify that restraints are following current policy and procedures on the use of a restraint. Findings will be reported to facility QAPI Committee monthly x 3 months or until a lesser frequency is deemed appropriate.	

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On 06/14/21 at 10:00 AM, R170 was noted to be sitting in a wheelchair near the hallway. R170 was non-verbal, did not respond to questions and appeared in no distress.

On 06/18/21 at 10:19 AM, Certified Nurse Aide (CNA) 4 was interviewed about the FRI. CNA4 stated the incident happened on another shift and that the staff had received training about restraints. CNA4 stated R170 does try to get up from the wheelchair, but that the staff is trained to just follow and monitor for safety. CNA4 said that they do not restrain R170.

During an interview with the Regional Nurse Consultant (RNC) on 06/18/21 at 02:30 PM, RNC discussed the FRI and stated that the facility further initiated a Performance Improvement Action Plan which included the following: Corrective Actions; gait belt removed from the resident, skin check completed, 1:1 (one staff to one resident care) initiated for the residents, psychosocial assessment and monitoring in place, medication review by the doctor and/or nurse practitioner, referral to psychiatry, doctor notified, resident representative notified, care plan updated as indicated, resident placed on 72 hour alert charting for monitoring of skin and behavior, staff on administrative leave pending further investigation, baseline audit of residents on all units, no new restraints identified, cohort interviews for several residents completed. Systemic Changes: staff members re-educated in definition of abuse, neglect, mistreatment, emphasis on education in definition of a restraint and, if indicated requirements around use of a restraint, staff members educated in management of challenging behaviors with

Provider's plan of correction (F 604):

Date of compliance: 7/29/2021.
DON is responsible for on-going compliance.

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F 604	Continued From page 15 emphasis on who is at risk, Director of Nursing (DON) or designee will conduct random audits of residents for evidence of restraint usage, audits will be conducted for two residents per unit per shift daily for one week, then two residents daily for two weeks, audit trends will be presented to the facility Quality Assurance Performance Improvement (QAPI) Committee for review and further recommendations. RNC provided documentation following the Performance Improvement Action Plan.	F 604		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the	F 622		7/29/21

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resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or

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F 622	Continued From page 17 discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to provide the physician's discharge summary to an acute care provider for R229. This deficient practice placed a risk of the emergency room (ER) of not knowing R229's medical history and the care given to R229 for his acute diagnosis at the facility. This has the potential to affect all residents needing to be transferred to the ER or hospital. Finding includes: A review of R229's EHR on 06/18/21 at 12:04 PM was done. R229 was admitted to the facility on 02/12/21 with a primary diagnosis of unspecified dementia with behavior disturbance. He was transferred to the ER on 06/09/21 for worsening	F 622	CORRECTIVE ACTIONS R229 physician was re-educated regarding Discharge Summary. IDENTIFICATION OF OTHERS Residents requiring transfer to the Emergency Room (ER) are at risk. SYSTEMIC CHANGES Medical Director/designee will re-educate facility providers related to timely completion of Physician Discharge Summary. MONITORING DON/designee will audit medical records of residents transferred to the ER or	

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F 622	Continued From page 18 fever, low oxygen levels and increased confusion. He was on an antibiotic pill for the treatment of his pneumonia (lung infection), but had been refusing his medications. No physician discharge summary was found in R229's medical record and surveyor requested the document from the RNC on 06/18/21 at 12:18 PM. Surveyor requested the document from the RNC again at 01:48 PM, but it was not provided. At 02:33 PM, the Assistant Director of Nurses (ADON) provided a blank "Physician Discharge Summary" for R229.	F 622	discharged to verify timely completion of Physician Discharge Summary, 5 charts/week x 4 weeks, then 4 charts/week x 2 months. Findings will be reported to the facility QAPI Committee monthly x 3 months and if needs are identified in our audits, then we will start to audit again. Date of compliance 7/29/2021 DON is responsible for on-going compliance.	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		7/29/21

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F 657	Continued From page 19 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to invite R131 and/or their representative acting on their behalf, to their care plan meeting and failed to individualize the care plan for three residents, R115, R224, and R506. These deficient practices violates the resident's right to participate in their plan of care and treatment and to be provided individualized care. This has the potential to affect all residents in the facility. Findings include: 1) Surveyor reviewed the IDT meeting notes dated 03/08/21, noted R131 was not invited or attended the IDT meeting. Surveyor did not find any documentation in the EHR to indicate why the resident or their representative was not invited. Surveyor interviewed the social services assistant (SSA)5 on 06/18/21 at 12:52 PM. SSA5 is not the assigned SSA for R131 but assisting to locate the information in the EHR. SSA looked into the EHR and was not able to locate documentation that R131 was invited to attend the IDT meeting. SSA5 stated that the letters are sent out usually one to two weeks prior to the IDT meeting. There is no documentation to show that the resident was invited to attend the meeting. SSA5	F 657	CORRECTIVE ACTIONS Res 131 will be invited to his/her next IDT Care Planning meeting. Res 115 was added to the dental and vision lists, and care plan was updated to reflect the need. Res 224 care plan was updated to include fall interventions and the dates the interventions were implemented. Res 506 care plan was updated to reflect communication challenges and interventions. IDENTIFICATION OF OTHERS Residents with vision, dental and communication needs or have falls are at risk. An audit was conducted of care plans for residents with identified communication, vision and dental needs to verify their care plans reflected these needs and included interventions. Those with falls were reviewed to verify the care plan reflected current fall interventions. Identified concerns were updated. SYSTEMIC CHANGES Administrator/designee re-educated Social Services staff on 6/18/21 related to the process for inviting	

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stated, if R131 was invited to the meeting, the social worker (SW) would invite them verbally. There may not be documentation about the conversation with the resident in the EHR.

SSA5 stated that the notice was sent out to the public guardian and there was no response. There was no documentation found that shows that there was a response from them. SSA5 provided a copy of the invitation that was sent to the public guardian for review by the surveyor.

2) Interview and concurrent observation were done on 06/15/21 at 07:20 AM revealed resident R115 with missing teeth. R115 stated that he has dentures at home, but they are too small, and he would like to see a dentist. R115 stated that no one has talked to him about his dentures or his vision and he would like to be evaluated.

Interview on 06/16/21 at 12:43 PM with SSA3 stated, "There is a dentist that comes around and makes visits twice a year. I will endorse it to the nursing staff."

Record review (RR) done on 06/17/21 of the orders of R115 did include a standard order for vision and dental to be checked. Surveyor reviewed the IDT meeting notes and there was no mention of dental or vision.

3) R224 entered the facility on 05/28/21. Record review on 06/14/21 at 2:00 PM revealed R224 had a history of falls and fell at home. Physician assistant (PA) note dated 06/16/21 at 09:06 documents a chief complaint of impaired mobility and activities of daily living dysfunction secondary to a myocardial infarction (heart attack). R224 was on a blood thinner in the hospital and then

residents/representatives to Care Plan IDT meetings, including documentation of the invitation and response.
DON/designee re-educated LN on 6/18/21 related to the process for updating care plans in a timely manner so care plans reflect current resident needs/status and interventions, including vision and dental needs, communication needs and interventions related to falls.

MONITORING
DON/designee will audit care plans to validate that care plans reflect current resident needs and interventions related to falls, vision, and dental needs, 5/week x 4 weeks, then, 4/week x 2 months.
Administrator/designee will audit documentation related to Care Planning IDT meetings to verify that the resident/representative was invited to the meeting, and it is documented in the medical record, 5/week x 1 month, then 4/week x 2 months.
Findings will be reported to the facility QAPI Committee monthly x 3 months and if needs are identified in our audits, then we will start to audit again.
Date of compliance: 7/29/2021
Administrator and DON are responsible for on-going compliance.

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F 657	Continued From page 21 placed on blood thinners when entering the facility. (Refer F689) On 06/16/21 at 8:20 AM, an interview was done with UD6 regarding R224. UD6 stated that R224 had a fall on 06/03/21. "This occurred in the bathroom when he was briefly left alone, and he fell and hit his head. The fall did cause bleeding to his brow area. On the second fall, 06/12/21, this occurred in his room, where he fell out of bed and hit the wheelchair. We took out his wheelchair from the room and added grab bars. R224 thought he was getting a visitor and fell out of bed." Surveyor queried regarding interventions to monitor residents who are on blood thinners and hit their head. UD6 stated that they did neurochecks and check for bleeding. UD6 stated that he got the black eye from his first fall. Queried UD6 regarding room proximity to the nursing station as R224's bed was farthest from the nursing station. UD6 stated that they did not have a room closer to the nursing station at this time. (Refer F689) RR of care plan on 06/16/21, printed at 12:16 PM by this surveyor revealed that care plan was not updated to reflect interventions for fall on 06/03/21 and for fall on 06/12/21. UD6 provided a conflicting care plan on 06/18/21 which did include interventions; however, there were no dates on the care plan to reflect when the care plan was updated. Surveyor received an event report but did not receive flow sheets. (Refer F689) 4) Initial observation of R506 was made on 06/14/21 at 09:14 AM. She was sitting up in her wheelchair in the hallway of the nursing facility, holding a piece of paper, stating "I don't know anything." She had a faded blue bruise to her	F 657		

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right eye.

A subsequent observation of R506 on 06/15/21 at 09:33 AM revealed R506 in the same situation as on 06/14/21. Surveyor attempted an interview with R506, but was unable to, due to her confusion. She was holding a paper with Japanese writing, translated to English. She asked surveyor, "What day today?" "How long I here?" and "Is my son coming today?" CNA2 assisted R506 by pointing to the Japanese writing and answering her questions in simple English.

On 06/15/21 at 12:31 PM, an abbreviated resident representative interview was done with R506's son. He stated that R506 communicates mostly in Japanese and that the staff member that assists with interpreting or engages in conversation with R506 is not fluent in Japanese. He further stated that the facility had difficulty finding a Japanese interpreter.

On 06/16/21 at 11:05 AM, R506's EHR was reviewed. She was admitted on 06/02/21 for a right hip fracture and had a diagnosis for "unspecified dementia with behavioral disturbance." Admission MDS dated June 5, 2021 revealed under "Section B Hearing, Speech, and Vision": "B0700. Makes Self Understood" coded as "2. Sometimes understood."; "B0800. Ability To Understand Others" coded as "2. Sometimes understands."; under "Section C Cognitive Patterns": "Brief Interview for Mental Status (BIMS)," "C0500. BIMS Summary Score" "01" which indicates severe impairment.

R506's care plan revealed no entry for impaired communication or for individualized interventions to facilitate communication such as the use of an

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F 657	Continued From page 23 interpreter, who is a staff member, or for the use of her sheet which listed Japanese writing with English translations. On 06/16/21 at 01:12 PM, R506 was observed to be sitting in her wheelchair in the doorway of her room, repeatedly stating, "I don't know nothing" looking frustrated. She did not have her paper with the Japanese writing and English translations.	F 657		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation,	F 676		7/29/21

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F 676 Continued From page 24
including walking,

§483.24(b)(3) Elimination-toileting,

§483.24(b)(4) Dining-eating, including meals and snacks,

§483.24(b)(5) Communication, including
(i) Speech,
(ii) Language,
(iii) Other functional communication systems.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to provide R2 with an adaptive device to help the resident communicate with the staff. The deficient practice resulted in a communication barrier for R2 that did not allow her to make her needs known to the people caring for her. This deficient practice has the potential to affect all residents who have difficulty hearing.

Finding includes:

Surveyor made an observation with R2 on 06/15/21 at 10:38 AM. R2 was lying in bed when surveyor introduced herself. R2 appeared not to hear or understand what the surveyor was saying. Surveyor leaned in closer to R2 who cupped her ears and leaned toward the surveyor. R2 shook her head "no." R2 reached out and took hold of the surveyor's name badge, put her glasses on, then read the surveyor's first name. RN1 stated that R2 is very hard of hearing.

R2's EHR was reviewed on 06/15/21 at 10:38 AM. Surveyor reviewed the minimum data set (MDS) quarterly evaluation with an assessment

F 676

CORRECTIVE ACTIONS
R2 was provided with a communication board to improve her ability to communicate with staff and make her needs known.

IDENTIFICATION OF OTHERS
Residents with communication deficits due to hearing or language are at risk. An audit was conducted to identify other residents with communication deficits. Identified concerns were addressed.

SYSTEMIC CHANGES
Administrator/designee re-educated staff, including Social Services, on 6/18/21 related to providing and using communication boards for residents with communication deficits.

MONITORING
Administrator/designee will audit residents identified with a communication deficit to verify communication boards are present and available for use, 5/week x 4 weeks, then 4 residents/week x 2 months.

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F 676	Continued From page 25 review date (ARD) of 05/25/21. Section B (Vision and hearing) was coded with moderate difficulty hearing. Care plan reviewed. R2 has periods of forgetfulness with problem understanding others as well as making herself understood due to a hearing deficit, cognitive communication deficit and language barrier. Her primary language spoken is Japanese, but she is able to converse in basic English language. She is alert and oriented two to three (person, place, time). Her goal will be that she will be able to communicate basic needs on a daily basis through the care plan review date. Physician orders dated 02/16/21 were reviewed. "Audiology consult if indicated. May have dental, podiatry, vision and hearing and eye health consults as needed." Surveyor interviewed RN2 on 06/18/21 at 10:56 AM. Surveyor asked how R2 is able to communicate her basic needs since she has a significant hearing deficit and speaks Japanese? RN2 stated that before she had a writing board to write what she needed, and now she uses the symbol board that has pictures of items so she can point to the items that she wants. Surveyor asked RN2 what is the process to refer a resident for an audiology exam? RN2 stated, "If the resident totally cannot hear us, I will tell the unit manager and the Doctor or Nurse Practitioner (NP) can order a hearing evaluation." R2 did not receive a hearing evaluation. On 06/18/21 at 11:02 AM, Surveyor went to R2's room with RN2 and asked her to show the surveyor where the board is. After looking	F 676	Finding will be reported to facility QAPI committee monthly x 3 months and if needs are identified in our audits, then we will start to audit again. Date of compliance: 7/29/2021 Administrator is responsible for on-going compliance.	

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F 676	Continued From page 26 through all of the drawers and closet, RN2 said, "It's not here, I will let my supervisor know."	F 676		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interview with residents and staff, the facility failed to provide an ongoing program of activities for two (R52 and R184) of 12 residents reviewed for concerns related to activities and two add-on residents (R506 and R30). The facility did not assure equipment and supplies were provided for residents that benefit from room-based activities. Residents that receive room-based activities are being coded as resting/relaxing as an activity. The deficient practice has the potential to result in the decline of residents' mental and psycho-social well-being and could affect all residents. Findings include: 1) R52 was admitted to the facility on 12/19/17. Diagnoses included the following: paraplegia, unspecified (paralysis of the legs); major depressive disorder, recurrent, severe with	F 679	CORRECTIVE ACTION Equipment and supplies were provided for Residents 30, 52, 184 and 506) to provide them with activities and recreation. IDENTIFICATION OF OTHERS Residents who have room-based activities are at risk. An audit was conducted of residents identified as benefiting from room-based activities to verify activities are being provided and necessary equipment and supplies are available. Identified concerns will be addressed. SYSTEMIC CHANGES Administrator/designee re-educated activities staff regarding provision of in-room visits for residents who benefit from room-based activities on 6/18/21 and ongoing. Included in the re-education was	7/29/21

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psychotic symptoms (i.e. hallucinations); Type 2 DM (diabetes mellitus, high blood sugar) with other specified complication; unspecified dementia (progressive loss of cognitive function) with behavioral disturbance; unspecified mental disorder due to known physiological condition; and paranoid schizophrenia (mental illness with delusions).

R52 was observed lying in bed on 06/14/21 at 08:05 AM. R52 has a television on a stand; however, the television was not on. Subsequent observation on 06/14/21 at 12:36 PM and 01:05 PM found resident laying in bed, awake. The television was not on. On 06/15/21 at 08:29 AM and 11:29 AM observed R52 laying in bed. On 06/16/21 at 09:32 AM, R52 was sitting up in bed. Second observation on 06/16/21 at 10:26 AM, R52 was seated in her wheelchair outside of her room. R52 reported that there was something wrong with her bed so she needed to get up. Observed staff member changing the bed linen. R52 was not observed engaged in activities and usually laying in bed awake. The television was not on and the resident was not provided with a radio to listen to music.

On 06/15/21 at 09:21 AM, R52 reported she does not watch television because her remote control for the television was stolen and facility was working on getting another remote or television.

Record review was done on 06/17/21 at 03:29 PM. A review of the annual activities assessment dated 12/29/20 noted R52 has a cognitive impairment and is able to express her needs verbally. R52 will participate in 1:1 (one to one) visits consisting of Talking/Reminiscing (hiking, horseback riding, traveling, books, current

F 679

how to document room-based activities to reflect what activity was provided.

MONITORING
Administrator/designee will conduct random observations to validate room-based activities are occurring as planned and verify documentation is reflective of provided activities, 4 residents/week x 4 weeks, then 3 residents/week x 2 months.
Findings will be reported to the facility QAPI Committee monthly x 3 months or until a lesser frequency is deemed appropriate.

Date of Compliance: 7/29/2021
Administrator is responsible for on-going compliance.

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events, and reality orientation), bed side exercises, music (Hawaiian/Rock), and pet visits. She also engages in independent activities such as listening to music, watching bedside TV and resting/relaxing (may want TV off depending on mood). She exhibits active level of participation.

On 06/18/21 at 09:39 AM, the Activities Director (AD) provided a copy of R52's activity care plan and participation record for the last 30 days. The care plan included interventions for engaging in independent activities such as listening to music, watching bedside TV and resting/relaxing. The participation log notes television on 05/27/21 and 05/28/21; music on 06/08/21, 06/09/21, 06/14/21 and 06/16/21; 1:1 on 05/24/21, 05/26/21, 05/31/21, 06/01/21, 06/02/21, and 06/07/21; and resting/relaxing on 05/22/21, 05/30/21, 06/05/21, 06/06/21, 06/12/21, and 06/13/21. In the past 30 days, R52 received activities on 17 of 30 days, including six days that were coded as resting/relaxing.

On 06/16/21 at 01:16 PM an interview was conducted by the survey team with AD in the conference room. The AD stated residents are to bring their own television and the follow-up for the missing remote is for nursing or maintenance. The AD was unaware of how long the resident's remote control was missing. AD reported activities staff attempt to visit residents two to three times a week for approximately 15 minutes. Further queried whether the facility has radios to provide residents for music, AD replied the facility has radios but it goes out fast. The activities staff will play music for residents during their 15 minute visit. Further queried regarding the coding for resting/relaxing, is this really an activity. The AD clarified activities staff will mark this activity

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when they find the resident asleep or resting. The AD also reported activities will mark walk/stroll if residents are observed to be walking with nursing/rehab staff.

2) R30 was admitted to the facility on 12/06/13. Diagnoses include status post stroke, diabetes mellitus, dementia and manic depressive disorder (mental illness with extreme mood swings).

Observation on 06/14/21 at 10:31 AM and 12:41 PM, R30 was asleep. On 06/15/21 at 08:18 AM, R30 was observed with Restorative Aide (RA)2 receiving passive range of motion and application of boots/splint to prevent feet contractures. At 11:21 AM, R30 was observed laying in bed. R30 did not have a television or radio on during the observations.

On 06/18/21 at 10:14 AM, the AD provided a copy of the activities care plan and activity participation log. The care plan note that R30 is not interested in group activities and has impaired cognition and communication. R30 spends time listening to her bedside radio. Care plan interventions include provide/offer activity material of interests (reading material, crafts) and facilitating phone calls/video chat with family. R30 noted to participate in 1:1 visits consisting of talking/reminiscing and music (Hawaiian). R30 was coded for participation in music 12 times in the last 30 days. And she was coded for resting and relaxing nine times in the last 30 days.

Interview with AD on 06/18/21 at 10:19 AM in the conference room, queried whether R30 had a radio as no music was heard during observations. AD reported that R30's radio, without batteries, was found in the resident's closet. Batteries have

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been provided and R30 now has her radio. AD also reported R30 enjoyed coming outdoors to listen to music, however, due to COVID-19 this group activity was not being provided.
3) Surveyor observed R184 lying in her bed on 06/14/21 at 03:42 PM. She was laying in the bed next to the window, curtain on her right closed allowing her total privacy. She was facing to the left awake, not alert and non verbal. Surveyor noted there was no television in the room on her side or the resident in the bed on her right. R184 had a tracheostomy (Trachea) collar connected to a humidifier. She didn't respond to questions from the surveyor. She laid in bed staring straight. Subsequent visits to R184's room were made by the surveyor in the morning and afternoons on 06/14/21 through 06/18/21. Surveyor noted no changes that allowed the resident to have music.

Surveyor reviewed the EHR on 06/16/21 at 04:04 PM. MDS quarterly evaluation with ARD of 05/14/21. "Activities: Section F...B. How important is it to you to listen to music you like?" Response was coded "2. Somewhat important."

Surveyor reviewed care plan dated 02/24/21 on 06/16/21 at 03:02 PM. R184's care plan stated the following:
ACTIVITIES
R184 has a communication impairment which may affect her activity participation. She engages in independent activities such as listening to music and participating in virtual visits with her family.
Provide R184 with 1:1 visits consisting of Sensory, reading (the bible) and music (spiritual) and virtual visits.
Provide, offer and assist the resident with in-room individualized activity visits to maintain the

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F 679	Continued From page 31 residents psycho social well- being and to provide the resident with recreational opportunities. Surveyor interviewed the AD on 06/16/21 at 01:19 PM in the conference room. Surveyor asked what type of sensory and auditory stimulation is provided for those who are bed bound and not responsive. AD replied that she reaches out to their families, music is a big thing, I have some that are religious so my staff will read chapters from the bible. For a resident with music on the care plan, we try to give them a radio and put on a station that they like. Once the assessment is done, then its put on the care plan. I provide an activity calendar for each resident. If they can't get anything like a television or radio from home, we offer them a radio. Surveyor asked why R184 doesn't have a radio? The AD responded we only have one radio available to be given out. There were 10 ordered last time and there is only one left. Surveyor interviewed Activity Assistant (AA)3 on 06/18/21 at 10:36 AM on Piikoi 1 lanai. Surveyor asked AA3 how music is provided to R184 as it is written on the care plan. AA3 stated our staff go into her room and play music on their cell phone or other electronic device for 15 minutes about two to three times per week or as often as they can. The staff also schedule a Zoom call with the family and go in and provide virtual visits using a facility electronic device. 4) Initial observation of R506 was made on 06/14/21 at 09:14 AM. She was sitting up in her wheelchair in the hallway of the nursing unit, holding a piece of paper, stating "I don't know anything." She had a faded blue bruise to her right eye.	F 679		

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A subsequent observation of R506 on 06/15/21 at 09:33 AM revealed R506 in the same situation as on 06/14/21. Surveyor attempted an interview with R506, but was unable to, due to her confusion. She was holding a paper with Japanese writing, translated to English. She asked surveyor in a frustrated tone, "What day today?" "How long I here?" and "Is my son coming today?" CNA2 assisted R506 by pointing to the Japanese writing and answering her questions in simple English.

On 06/15/21 at 12:31 PM, an abbreviated resident representative interview was done with R506's son. He stated that R506 communicates mostly in Japanese and that the staff member that assists with interpreting or engages in conversation with R506 is not fluent in Japanese. He further stated that the facility had difficulty finding a Japanese interpreter.

On 06/16/21 at 11:05 AM, R506's EHR was reviewed. She was admitted on 06/02/21 for a right hip fracture and had a diagnosis for "unspecified dementia with behavioral disturbance." Admission MDS dated June 5, 2021, revealed under "Section B Hearing, Speech, and Vision": "B0700. Makes Self Understood" coded as "2. Sometimes understood."; "B0800. Ability To Understand Others" coded as "2. Sometimes understands."; under "Section C Cognitive Patterns": "Brief Interview for Mental Status (BIMS)," "C0500. BIMS Summary Score" "01" which indicates severe impairment.

An "Activities/Recreation - Initial Review" note stated: "...she prefers to participate in

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independent activities such as resting, watching TV, and engaging in physical therapy. Staff will provide her leisure supplies as needed and encourage her to engage in social stimulation." Her treatment administration record (TAR) for 1:1 activity showed no data for the look back date of 30 days. The TAR for independent activity showed one activity done on 06/02/21, 06/07/21, 06/10/21, and 06/14/21.

On 06/16/21 at 01:12 PM, R506 was observed to be sitting in her wheelchair in the doorway of her room, repeatedly stating, "I don't know nothing" and looking frustrated. She did not have her paper with the Japanese writing and English translations.

An interview was done with the AD on 06/16/21 at 01:16 PM in the conference room. For residents with dementia, they "try to provide them (activities) as much as we can...try to provide two - three times per day."

In an interview with RN5 on 06/17/21 at 11:26 AM, he stated that R506 "understands some English." For residents with a language barrier, he stated that they would utilize the Language Line for interpreting. He stated that for R506, "One of the therapists wrote down some notes. No staff can speak Japanese, you need to be patient answering her, be calm. Offer to keep her busy." Surveyor asked for clarification about having staff that were able to speak Japanese and he stated, "There are therapists that speak Japanese, but they don't work on this floor. I don't know why they don't work on this floor."

In an interview with the UD8 on 06/18/21 at 09:04 AM, she stated that R506 needs someone to talk

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F 679	Continued From page 34 to because her attention span is short. She also stated that she would ask the recreations department to assist with providing activities for residents with dementia and ask for individual activities, reading material or someone to talk with the resident. She further stated for R506, "I will ask activities to provide Japanese magazines and music." (Refer F744)	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interview with staff members, the facility failed to assure accurate blood pressures were taken for residents diagnosed and treated for hypertension for one resident, R37; and failed to provide tracheostomy care that demonstrated professional standard of nursing practice for R184 who had a tracheostomy, evidenced by the following: Staff did not monitor R184 for suctioning as frequent, as necessary. Staff failed to identify when the resident needed assistance with her respiratory care. Two RNs who suctioned and provided trachea care for R184 made an error in the technique and breached infection prevention & control	F 684	CORRECTIVE ACTION R37 blood pressure (BP) is being taken on her upper arm. R184 is receiving trach care and being suctioned, as needed. R207 was provided with a larger BP cuff. IDENTIFICATION OF OTHERS Residents diagnosed with hypertension and residents requiring tracheal suctioning are at risk. An audit was conducted to identify residents with a diagnosis of hypertension. It was verified that BP is being taken on the upper arm. There are no additional residents	7/29/21

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standards.
Management staff are not monitoring the nurses for competency of trachea care that is being provided to R184.
This deficient practice has the potential to result in the following:
Inappropriate treatment of hypertension (high blood pressure) and compromise respiratory status, placing both residents at risk for severe illness.

Findings include:

1) Observation on 06/17/21 at 08:25 AM, CNA3 was at R37's bedside taking her blood pressure (BP). The BP cuff was placed on R37's left forearm. Subsequent observation on 06/17/21 at 09:11 AM found RN50 taking R207's blood pressure across the nurses' station. RN50 placed the blood pressure cuff on resident's forearm. R207 was asked why her BP cuff was placed on her forearm and not upper arm. R207 replied she prefers it on the forearm as when the BP cuff is placed on her upper arm, the Velcro either rips open or squeezes her arm too tightly resulting in pain.

Record review was done on 06/17/21 at 12:06 PM. R37 has a diagnosis of hypertension and is prescribed metoprolol succinate ER, 25 mg, hold if BP is below 100, call if systolic BP is above 180, and hold if apical pulse is below 55. The BP reading taken on 06/17/21 at 09:09 AM was 143/77. R37's systolic BP ranged from 136 to 144 for the time period of 06/16/21 to 06/17/21.

Record review was done on 06/17/21 at 12:06 PM. R207 is diagnosed with hypertension and is prescribed Lasix (diuretic), 40 mg, give 80 mg by

F 684

requiring tracheal suctioning.

SYSTEMIC CHANGES
The DON/designee on 6/18/21 and ongoing re-educated LN and CNAs regarding technique for taking BPs. On 6/18/21 and ongoing, DON/designee re-educated LN related to care of a tracheostomy, including cuff placement, infection control and suction technique. Annual and as needed suctioning competency was verified for LN who work on the unit with a resident requiring tracheal suction.

MONITORING
DON/designee will conduct random observations of BP being taken on 5 residents/week x 4 weeks, then 4 residents/week x 2 months to validate technique.
DON/designee will observe trach care being performed 5 times/week x 4 weeks, then 3 times/week x 2 months.
Findings will be reported to facility QAPI Committee monthly x 3 months or until a lesser frequency is deemed appropriate.

Date of Compliance: 7/29/2021
DON is responsible for on-going compliance.

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mouth once a day related to hypertension, hold if systolic BP is less than 100. A review of R207's BP reading for 06/17/21 at 09:14 AM was 140/70 and subsequent reading at 09:43 AM was 150/90. R207's systolic BP ranged from 140 to 182.

Interview with Director of Nursing (DON), RNC, and ADON was done on 06/17/21 at 12:25 PM in the DON's office. The DON reported taking a BP on the forearm is done per a physician order. Further queried whether R207 and R37 had an order to take BP on the forearm. DON responded R207 and R37 does not have an order to take BP on the forearm. Requested a copy of the facility's policy and procedure. RNC accompanied surveyor out of the DON's office and while standing in the hall, agreed to provide a policy and procedure regarding taking of BP.

On 06/18/21 at 08:15 AM interviewed Unit Director (UD)5 at the unit's nursing station. UD5 reported due to the pandemic, CNAs are taking residents' vitals. UD5 reported R207's BP was retaken using a larger cuff and it is not clear why a larger cuff was not being used for R207. UD5 called R207's physician regarding taking BP on the forearm vs. upper arm as requested by the resident. UD5 also reported CNA3 has been reeducated to place the BP cuff on the upper arm to obtain an accurate reading.

The requested policy and procedure was not provided by the time of exit, 06/18/21 at 03:30 PM.
2) On 06/14/21 at 02:12 PM, Surveyor entered R184's room and noted her tracheostomy collar was not on correctly, it was tied in on her neck facing the wrong position, and not directly over the tracheostomy opening. The trachea collar

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provides humidified air to R184's trachea. Surveyor noted R184 coughing forcefully, expectorating thick white secretions from the tracheostomy. R184 appeared to have an increased respiratory rate. Right arm was noted with a slight tremor with each heavy cough. At 02:16 PM surveyor went out to the hallway to ask RN2 to check on the resident. RN2 came into the room to provide R184 with tracheostomy care. Surveyor noted RN2 did not sanitize her hands when taking off the soiled gloves, removing them and donning the sterile glove from the suction kit. When going into R184's trachea with the suction catheter, she was noted to apply suction when going into the trachea. Resident continued to cough and expectorate mucus. Also noted RN2 did not have control of the suction tube, which fell onto the resident's neck (Refer F880).

On 06/16/21 at 03:02 PM, surveyor reviewed R184's care plan dated 02/24/21. R184's care plan stated the following:
"Problem: Respiratory. Resident has a tracheostomy.
At risk for ineffective airway clearance...
Provide tracheostomy care as ordered.
Resident has Tracheostomy.
Suction as needed for congestion or increased secretions."

During an observation on 06/16/21 at 09:23 AM, Surveyor noted R184's trachea collar was halfway full of thick white secretions. Surveyor went out to the hallway and asked RN3 to come check the resident. RN3 stated "I will suction her, I need to get a key to get the supplies, the person who has the key isn't here right now".

Surveyor interviewed RN3 on 06/16/21 at 09:26

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AM. Surveyor asked how often R184 receives suctioning and trachea care. RN3 stated, "We suction her as needed, before breakfast and when we make rounds. I can suction her." At 09:29 AM, surveyor noted RN3 standing by the elevator, and she stated, "I'm going to her, I need the materials, I'm waiting for the key..."

Surveyor interviewed UD9 on 06/16/21 at 03:23 PM. Surveyor asked UD9 if the staff who take care of R184 receive training prior to coming to work on the floor. The UD9 responded that the training is provided by the staff development director (SDD). When asked if the resident is being evaluated to determine her status as a stable trachea patient and how often? Replied that the doctors see her every month and evaluate her, she is a stable trachea patient.

Surveyor interviewed the SDD on 06/17/21 at 09:53 AM. Surveyor asked how they monitor staff who are providing trachea care to ensure compliance and that they are competent. SDD stated "Usually the unit manager will provide the spot checks. If there is a concern about the skill being provided, I will work with the staff 1:1." There is no monitoring documentation available (for the staff i.e. spot checks) (Refer F726).

Surveyor observed RN1 on 06/17/21 at 10:13 AM providing trachea care to R184. RN1 pulled off trachea collar, noted thick white sputum on the washcloth on R184's chest around the trachea. RN1 removed the secretions with a napkin and threw it in a garbage bag resting on the floor next to the bed. RN1 took off gloves and set up a sterile field, then RN1 applied the clean gloves. Noted she didn't sanitize her hands in between the glove changes. Surveyor noted the sputum

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color changed to a white/ yellow thick mucus since 06/14/21. Noted she moved her clean area up onto the basin then moved it back down on the table which placed her clean area into a dirty area (refer F880). Surveyor asked RN1 when she changed her gloves does she need to sanitize her hands? RN1 stated, "Yes, I do." When asked why she didn't suction the resident before providing the care she responded that she suctions her as needed (prn). I usually check on her at least every hour. If she has a lot of drainage, I suction her trachea. Sometimes when CNA changes her, the trachea collar gets misplaced, so I come to check and see if she needs attention (refer F880).

Surveyor reviewed the facility's "Quality of care Respiratory Care/ Tracheotomy Care & Suctioning" policy dated 07/2018. "Purpose: To provide residents with necessary respiratory care and services that are in accordance with professional standards of practice, the residents care plan..."

On 06/17/21, the surveyor reviewed the "Competency Check - Tracheotomy Care" dated March 2018 that was provided by the SDD: "Performance criteria: ...Suctioning a Tracheostomy Tube...16) Attach the catheter to suction. 17) Insert the catheter into the trachea without suction. 18) Apply suction intermittently while rotating the catheter and withdrawing it from the trachea. 19) Wrap disposable suction catheter around the sterile dominant hand while withdrawing it from the tracheal tube"(refer F726).

Surveyor reviewed the Treatment administration record (TAR) for R184 on 06/18/21 at 03:00 PM: April 2021. R184 was suctioned once on 04/27 at

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F 684	Continued From page 40 10:30 AM. May 2021. R184 was suctioned on 05/01 at 11:05 AM and 05/11 at 10:00 AM. June 2021. R184 was suctioned on 06/14 at 04:11 AM. Surveyor observed RN2 suction R184 on 06/14/21 at 2:15 PM, no documentation was found on the TAR that R184 was suctioned by RN2 (Refer F695). Surveyor interviewed UD9 on 06/18/21 at 11:07 AM. Surveyor asked UD9 how are you as the unit manager monitoring your staff for compliance ensuring that they are providing the trachea care within professional nursing standards of practice? The SDD does the inservices for the staff. Periodically when they are giving care I go in and check on them. If they are providing the care incorrectly, I will take them aside and talk to them. They may be referred back to the nurse educator and will get additional 1:1 education. Surveyor asked if she has any documentation that shows when and how you're doing your spot checks on the staff and what is the outcome? UD9 was not able to show the surveyor documentation to show the staff are being monitored for competency in providing trachea care. (Refer F726)	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		7/29/21

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F 689	Continued From page 41 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the facility was free of accident hazards and failed to provide adequate supervision for fall precautions for two residents, R406 and R224. This deficient practice has the potential to affect all residents in the facility. Findings include: 1) On 06/18/21 at 03:00 PM, surveyor reviewed R406's discharge summary from an acute care hospital dated 09/28/20. R406 is an 89 year old male with prior medical history of dementia. R406 experienced an unwitnessed fall on 9/24/20 at facility. The fall resulted in a skin laceration to back of his head with uncontrolled bleeding. R406 received five surgical staples to the back of his head. His prescribed anticoagulants (blood thinner medication) were held due to small subarachnoid hemorrhage (bleeding in the brain). Afibrilation (irregular heart beat) rate controlled. Surveyor reviewed the electronic medical record on 06/18/21 at 02:13 PM. "Nursing Note: 9/24/2020 22:16 (10:16 PM). At 1950 (07:50 PM) heard a thud inside residents room. Found resident on the floor, supine position near his bed. Resident is naked, alert & oriented x 1 (name) profuse bleeding at the back of his head, noted a laceration 5 cm (centimeters), pressure applied on it. Daughter was informed about the fall." "Nursing Note: 9/26/2020 22:26 (10:26 PM) Admitted R406 back to the facility, status post (S/P) fall and altered mental state (AMS)."	F 689	CORRECTIVE ACTION R406 no longer resides in the facility. R224 was moved closer to the nursing station. Care Plan was updated to reflect current interventions. IDENTIFICATION OF OTHERS Residents who experience falls are at risk. Care plans and Fall Risk Evaluations were reviewed for residents who have experienced a fall in the past 60 days to verify evaluation was current and care plans reflected residents□ current status and interventions. Identified needs were addressed. SYSTEMIC CHANGES DON/designee on 6/18/21, re-educated nursing staff regarding monitoring of residents following a fall and implementation of interventions. LN were re-educated related to updating care plans and fall evaluations in a timely manner after a fall. Residents who experience a fall will be discussed in the next morning clinical meeting. Care plans and fall evaluations will be reviewed during the meeting to verify they are reflective of residents□ current status. MONITORING DON/designee will audit care plans and fall evaluations of residents who experience a fall, 5 residents/week x 4 weeks, then 4 residents/week x 2 months. Findings will be reported to facility QAPI	

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F 689	Continued From page 42 "Skilled Nursing Note: 9/27/2020 23:32 [22:32 PM]. R406 current reason for skilled stay is assessment/management of Encephalopathy (disease that affects the brain), AMS and post fall; Physical Therapy (PT) and Occupational therapy (OT) to maximize functional and safe mobility; care planning on fall prevention. "Nursing Note: 9/29/2020 12:03. R406 noted with moist cough, longer for him to swallow. NP ordered chest X-ray today and Speech therapy (ST) eval." "Nutrition/Dietary Note: 9/30/2020 09:09. Significant change, ARD 9/30/20. Refer to nutrition eval 9/28 - resident at risk of malnutrition. Continue to monitor on weekly weights." "Therapy Note: 9/30/2020 12:34. Currently, patient presents with severe dysphagia (difficulty swallowing) characterized by oral holding. Additionally, patient with wet/productive cough after the swallow... Patient is currently not safe to consume any solids or liquids mouth." "Nursing Note: 9/30/2020 13:55 (01:55 PM). Still with moist cough, received a message from SLP (speech language pathologist) that resident is not safe to eat anything by mouth (NPO). Called medical doctor (MD) office to inform. MD office ordered to put on NPO until further notice." "10/02/2020 15:58 (03:58 PM) Nutrition/Dietary Note: Nasogastric tube (NGT) placed." "10/08/2020 23:53 (11:53 PM) Nursing Note: At 1540 (03:40 PM), this writer went to resident's room to check on resident and then noted	F 689	Committee monthly x 3 months or until a lesser frequency is deemed appropriate. Date of Compliance: 7/29/2021 DON is responsible for on-going compliance.	

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resident lying on his left side next to bed on floor. No injuries to the head and other part of body noted. No facial grimacing noted. Head to toe assessment done. Resident was assisted by this writer and certified nurse aide (CNA) back into bed. Informed nurse supervisor. Notified daughter."

MDS with ARD of 09/30/20 quarterly evaluation. Resident had a significant change in status due to at risk for nutrition.
"Section J: One fall.
Section K (Nutrition/ Swallowing): holding food in mouth/ cheeks or residual food in mouth after meals. Yes.
Coughing or choking during meals or when swallowing medications yes.
On mechanically altered diet.
Therapeutic diet."

Surveyor reviewed the previous MDS with ARD of 07/14/20 and compared the two evaluations.
"Functional status: extended assist.
K: Nutrition: No loss of liquids/solids from mouth when eating or drinking. No holding food in mouth/ cheeks or residual food in mouth after meals.
No coughing or choking during meals or when swallowing medications."

Care plan dated 03/22/20 reviewed:
"Fall: The resident is at risk for falls due to decreased generalized strength, impaired balance/ mobility, poor cognition, history of repeated falls."

Surveyor interviewed the Director of Nursing (DON) and RNC on 06/22/21 at 02:05 PM. Surveyor asked what are R406 risk factors for

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having a fall, how often are they assessed and where is it documented? The DON replied that the last Fall risk assessment was on 01/08/21. He scored high he was a pretty high risk.

The DON stated that prior to the fall staff were ensuring resident placed up in wheelchair (WC) or recliner during the day time. When in bed, keep in lowest position. Check resident for every one to two hours, toilet resident before meals. Check at least every two hours.

When the resident has a fall they are on alert charting, so they are being monitored closely.

What were the circumstances around the cause of the fall, September 24, when R406 was found on the floor? He just wanted to get out of his bed when asked by the staff.

Surveyor asked if this fall was preventable. DON responded, with his diagnosis, his behavior, he would be awake at night. His diagnosis of dementia and sundowning. He was hard to manage at times. The staff were saying he would be unpredictable. He was in his late alzheimers disease process. I don't feel that the accident was preventable. He was checked 10 minutes prior to the fall. It was an unavoidable fall.

Surveyor asked if a 1:1 was ever considered for R406 since he was "unpredictable"?
Both DON and RNC responded that they don't believe he required a 1:1 before the fall.

This deficient practice resulted in R406 sustaining a laceration to his head. The facility's staff were unable to control the bleeding associated with the laceration. R406 required emergency medical

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attention to have the bleeding controlled. R406 received five surgical staples to the laceration sustained as a result of the facility's deficient practice. Upon returning to the facility after receiving emergency medical attention, R406 was never the same. R406 progressively declined of functional status and significant negative weight loss.

Surveyor discussed the functional decline after R406 returned to the facility after the fall on 09/26/21. R406 expired on 03/22/21.
2) R224 entered the facility on 05/28/21. Record review on 06/14/21 at 2:00 PM revealed R224 had a history of falls and fell at home. Physician assistant (PA) note dated 06/16/21 at 09:06 documents a chief complaint of impaired mobility and activities of daily living dysfunction secondary to a myocardial infarction (heart attack). R224 was on a blood thinner in the hospital and then placed on blood thinners when entering the facility.

A concurrent interview and observation were done on 06/14/21 at 10:30 AM with R224. Surveyor observed that R224 had black and blue bruises to his face and especially to his right orbital area. Resident stated that he fell and hit his head very hard.

Interview with UD6 was done on 06/15/21 at 10:58 AM. UD6 was queried regarding facial bruising to R224. UD6 was not aware of R224's facial bruising. An event report and flowsheets were requested.

On 06/16/21 at 8:20 AM, an interview was done with UD6 regarding R224. UD6 stated that R224 had a fall on 06/03/21. "This occurred in the

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F 689	Continued From page 46 bathroom when he was briefly left alone, and he fell and hit his head. The fall did cause bleeding to his brow area. On the second fall, 06/12/21, this occurred in his room, where he fell out of bed and hit the wheelchair. We took out his wheelchair from the room and added grab bars. R224 thought he was getting a visitor and fell out of bed." Surveyor queried regarding interventions to monitor residents who are on blood thinners and hit their head. UD6 stated that they did neurochecks and check for bleeding. UD6 stated that he got the black eye from his first fall. Queried UD6 regarding room proximity to the nursing station as R224's bed was farthest from the nursing station. UD6 stated that they did not have a room closer to the nursing station at this time. Record review (RR) done on 06/16/21 shows that a Fall risk evaluation was done on 05/28/21, 06/03/21 and 06/12/21. The evaluations show that after the second fall, for gait and balance, use of assistive device was marked on 06/12/21 evaluation. There were no additional notes recorded on the evaluations. RR of the physical therapy (PT) note shows that R224 needed cues for transfers due to poor safety skills. Distance skills equals 500 feet and assistive device equals two-wheeled walker. PT completed evaluation on 06/17/21. RR of care plan on 06/16/21, printed at 12:16 by this surveyor revealed that Care plan was not updated to reflect interventions for fall on 06/03/21 and for fall on 06/12/21. UD6 provided a conflicting care plan on 06/18/21 which did include interventions; however, there were no dates on the care plan to reflect when the care plan was updated. Surveyor received an event	F 689		

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F 689	Continued From page 47	F 689		

report but did not receive flow sheets.

An interview on 06/17/21 at 1:29 PM with the DON regarding R224's facial bruising. DON stated she did not know about the facial bruising and would talk with the UD.

On 06/17/21, R224's room was moved in front of nursing station. RN10 stated "We had an open room and was able to move R224."

RR on 06/18/21 07:29 AM showed a nursing note that RN10 called MD's office and spoke with MD's nurse to report facial bruising.

RR of policy and procedure for accident Haards/supervision/devices, policy number 689, under guidelines No 13 states:
"Monitoring and modification process may include:
a. Verifying that interventions are implemented as planned;
b. Evaluating the effectiveness of interventions;
c. Modifying or replacing inteventions as needed, and;
s. Evaluating the effectives of new interventions."

R224 had a history of a fall at home and had two falls in the facility. Investigation by observation, record review and interview reveals that the facility did not ensure best practice: 1) staff not aware of facial bruising after a fall with a resident on blood thinners, 2) MD called 15 days after injury to notify about facial bruising, 3) careplans not reflecting interventions and questionable evaluations were appropriate for resident as revealed by lack of documentation, interventions

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F 689	Continued From page 48 and protocols delaying care in prevention of a second fall with a resident who is on blood thinners. This deficient practice has the potential to affect other residents in the facility.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record reviews, the facility failed to maintain the hydration status of one resident, R356, according to doctor's orders to maintain nutritional status. This deficient practice has the potential to affect all residents. Finding includes:	F 692	R356 was provided with hydration according to doctor's orders to maintain nutritional status. IDENTIFICATION OF OTHERS Residents with hydration and nutritional deficits due to lack of fluid consumption are at risk. An audit was conducted to	7/29/21

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F 692	Continued From page 49 Surveyor interviewed R356 on 06/14/21 at 12:49 PM. R356 stated that he asked for hot tea at 08:40 AM and every staff he asked said they would be back, but no one brought it. That was over four hours ago. My doctor came in and then he received it. It would usually be at lunch time when I receive it. I only received it now. R356 had two cups of water on his bedside table along with a pitcher of water. However, his preference is hot tea. Interview with CNA5 was done on 06/17/21 at 08:18 AM. CNA5 stated that the problem is that the kitchen takes about 30 minutes and stated that they must do down and get it. UD6 went down to get R356's requested tea. UD6 spoke with R356 and he stated he likes tea 3-4 times a day. UD6 said she would be looking to improve the arrival time. Surveyor reviewed the doctors' orders on 06/17/21 at 09:31 AM which revealed that resident had an order for hydration at least 240 ml (milliliters) four times a day. Task sheet shows that resident has not been getting his 240 ml four times a day this week. Resident is also on a diuretic (medication to help rid the body of excess fluid). RR of R356's care plan revealed that resident has dehydration or potential fluid deficit related to history of constipation and dehydration.	F 692	identify other residents with hydration and nutritional deficit. Identified concerns were addressed. SYSTEMIC CHANGES DON/designee re-educated staff, including dietary staff, on 6/18/21 related to providing required hydration and nutrition and adhering to residents preferred and requested beverages. A list of resident beverage preferences will be maintained at each nurses station to assist staff in identifying resident preferences. Residents with orders for a specified amount of fluid will be reviewed by dieticians to verify consumption of the ordered amount on a weekly basis. MONITORING DON/designee will audit residents identified with nutritional deficit to verify that they are receiving hydration of their choice to maintain nutritional status, 5 residents/week x 4 weeks, then 4 residents/week x 2 months. Findings will be reported to facility QAPI committee monthly x 3 months or until a lesser frequency is deemed appropriate. Date of compliance: 7/29/2021 DON is responsible for on-going compliance.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F 695		7/29/21

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F 695	Continued From page 50 The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review, the facility failed to provide tracheostomy care that demonstrated professional standard of practice for one resident, R184. Nursing staff failed to identify and monitor R184 for suctioning when necessary. R184 is a resident who is non verbal, unresponsive and cannot use a call light to request for help. R184 needs suctioning and monitoring more often than was demonstrated and documented by the nursing staff. Two RNs who suctioned and provided trachea care for R184 made an error in the technique, breaching infection prevention & control standards. Surveyors made observations on Monday, Tuesday and Wednesday and noted that the resident needed immediate assistance on two separate occasions. Two times the surveyor brought it to the attention of staff to come in and suction her. Management staff are not monitoring the nurses for competency of trachea care that is being provided to R184. These deficient practices compromised the resident's respiratory status and placed the resident at risk for severe illness and infection and has the potential to affect all residents who need tracheostomy care.	F 695	CORRECTIVE ACTION R184 tracheostomy care and suctioning is being provided to demonstrated professional standard of practice. R184 is receiving trach care and being suctioned, as needed. IDENTIFICATION OF OTHERS Residents with a tracheostomy requiring suction are at risk. There are currently no additional residents requiring tracheal care or suctioning. SYSTEMIC CHANGES The DON/designee on 6/18/21 re-educated LN regarding technique to care for a tracheostomy, including infection control and suction technique. Tracheostomy Care competency was verified for LNs who work on the unit with a resident requiring tracheal suction. When a resident with a tracheostomy is admitted to a unit, education will be provided, at the time of admission, to staff who work the unit followed by return demonstration competencies for staff. Suctioning competency completion will be done for LNs annually. MONITORING	

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F 695	Continued From page 51 Finding includes: On 06/14/21 at 02:12 PM , Surveyor entered R184's room and noted her tracheostomy collar was not on correctly, it was tied in place on her neck facing the wrong way, the collar was not positioned over the tracheostomy opening. The trachea collar provides humidified air to R184's trachea. Surveyor noted R184 coughing forcefully, expectorating thick white secretions from the tracheostomy. R184 appeared to have increased respirations and right arm was noted with a slight tremor with each heavy cough. At 02:16 PM surveyor went out to the hallway to ask RN2 to assist the resident. RN2 came in to the room to provide R184 with tracheostomy care. Surveyor noted RN2 didn't sanitize hands when taking off the soiled gloves and before putting on the sterile glove from the suction kit. When going into R184's trachea with the suction catheter she was noted to apply suction when going into the trachea. Resident continued to cough and expectorate mucus. Also noted the RN2 didn't have control of the suction tube which fell onto the residents neck. On 06/16/21 at 03:02 PM, surveyor reviewed R184's care plan dated 02/24/21. R184's care plan stated the following: "Problem: Respiratory. Resident has a tracheostomy. At risk for ineffective airway clearance. Will maintain clear airway every shift through the review date. Will have no signs and symptoms (S/sx) of infection through the review date. Will Monitor/document respiratory rate, depth and quality. Check and document q [every]shift/as ordered.	F 695	DON/designee will observe trach care being performed 5 times/week x 4 weeks, then 3 times/week x 2 months. Findings will be reported to facility QAPI Committee monthly x 3 months and if needs are identified in our audits, then we will start to audit again. Date of Compliance: 7/29/2021 DON is responsible for on-going compliance.	

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Provide tracheostomy care as ordered.
Resident has Tracheostomy.
Suction as needed for congestion or increased secretions."

During an observation on 06/16/21 at 09:23 AM, surveyor noted R184's trachea collar was halfway full of thick white secretions. Surveyor went out to the hallway and asked the RN to come check the resident. The RN3 stated "I will suction her, I need to get a key to get the supplies, the person who has the key isn't here right now".

Surveyor interviewed RN3 on 06/16/21 at 09:26 AM. Surveyor asked how often RN184 receives suctioning and trachea care. RN3 stated, "We suction her as needed, before breakfast and when we make rounds. I can suction her." At 09:29 AM, surveyor noted RN3 standing by the elevator and she stated, "I'm going to her,, I need the materials, I'm waiting for the key..."

On 06/16/21 at 03:19 PM, surveyor asked RN3 when does R184's trachea care get done? When asked if she received training on providing trachea care she responded that training was provided during the fourteen day training prior to being hired.

Surveyor interviewed the UD9 on 06/16/21 at 03:23 PM. Surveyor asked UD9 if the staff who take care of R184 receive training prior to coming to work on the floor. The UD9 responded that the training is provided by the Staff Development Director (SDD). When asked if the resident is being evaluated to determine her status as a stable trachea patient and how often? Replied that the doctors see her every month and evaluate her, she is a stable trachea patient.

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Surveyor interviewed the Staff Development Director (SDD) on 06/16/21 at 03:53 PM and asked if nursing staff are provided trachea care and suctioning at annual training and training to new hires. He stated, "There is nothing specific. We provide 1:1 education to staff, if they need additional training and we do spot checks on staff."

Surveyor requested the training content and documentation from the SDD and how staff are being monitored on the unit providing the care (spot checks).

Surveyor interviewed the SDD on 06/17/21 at 09:53 AM. Surveyor asked how they monitor staff who are providing trachea care to ensure compliance and that they are competent. SDD replied "Usually the unit manager will provide the spot checks. If there is a concern about the skill being provided, I will work with the staff 1:1." There is no monitoring documentation available (for the staff i.e. spot checks).

Surveyor observed RN1 on 06/17/21 at 10:13 AM providing trachea care to R184. RN1 pulled off trachea collar, noted thick white sputum on the washcloth on R184's chest around the trachea. RN1 removed the secretions with a napkin and threw it in a garbage bag resting on the floor next to the bed. RN1 took off gloves and set up a sterile field. Noted RN1 poor out the hydrogen peroxide and normal saline into the small boxes from the kit. RN1 applied the clean gloves. Noted she didn't sanitize her hands in between the glove changes. Surveyor noted the sputum changed to a white/ yellow thick mucus from the previous observation on 06/14/21.

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Surveyor asked RN1 when she changed her gloves does she need to sanitize her hands? RN1 stated, "Yes, I do." When asked why she didn't suction the resident before providing the care she responded that she suctions her as needed (prn). I usually check on her at least every hour. If she has a lot of drainage, I suction her trachea. Sometimes when the CNA changes her, the trachea collar gets misplaced, so I come to check and see if she needs attention (refer F880).

Surveyor reviewed the facility's "Quality of care Respiratory Care/ Tracheotomy Care & Suctioning" policy dated 07/2018. "Purpose: To provide residents with necessary respiratory care and services that are in accordance with professional standards of practice, the residents care plan..."

On 06/17/21, surveyor reviewed the "Competency Check-Tracheostomy Care" dated March 2018, that was provided by the SDD:
"Performance criteria: ... Suctioning a Tracheostomy Tube... 16) Attach the catheter to suction. 17) Insert the catheter into the trachea without suction. 18) Apply suction intermittently while rotating the catheter and withdrawing it from the trachea. 19) Wrap disposable suction catheter around the sterile dominant hand while withdrawing it from the tracheal tube."

Surveyor reviewed the TAR for R184 on 06/18/21 at 03:00 PM.
April 2021. R184 was suctioned once on 04/27 at 10:30 AM.
May 2021. R184 was suctioned on 05/01 at 11:05 AM and 05/11 at 10:00 AM.

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F 695	Continued From page 55 June 2021. R184 was suctioned on 06/14 at 04:11 AM. Surveyor observed RN2 suction R184 on 06/14/21 at 2:15 PM, no documentation was found on the TAR that R184 was suction by RN2. Surveyor interviewed the UD9 on 06/18/21 at 11:07 AM. Surveyor asked UD9 how are you as the unit manager monitoring your staff for compliance ensuring that they are providing the trachea care within professional nursing standards of practice? The Nurse Educator does the inservices for the staff. Periodically when they are giving care I go in and check on them. If they are providing the care incorrectly I will take them aside and talk to them, they may be referred back to the nurse educator and will get additional 1:1 education. Surveyor asked if she had any documentation that shows when and how the staff are being monitored and what is the outcome? UD9 was not able to show the surveyor documentation to show the staff are being monitored for competency in providing trachea care. (Refer F726)	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview with staff members, the facility failed to ensure dialysis care and services were provided	F 698	CORRECTIVE ACTION R162 fluid restriction plan was developed based on new physician order and care	7/29/21

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F 698	Continued From page 56 to meet the needs for one resident, R162, of two residents sampled for dialysis. The facility failed to develop fluid parameters for R162 who is non-compliant with renal dietary requirements. This deficient practice has the potential to result in fluid overload and further affect the resident's health. Finding includes: R162 was re-admitted after an acute hospitalization on 02/01/21 requiring hemodialysis treatment. Diagnoses include, end stage renal disease, hemiplegia and hemiparesis (paralysis affecting one side of the body) following cerebral infarction (stroke) affecting right non-dominant side, dysphagia (difficulty swallowing), dysarthria (difficulty speaking), Type 2 diabetes mellitus (high blood sugar) with diabetic neuropathy (nerve damage caused by high blood sugar). On 06/14/21 at 09:36 AM, observation and interview was conducted with R162. The resident was observed sitting up in bed, holding his "Snoopy" dog to his chest. R162 reported he goes for hemodialysis on Monday, Wednesday and Friday evening for four hours and experiences nausea and vomiting following dialysis. The resident was eating his breakfast which consisted of a sausage, biscuit and cereal. R162 also had an empty container of instant ramen, he confirmed that he drank the soup from the ramen. R162 also reported he drank water for breakfast, had a cup of ice, an opened can of sugar-free soda, an opened bottle of juice and an unopened bottle of juice on his tray. On 06/15/21 at 08:31 AM, R162 was observed to have eaten instant ramen for breakfast and drank a cup of water and had an opened water bottle. On	F 698	plan updated to reflect current interventions. IDENTIFICATION OF OTHERS Residents requiring hemodialysis who are non-compliant with fluid and dietary restrictions are at risk. An audit was conducted of residents receiving hemodialysis to verify that care plans reflect current physician orders related to dietary and fluid restrictions. Residents identified with fluid restrictions were reviewed for compliance with fluid restriction. Identified issues were addressed. SYSTEMIC CHANGES DON/designee re-educated LN and CNAs, on 6/18/21, regarding implementation of fluid restrictions, including coordination with dietary and documentation of fluid intake. LNs re-education included up-dating care plans when physician orders change so care plan reflects current interventions and resident response. New admissions on hemodialysis will be reviewed during next morning clinical meeting to identify potential fluid restriction needs. Care plan will be reviewed and updated, as needed. MONITORING DON/designee to audit care plans for new admissions receiving hemodialysis and current dialysis residents with new orders to verify care plans reflect current physician orders for dietary and fluid restrictions and resident non-compliance,	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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06/17/21 at 08:10 AM, R162 was requesting a grilled cheese sandwich for breakfast.

Record review done on 06/16/21 at 12:43 PM noted that R162 was prescribed a consistent carbohydrate diet, mechanical soft texture, thin consistency. There was no physician order for fluid restriction.

Review of the care plan on 06/16/21 at 01:00 PM notes under the focus area of hydration, R162 noted to be at risk for dehydration or potential fluid deficit related to needing assistance to access fluids, variable intake, constipation and on diuretics. Interventions include: encourage intake of water or sugar free beverages rather than juice (date initiated: 06/08/20); monitor/document/report PRN [as needed] signs and symptoms of dehydration (date initiated: 06/14/19); operation H20 [water], offer and encourage the resident to drink at least 240 ml [mililiters] of fluids four times per day (date initiated 02/03/21).

The focus area of "metabolic" to address fluid overload or potential fluid volume overload related to kidney failure, sometimes refuses dialysis, history of edema, eating outside food and asking for high sodium foods include interventions of providing diet as ordered and monitor/document/report PRN any signs and symptoms of fluid overload.

The focus area for use of diuretic therapy due to chronic kidney disease include interventions to administer diuretic medications as ordered; monitor/document/report PRN adverse reactions to diuretic therapy; and report pertinent lab results to physician (especially hematocrit [blood count]

Provider's Plan of Correction (F 698):

4 random residents/week x 4 weeks, then 2 residents/week x 2 months.
Findings will be reported to facility QAPI Committee monthly x 3 months or until a lesser frequency is deemed appropriate.

Compliance date 7/29/21
DON is responsible for ongoing compliance.

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test, sodium and potassium).

The care plan did not include parameters for fluid restriction and resident was placed on Operation H20 to encourage him to drink at least 960 ml a day. The care plan did not address R162's non-compliance with fluid intake or renal diet.

A review of the Dietary Profile dated 02/01/21 noted R162 on renal diet with no fluid restrictions. The Registered Dietitian (RD) spoke with resident's mother on 02/05/21 regarding current texture and how to safely bring in outside food. R162 was placed on supplement, four ounces of healthshake once a day.

A review of the quarterly Dietary Report dated 05/12/21 noted R162 was on a renal diet with fluid restriction, with no documentation of how many ml per day is required. The RD noted R162 eats outside food and orders food outside of his diet order. The progress note of 05/12/21 documented R162 had additional hemodialysis on 05/11/21 due to fluid overload. The lab results show high potassium levels and low phosphate levels. The RD encouraged resident to avoid excessive fluids and foods high in sodium which contribute to fluid retention.

Interview with the UD5 was done on 06/17/21 at 08:34 AM at the nursing station. UD5 reported the resident is non-compliant with his diet, family members will bring in food for him that he shouldn't have: sodas, chicken platters, sushi, salmon, and instant ramen. UD5 further reported R162 will get angry at his parent, call to bring food and will also refuse to eat. UD5 stated they have reviewed risk vs. benefits with R162 related to food and drinking juice and soda. Inquired

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F 698	Continued From page 59 whether R162 had fluid restrictions. UD5 responded there is no documentation of fluid restriction. On 06/18/21 at 09:06 AM an interview and concurrent record review was conducted with Registered Dietitian (RD)1. Inquired whether R162 has fluid restrictions and asked why the care plan for hydration notes to encourage fluids (Operation H20). The RD reviewed the resident's care plan and found that Operation H20 was no longer included in the resident's care plan. RD1 stated fluid restriction was added to the physician orders yesterday (06/17/21) for 1500 ml and previously there were no fluid restrictions for R162. RD1 explained she is not the assigned RD and was asked to evaluate R162 as he has a history of non-compliance with drinking and eating and he also missed another dialysis requiring addition of another hemodialysis treatment. RD1 noted due to fluid overload and the need to pull out more fluids, R162 has nausea after treatment. RD1 met with R162 regarding fluid restriction to 1500 ml. The RD explained to the resident one bottle of his drinks is 500 ml. RD1 implemented a plan to decrease fluids provided by the facility as R162 receives drinks from outside and the fluids provided by the facility were split between dietary and nursing to try to limit the resident's fluids as much as possible.	F 698		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest	F 726		7/29/21

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F 726	Continued From page 60 practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide competent nursing care and treatment in accordance with professional standards of practice as evidenced by the following: Nursing staff who have been trained annually on respiratory/ tracheostomy care failed to demonstrate competency in providing safe accurate and prudent care of the resident with a tracheostomy. Nursing management failed to provide supervision and ensure its nursing staff	F 726	CORRECTIVE ACTION RN1 and RN2 were provided with 1:1 re-education with return demonstration related to caring for a tracheostomy. IDENTIFICATION OF OTHERS Residents with a tracheostomy are at risk. There are currently no additional residents requiring tracheal care. SYSTEMIC CHANGES DON/designee on 6/18/21, re-educate LN	

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demonstrated competency to provide safe and accurate tracheostomy care.
These deficient practices compromised the resident's respiratory status and placed the resident at greater risk for severe illness and infection. This has the potential to affect all residents needing tracheostomy care.

Finding includes:

On 06/14/21 at 02:12 PM, surveyor entered R184's room and noted her tracheostomy collar was not on correctly, it was tied in place on her neck facing the wrong way, the collar was not positioned over the tracheostomy opening. The trachea collar provides humidified air to R184's trachea. Surveyor noted R184 coughing forcefully, expectorating thick white secretions from the tracheostomy. R184 appeared to have increased respirations and right arm was noted with a slight tremor with each heavy cough. At 02:16 PM surveyor went out to the hallway to ask Registered Nurse (RN) 2 to assist the resident. RN2 came in to the room to provide R184 with tracheostomy care. Surveyor noted RN2 didn't sanitize hands when taking off the soiled gloves and before putting on the sterile glove from the suction kit. When going into R184's trachea with the suction catheter she was noted to apply suction when going into and out of the trachea. Resident continued to cough and expectorate mucus. Also noted the RN2 didn't have control of the suction tube which fell onto the residents neck.

Surveyor reviewed care plan dated 02/24/21 on 06/16/21 03:02 PM. R184's care plan states the following:
"Problem: Respiratory. Resident has a

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working on units with tracheostomy residents regarding caring for a tracheostomy. Re-education will include suctioning and infection control and will include a return demonstration.
DON/designee will perform PRN random observations of LN providing trach care and provide 1:1 education, as needed.When a resident with a tracheostomy is admitted to a unit, education will be provided, at the time of admission, to staff who work the unit followed by return demonstration competencies for staff. Suctioning competency completion will be done for LNs annually.

MONITORING
DON/designee will observe trach care being performed 5 times/week x 4 weeks, then 3 times/week x 2 months.
Findings will be reported to facility QAPI Committee monthly x 3 months and if needs are identified in our audits, then we will start to audit again.
Date of Compliance: 7/29/2021
DON is responsible for on-going compliance.

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tracheostomy.
At risk for ineffective airway clearance.
Provide tracheostomy care as ordered.
Suction as needed for congestion or increased secretions."

Surveyor interviewed the UD9 on 06/16/21 at 03:23 PM. Surveyor asked UD9 if the staff who take care of R184 receive training prior to coming to work on the floor. The UD9 responded that the training is provided by the SDD. When asked if the resident is being evaluated to determine her status as a stable trachea patient and how often? Replied that the doctors see her every month and evaluate her, she is a stable trachea patient.

Surveyor interviewed the SDD on 06/16/21 at 03:53 PM and asked if nursing staff are provided trachea care and suctioning at annual training and training to new hires. There is nothing specific. We provide 1:1 education to staff if they need additional training and they do spot checks on staff.

Surveyor requested the training content and documentation from the SDD how staff are being monitored on the unit providing the care (spot checks).

Surveyor interviewed the SDD on 06/17/21 at 09:53 AM. Surveyor asked how they monitor staff who are providing trachea care to ensure compliance and that they are competent. SDD replied "Usually the unit manager will provide the spot checks. If there is a concern about the skill being provided I will work with the staff 1:1. There is no monitoring documentation available" (for the staff i.e. spot checks).

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Surveyor observed RN1 on 06/17/21 at 10:13 AM providing trachea care to R184. RN1 pulled off trachea collar, noted thick white sputum on the washcloth on R184's chest around the trachea. RN1 removed the secretions with a napkin and threw it in a garbage bag resting on the floor next to the bed. RN1 took off gloves and set up a sterile field. Noted RN1 poor out the hydrogen peroxide and Normal saline into the small boxes from the kit. RN1 applied the clean gloves. Noted she didn't sanitize her hands in between the glove changes. Surveyor noted the sputum changed to a white/ yellow thick mucus from the previous observation on 06/14/21.

Surveyor asked RN1 when she changed her gloves does she need to sanitize her hands? RN1 stated, "Yes, I do." When asked why she didn't suction the resident before providing the care she responded that she suction's her as needed (prn). "I usually check on her at least every hour. If she has a lot of drainage, I suction her trachea. Sometimes when the CNA changes her, the trachea collar gets misplaced, so I come to check and see if she needs attention." (refer F880).

Surveyor reviewed the facility's policy, "Quality of care Respiratory Care/ Tracheotomy Care & Suctioning" dated 07/2018. "Purpose: To provide residents with necessary respiratory care and services that are in accordance with professional standards of practice, the residents care plan..."

On 06/17/21, Surveyor reviewed the "Competency Check-Tracheotomy Care" dated March 2018 that was provided by the SDD. "Performance criteria: ...Suctioning a Tracheostomy Tube...16) Attach the catheter to

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F 726	Continued From page 64 suction. 17) Insert the catheter into the trachea without suction. 18) Apply suction intermittently while rotating the catheter and withdrawing it from the trachea. 19) Wrap disposable suction catheter around the sterile dominant hand while withdrawing it from the tracheal tube." Surveyor interviewed the UD9 on 06/18/21 at 11:07 AM. Surveyor asked UD9 how are you as the unit manager monitoring your staff for compliance ensuring that they are providing the trachea care within professional nursing standards of practice? The Nurse Educator does the inservices for the staff. Periodically when they are giving care I go in and check on them. If they are providing the care incorrectly I will take them aside and talk to them, they may be referred back to the nurse educator and will get additional 1:1 education. Surveyor asked if she had any documentation that shows when and how the staff are being monitored and what is the outcome? UD9 was not able to show the surveyor documentation to show the staff are being monitored for competency in providing trachea care. (Refer F726)	F 726		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide adequate care to maintain R506's highest practicable	F 744	CORRECTIVE ACTION Education provided on individualized interventions for managing	7/29/21

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F 744	Continued From page 65 mental and psychosocial well-being. This has the potential to affect all residents with dementia in the facility. Finding includes: Initial observation of R506 was made on 06/14/21 at 09:14 AM. She was sitting up in her wheelchair in the hallway of the nursing unit, holding a piece of paper, stating "I don't know anything." She had a faded blue bruise to her right eye. A subsequent observation of R506 on 06/15/21 at 09:33 AM revealed R506 in the same situation as on 06/14/21. Surveyor attempted an interview with R506, but was unable to, due to her confusion. She was holding a paper with Japanese writing, translated to English. In a frustrated tone, she asked surveyor, "What day today?" "How long I here?" and "Is my son coming today?" CNA2 assisted R506 by pointing to the Japanese writing and answering her questions in simple English. On 06/15/21 at 12:31 PM, an abbreviated resident representative interview was done with R506's son. He stated that R506 communicates mostly in Japanese and that the staff member that assists with interpreting or engages in conversation with R506 is not fluent in Japanese. He further stated that the facility had difficulty finding a Japanese interpreter. On 06/16/21 at 11:05 AM, R506's EHR was reviewed. She was admitted on 06/02/21 for a right hip fracture and had a diagnosis for "unspecified dementia with behavioral disturbance." Admission MDS dated June 5, 2021, revealed under "Section B Hearing,	F 744	"MOOD/BEHAVIOR and preferred activities for R506. IDENTIFICATION OF OTHERS All residents residing in a facility are at risk. An audit was conducted to identify residents with behavior and communication issues. care plan audit was completed for individualized interventions for managing confusion, "MOOD/BEHAVIOR" and preferred activities. There are no additional residents care plan found without communication, mood/behavior issues related to foreign language. SYSTEMIC CHANGES The DON/designee on 6/18/21 re-educated LN, social services and activities staff regarding individualized interventions for managing "MOOD/BEHAVIOR" and preferred activities. MONITORING DON/designee will observe that the care plan intervention of R506, and other residents with confusion, mood/behavior are being performed 5 times/week x 4 weeks, then 3 times/week x 2 months. Findings will be reported to facility QAPI Committee monthly x 3 months or until a lesser frequency is deemed appropriate. Date of Compliance: 7/29/2021 DON is responsible for on-going compliance.	

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Speech, and Vision": "B0700. Makes Self Understood" coded as "2. Sometimes understood."; "B0800. Ability To Understand Others" coded as "2. Sometimes understands."; under "Section C Cognitive Patterns": "Brief Interview for Mental Status (BIMS)," "C0500. BIMS Summary Score" "01" which indicates severe impairment.

Review of R506's care plan showed no individualized interventions for managing her "MOOD/BEHAVIOR."

An "Activities/Recreation - Initial Review" note stated: "...she prefers to participate in independent activities such as resting, watching TV, and engaging in physical therapy. Staff will provide her leisure supplies as needed and encourage her to engage in social stimulation." Her TAR for 1:1 activity showed no data for the look back date of 30 days. The TAR for independent activity showed one activity done on 06/02/21, 06/07/21, 06/10/21, and 06/14/21.

On 06/16/21 at 01:12 PM, R506 was observed to be sitting in her wheelchair in the doorway of her room, repeatedly stating, "I don't know nothing" and looking frustrated. She did not have her paper with the Japanese writing and English translations.

An interview was done with the AD on 06/16/21 at 01:16 PM in the conference room. For residents with dementia, they "try to provide them (activities) as much as we can...try to provide two - three times per day."

In an interview with RN5 on 06/17/21 at 11:26 AM, he stated that R506 "understands some

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English." For residents with a language barrier, he stated that they would utilize the Language Line for interpreting. He stated that for R506, "One of the therapists wrote down some notes. No staff can speak Japanese, you need to be patient answering her, be calm. Offer to keep her busy." Surveyor asked for clarification about having staff that were able to speak Japanese and he stated, "There are therapists that speak Japanese, but they don't work on this floor. I don't know why they don't work on this floor."

An interview was done with the Director of Therapies (DOT) on 06/18/21 at 08:38 AM in the Therapies department. She stated that the therapists are assigned by floors and that a therapist strictly for Kaiser residents is assigned to the floor where R506 resides because of short term rehabilitation. She stated that the therapist who speaks fluent Japanese is assigned to a different floor. She further stated, "If they have a difficult time with communication, then I'll assign. I haven't heard anything from the unit manager."

In an interview with the UD8 on 06/18/21 at 09:04 AM, she stated that R506 needs someone to talk to because her attention span is short. She also stated that she would ask the recreations department to assist with providing activities for residents with dementia and ask for individual activities, reading material or someone to talk with the resident. She further stated for R506, "I will ask activities to provide Japanese magazines and music." (Refer F679)

F 758 SS=D — Free from Unnec Psychotropic Meds/PRN Use — F 758 — 7/29/21

CFR(s): 483.45(c)(3)(e)(1)-(5)

§483.45(e) Psychotropic Drugs.

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§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and

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HALE NANI REHABILITATION AND NURSING CENTER	1677 PENSACOLA STREET HONOLULU, HI 96822

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 69 indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff members, the facility did not ensure that one of five residents were reviewed for unnecessary medications. The facility did not assure the indication for use of psychotropic medications to treat a specific, diagnosed and documented mental health disorder, was done. R70 received psychotropic medications, the efficacy of the medications and the dosage to treat the resident was not being monitored as the facility did not identify the resident's targeted behaviors (i.e., insomnia). This deficient practice has the potential to result in the unnecessary use of psychotropic medication. Finding includes: R70 was admitted to the facility on 08/05/19. Diagnoses include, but not limited to unspecified dementia with behavioral disturbance, borderline personality disorder and major depressive disorder (recurrent, moderate). Record review was done on 06/16/21 at 02:32 PM. A review of the physician order for June 2021 found orders for Risperidone (antipsychotic medication) tablet 0.25 milligram (mg) (give 0.125 mg by mouth at bedtime related to unspecified dementia with behavioral disturbance) and Trazodone HCI tablet 100 mg (give 125 mg by	F 758	CORRECTIVE ACTIONS R70s Behavior Monitoring was updated so targeted behaviors and care plan were consistent with physician orders and observed behaviors. IDENTIFICATION OF OTHERS Residents receiving psychotropic medications requiring behavior monitoring are at risk. An audit was conducted of residents requiring behavior monitoring to verify that monitored behaviors were consistent with the care plan and physician orders and reflective of residents behaviors. Identified issues were addressed. SYSTEMIC CHANGES DON/designee on 6/18/21, re-educated LN related to monitoring identified behaviors requiring treatment with medication, including care plan and monitors being consistent with physician orders. New admits with orders for psychotropic medications will be reviewed during the next morning clinical meeting to verify monitoring of targeted behaviors has been implemented and is consistent between physician orders, care plan and behavior	

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F 758 Continued From page 70

mouth at bedtime related to insomnia, unspecified, please offer medicine to resident at 08:00 PM). Further review found a dose reduction for Risperidone on 06/08/21 from twice daily to once daily. On 05/20/21, there was an increase in Trazodone due to resident's complaint of insomnia.

The physician ordered monitoring of targeted behaviors for the use of Risperidone, afraid/panic, angry, screaming/yelling, danger to self, danger to others, hallucinations, and delusions. The physician also ordered monitoring of targeted behaviors for the use of Trazodone (antidepressant), difficulty sleeping/staying asleep at night, and suicidal interventions.

A review of R70's care plan noted a focus area for use of antidepressant medication which identified R70 had a history of endangering others by throwing things, irritability, anxiety, suicidal ideation and history of not being able to sleep. The focus area for use of an antipsychotic noted R70 has had periods of throwing things, can be irritable and anxious, suicidal ideation (history of suicidal attempts in the past), elopement, hiding medications without staff knowing, and verbalizing she'd rather die than to come back or stay in the facility.

A review of the Administration: Monitoring sheet for June 2021 noted Trazodone (antidepressant) was prescribed for difficulty sleeping/staying asleep at night. There was no documentation of R70's number of hours of sleep or ability to stay asleep at night. The identified target behaviors on the monitoring sheet are not congruent with the behaviors identified in R70's care plan.

F 758

monitors.

MONITORING
DON/designee will audit residents with new or changed orders for psychotropic medications to verify monitors have been initiated and are consistent in the medical record, 5 residents/week x 4 weeks, then 4 residents/week x 2 months.
Findings will be reported to facility QAPI Committee monthly x 3 months or until a lesser frequency is deemed appropriate.

Date of Compliance: 7/29/2021
DON is responsible for on-going compliance.

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F 758	Continued From page 71 ADON provided copies of the physician orders, behavior monitoring (June 2021) and care plan on 06/17/21 at 11:20 AM. During an interview on 06/17/21 at 11:50 AM in the DON office, the ADON confirmed the targeted behaviors for the use of the psychoactive medications did not match the resident's symptomatology related to the use of the medications.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		7/29/21

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F 761	Continued From page 72 Based on observation and interview, the facility failed to properly lock a medication cart when a licensed practical nurse (LPN)1 left the cart unattended. This deficient practice can result in the medications being tampered with or stolen and can potentially affect all residents in the facility. Finding includes: On 06/17/21 at 10:10 AM, surveyor walked into a nursing unit and approximately 20 feet down the hallway, the surveyor could see LPN1 with her back facing the medication cart. The bottom drawer was open and she was talking to staff sitting at the nursing station approximately four feet away. A resident was ambulating in the hallway with his walker, half-way between the surveyor and LPN1. LPN1 saw the surveyor and she immediately closed the medication drawer. An interview was conducted with LPN1 on 06/17/21 at 03:34 PM at the unit's nursing station. She acknowledged that the medication cart is to be secured at all times.	F 761	CORRECTIVE ACTIONS Medication carts are being kept locked. LPN1 was re-educated regarding keeping medication carts locked. IDENTIFICATION OF OTHERS Residents residing in the facility are at risk. SYSTEMIC CHANGES DON/designee on 6/18/21 re-educate LN, regarding keeping medication carts locked when not in use or not attended. MONITORING DON/designee will conduct random observations of medication carts on random units to validate carts are locked and drawers are closed, 4 carts/week x 4 weeks, then 3 carts/week x 2 months. Findings will be reported to facility QAPI Committee monthly x 3 months or until a lesser frequency is deemed appropriate. Date of Compliance: 7/29/2021 DON is responsible for on-going compliance.	
F 778 SS=D	Assist w/ Transport Arrangements to Radiology CFR(s): 483.50(b)(2)(iii) §483.50(b)(2)(iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to assist R142 in making an	F 778	CORRECTIVE ACTION R142 x-ray was re-scheduled, and	7/29/21

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F 778

Continued From page 73

appropriate transportation arrangement for a follow up x-ray appointment scheduled on 04/13/21.

Finding includes:

During an interview with R142 on 06/14/21 at 12:33 PM, R142 said that he was brought to a wrong location for a follow up x-ray appointment on his leg scheduled on 04/13/21.

Record review for R142 showed that he was admitted to the facility on 01/14/17 with a diagnosis of Major Depressive Disorder, Psychosis (mental illness), Anxiety, Seizures, Spondylosis with Myelopathy (spinal cord injury), Hypothyroidism (low thyroid hormone), Anemia (low blood count). R142 requires assistance when getting in and out of bed and uses a wheelchair for mobility.

Further record review showed that the transportation arrangement made for R142's follow up x-ray appointment was wrong and R142 was brought to a wrong clinic location in Honolulu instead of the hospital location in Moanalua where appropriate medical assistance could have been provided. As a result, the follow up x-ray appointment was cancelled and needed to be rescheduled for another day.

F 778

transportation was provided to the location. Resident was accompanied to the appointment by a staff member. The scheduler was provided 1:1 education related to verifying appointment addresses.

IDENTIFICATION OF OTHERS
Residents with appointments outside of the facility who require assistance with transportation are at risk. An audit was conducted to confirm that currently scheduled transportation to appointments is scheduled for the correct location. No incorrect addresses were found.

SYSTEMIC CHANGES
Administration/designee on 6/18/21 re-educated Medical Records staff, regarding the process for scheduling transportation and required staff escorts to outside appointments, including verifying the location and address of the appointment.

MONITORING
Medical Records Director will audit transportation list 3 x/week x 4 weeks, then 5 random appointments/week x 2 months to verify transportation information is consistent with scheduled appointments and escorts are provided as needed. Findings will be reported to facility QAPI Committee monthly x 3 months or until a lesser frequency is deemed appropriate.

Date of Compliance: 7/29/2021
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F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and	F 791		7/29/21

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F 791	Continued From page 75 §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to assist R142 in making an appropriate transportation arrangement for a dental appointment scheduled on 05/22/21. The facility also failed to follow up with a dental appointment for R146 who was examined by the facility dentist and recommended a referral to R146's private dentist. Findings include: 1) During an interview with R142 on 06/14/21 at 12:35 PM, R142 said that he was dropped off and left at a wrong location for a dental appointment scheduled on 05/22/21. Record review for R142 showed that he was admitted to the facility on 01/14/17 with a diagnosis of Major Depressive Disorder, Psychosis, Anxiety, Seizures, Spondylosis with Myelopathy, Hypothyroidism, Anemia. R142 requires assistance when getting in and out of bed and uses a wheelchair for mobility. Further record review showed that the transportation arrangement made for R142's dental appointment was wrong and R142 was brought to and left at a wrong location in Honolulu instead of the Aiea location as scheduled. As a result, the dental appointment was cancelled and needed to be rescheduled. 2) Surveyor interviewed R146 on 06/15/21 at 10:18 AM. R146 is a 79 year old alert female.	F 791	CORRECTIVE ACTION R142 dental appointment was re-scheduled. Transportation and staff escort was provided to the appointment as scheduled. R146 has an appointment scheduled with her personal dentist to follow-up on facility dentist visit and as requested by resident. Transportation to the personal dentist is scheduled. IDENTIFICATION OF OTHERS Residents with dental appointments outside of the facility or needing dental appointments outside of the facility are at risk. An audit was conducted of residents seen by the facility dentist on his last visit to the facility to identify if additional follow-up was recommended. No other issues were identified. SYSTEMIC CHANGES Facility-contracted dentist will provide post-evaluation reports to the LN responsible for the resident to review. The consult report forms will then be given to Medical Records to schedule any needed follow-up and arrange transportation as needed. Medical Records will inform LN of scheduled follow-up. DON/designee educated LN and Medical Records staff regarding new process for	

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F 791	Continued From page 76 When surveyor asked R146 if she was currently having problems with her teeth or dentures she replied, "I am missing a tooth, on the top. It does bother me. The dentist who works here came by and looked at my teeth but he didn't do anything. I would like to have the tooth fixed and I would like to see my own private dentist." On 06/16/21 at 01:11 PM, R146's EHR was reviewed. The MDS with an ARD of 05/02/21 revealed: "Section C. Cognitive patterns. Total Brief interview for mental status (BIMS) 11. Section L. Oral/ Dental Status. D. Obvious or likely cavity or broken natural teeth. #11 broken." R146's care plan dated 11/02/20 showed: "At risk for oral/dental health problems. Has broken upper teeth. Monitor/document/report as needed any signs and symptoms of oral/dental problems needing attention: Pain (gums, toothache, palate), Abscess, Debris in mouth, Lips cracked or bleeding, loose, eroded, decayed, Tongue (black, coated, inflamed, white, smooth), Ulcers in mouth, Lesions. Obtain dental consult or referral as indicated." Surveyor interviewed the UD5 on 06/18/21 at 10:47 AM. Surveyor asked UD5 regarding R146 broken tooth and the alleged dental visit. What is the process for referring a resident out to a dentist? UD5 checked the medical record and stated, "She had a dental consult as needed. There is a dental consult from 2/22/21. It was a visual exam done, natural teeth present, oral hygiene good, #11 broken, no infection. Recommendation: Will treat, follow up as needed. Checking to see if there was a follow	F 791	dental appointment follow-up on 6/18/2021. MONITORING Medical Records Director will audit transportation list 3 x/week x 4 weeks, then 5 random appointments/week x 2 months to verify transportation information is consistent with scheduled appointments and escorts are provided as needed. Findings will be reported to facility QAPI Committee monthly x 3 months or until a lesser frequency is deemed appropriate. Date of Compliance: 7/29/2021 DON is responsible for on-going compliance.	

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F 791	Continued From page 77 up." UD5 reviewed the consult report. "The note said, patient will call her dentist." UD5 stated, R146 "can tell the nurse on the floor that she wants to be seen by her private dentist, then the unit manager can call the dentist and make the appointment. Maybe the dentist assumed R146 would call her dentist. We can call the dentist for her. If they're vaccinated its okay for them to go out."	F 791		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		7/29/21

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F 880	Continued From page 78 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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F 880	Continued From page 79 Based on observation, interview and record review, the facility failed to provide care in accordance with professional infection control and prevention practices for two residents, R184 and R37, in the following scenarios: While providing trachea care and suctioning for R184 the RN dropped the suction catheter on the residents dirty gown then inserted the catheter into the trachea. Additionally neither of the two RN's providing trachea care and suction sanitized their hands after removing the dirty gloves then donning the sterile gloves. Residents reported that staff members dropped their wash cloth on the floor during showers. The staff member picked up the washcloth and placed it on the side (not getting a clean wash cloth) then used the same washcloth that fell on the shower floor to shower the resident with. There is one communal shower on the unit where the dirty washcloth was used. Nursing staff cleaned the blood pressure monitoring equipment between residents and placed the clean equipment into the dirty storage basket while monitoring the blood pressure for R37. There was no separation for storing clean items that were previously used by the resident. The deficient practice increases the residents risk for transmission of communicable disease and infection in the facility and has the potential to affect all residents in the facility. Findings include: 1) On 06/14/21 at 02:12 PM, surveyor entered R184's room and noted her tracheostomy collar was not on correctly, it was tied in place on her neck facing in the wrong position instead of being positioned over the tracheostomy opening. The	F 880	CORRECTIVE ACTION Education provided on CNA3 related to sanitizing multi-resident equipment and RN1 and RN2 related to trach care. IDENTIFICATION OF OTHERS Residents residing in the facility may be at risk. SYSTEMIC CHANGES The DON/designee on 6/18/21 re-educated LN and CNAs related to general infection control practices, including sanitizing multi-resident VS equipment between residents, not using something that has fallen on the floor and sanitizing hands when removing soiled gloves. Staff will bring in additional washcloths in the shower rooms, accessible during showers, for easy access if a cloth is dropped on the floor. LN working on the unit with a resident with a tracheostomy were re-educated regarding provision of tracheostomy care and suctioning.When a resident with a tracheostomy is admitted to a unit, education will be provided, at the time of admission, to staff who work the unit followed by return demonstration competencies for staff. Suctioning competency completion will be done for LNs annually. MONITORING DON/designee will conduct random observations of staff to verify hand sanitizing when removing soiled gloves. and sanitizing of multi-resident VS equipment between residents, 5	

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F 880	Continued From page 80 trachea collar provides humidified air to R184's trachea. Surveyor noted R184 coughing forcefully, expectorating thick white secretions from the tracheostomy. At 02:16 PM surveyor went out to the hallway to ask RN2 to assist the resident. RN2 came in to the room to provide R184 with tracheostomy care. Surveyor noted RN2 didn't sanitize hands when taking off the soiled gloves and donning the sterile gloves from the suction kit. Surveyor reviewed care plan dated 02/24/21 on 06/16/21 03:02 PM. R184's care plan states the following: "Problem: Respiratory. Resident has a tracheostomy. At risk for ineffective airway clearance. Will have no signs and symptoms (S/sx) of infection through the review date. Provide good oral care daily and PRN. Provide tracheostomy care as ordered. " Surveyor observed RN1 on 06/17/21 at 10:13 AM providing trachea care to R184. RN1 pulled off trachea collar, noted thick yellow/ white sputum on the washcloth on R184's chest around the trachea. RN1 removed the secretions with a napkin and threw it in a garbage bag resting on the floor next to the bed. RN1 took off gloves and set up a sterile field. RN1 applied the clean gloves noting that she didn't sanitize her hands in between the glove changes. Surveyor noted the sputum changed to a white/ yellow thick mucus from the previous two days. Surveyor asked RN1 when she changed her gloves does she need to sanitize her hands? RN1 stated yes, I do. Surveyor reviewed the facility's policy, "Quality of care Respiratory Care/ Tracheotomy Care &	F 880	observations/week x 4 weeks, then 3 t/week x 2 months. DON/designee will observe trach care being performed 5 times/week x 4 weeks, then 3 times/week x 2 months. Findings will be reported to facility QAPI Committee monthly x 3 months and if needs are identified in our audits, then we will start to audit again. Date of Compliance: 7/29/2021 DON is responsible for on-going compliance.	

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Suctioning" dated 07/2018. Guidelines: 2. k. "Infection control measures during implementation of care, handling, cleaning, ...for infection control practices of ...tracheostomy care..."

On 06/17/21, surveyor reviewed the "Competency Check-Tracheotomy Care" dated March 2018 that was provided by the SDD.
"Performance criteria: ... 6) Washed hands and applied clean gloves, face shield and other PPE if needed. Suction resident. ... 10) Open brush package and place aseptically into basin. ... Suctioning a Tracheostomy Tube. ... 14) Open suction catheter Apply sterile glove to dominant hand. Note: The suction catheter should be removed from the package with the dominant hand after application of the sterile glove. 15) Wrap the catheter tubing around the hand from the tip of the catheter down to the port end."

Surveyor interviewed the UD9 on 06/18/21 at 11:07 AM. Surveyor asked how are you as the unit manager monitoring your staff, ensuring they are providing the trachea care within professional nursing standards of practice? The Staff Development Director (SDD) does the inservices for the staff. Periodically when they are giving care I go in and check on them. If they are providing the care incorrectly I will take them aside and talk to them, they may be referred back to the SDD and will get additional 1:1 education. Surveyor asked if she has any documentation that shows when and how you're doing your spot checks on the staff and what is the outcome? UD9 was not able to show the surveyor documentation to show the staff are being monitored for competency in providing trachea care. (Refer F726)

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2) Interview with RC on 06/15/21 at 09:59 AM was conducted in the activity room. Residents reported staff members dropping their washcloth on the floor during showers. It was reported staff member will drop the washcloth on the floor. The resident asks the staff member not to use the washcloth on the floor, commenting to staff member, hope you're not going to use that washcloth on me. The staff member picks up the washcloth, places it on the side (not getting a clean washcloth) and uses the washcloth that fell on the shower floor. The resident reported the request to not use the washcloth that fell on the floor is not honored and staff proceed to wash her peri area with the dirty washcloth. The other resident commented that this happens a lot. One resident is showered in a communal shower and the other resident's room has its own shower.

3) Interview with the RC on 06/15/21 at 09:49 AM in the activity room, residents reported occurrence of staff members running out of peri wipes while providing care. Resident reported that the bag has 100 wipes and sometimes staff need to use two or three at a time so the wipes run out fast. The resident noted one bag is often shared for two residents and oftentimes wipes runs out and staff will borrow wipes from another resident.

Interview was done with the UD5 on 06/18/21 at 08:16 AM. UD5 reported the peri wipes are dedicated to residents and are not to be shared between residents.

4) On 06/17/21 at 08:25 AM observed CNA3 taking R37's vitals (blood pressure, temperature, and pulse) in her room. The blood pressure (BP) machine was portable (on wheels) and had a

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F 880	Continued From page 83 basket to store the thermometer and pulse oximeter. A canister of disinfectant wipes was also stored on the cart. CNA3 was observed to place BP cuff on R37's forearm and placed the pulse oximeter clip on her finger. CNA3 used a touchless digital thermometer to take R37's temperature. After using the thermometer and pulse oximeter clip for R37, the items were placed in the basket. The BP cuff was rolled up and placed atop the blood pressure machine. CNA3 donned gloves and wiped down the BP cuff. She then wiped the pulse oximeter clip and thermometer and placed it back in the basket where she previously stored the equipment she used for R37. CNA3 was not observed to perform hand sanitizing before donning gloves. Although the pulse oximeter clip and thermometer were sanitized, it was placed back into the basket which previously stored the used items. There was no separation for storing clean and items that were previously used by the resident. Interviewed UD5 on 06/18/21 at 08:16 AM. Inquired what is the process for sanitizing shared equipment while taking residents' vitals. UD5 stated equipment is cleaned with each resident, then move on to the next resident. UD5 further clarified the thermometer is touchless, the BP cuff and pulse oximeter is sanitized. The observation of CNA3 was shared with the UD5. UD5 confirmed prior to donning gloves, hand sanitizing is performed. The UM also acknowledged the equipment used for R37 needed to be cleaned before placing equipment back into the basket.	F 880		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2)	F 908		7/29/21

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F 908

Continued From page 84

§483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and review of equipment service manual, the facility failed to ensure routine maintenance of the air particle filter, based on the manufacturer's recommendation, for one of four oxygen concentrators reviewed. This deficient practice put R22 at risk for the development and transmission of communicable diseases and infections and has the potential to affect all residents needing oxygen.

Finding includes:

During an observation, on 06/15/21 at 08:29 AM, of R22 ' s room, a NewLife Elite Oxygen Concentrator was noted at bedside providing oxygen to R22. The air particle filter located on the back of that oxygen concentrator appeared dirty with lint and/or dust on it.

A review of the EHR showed that R22 was admitted on 03/03/21 with a diagnosis of Conversion Disorder (unexplained nervous system symptom i.e. blindness), Paroxysmal Atrial Fibrillation (irregular heart rate), Alcohol Withdrawal, Malnutrition, Hypertension (high blood pressure), Benign Prostatic Hyperplasia (enlarged prostate gland), Urogenital Implants. R22 had a doctor's order to use oxygen.

On 06/17/21 at 02:32 PM, RN8 was queried about the air particle filter cleaning process. RN8 stated that the nursing staff did not clean that

F 908

CORRECTIVE ACTIONS
R22 air particle filter on the oxygen concentrator was cleaned and replaced according to manufacturer□s recommendation.

IDENTIFICATION OF OTHERS
Residents using oxygen concentrators are at risk.
A visual audit was conducted of air filters on oxygen concentrators to verify that the filter was in place and clean. Additionally, the visual audit of oxygen concentrators in use was compared to the Central Supply list to verify that each concentrator in use appeared on the list. No additional issues were identified.

SYSTEMIC CHANGES
Nursing staff will notify central supply clerk when an order for oxygen is received, and the oxygen concentrator will be added to the list for filter cleaning. Additionally, central supply staff will conduct walking rounds weekly to verify that each oxygen concentrator that is in use appears on the list for filter cleaning.
DON/designee educated LN and central supply staff regarding the process for oxygen concentrator tracking and filter cleaning on 06/18/2021.

MONITORING

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filter and that the Central Supply Department was responsible for that.

On 06/17/21 at 02:45 PM, Central Supply (CS) staff was queried about the air particle filter cleaning process. CS staff stated that they had a cleaning process in place for the filters to be changed on a weekly basis for all residents. However, CS staff revealed that R22 was not on the list of residents needing this air particle filter change. CS staff said that R22 may have moved rooms and thus not included in that list of residents.

On 06/18/21 at 03:00 PM, a review of the Service manual for the NewLife Elite Oxygen Concentrator - Filters stated the following: "Air enters the NewLife unit through an air intake gross particle filter located on the back of the oxygen concentrator. This filter removes dust particles and other large particles from the air. Before you operate the NewLife unit, make sure this filter is clean and positioned correctly."

DON/designee will audit Physician Orders for new oxygen orders and verify that the oxygen concentrators were added to the CS list, 5/week x 4 weeks, then 4/week x 2 months.
Findings will be reported to facility QAPI Committee monthly x 3 months or until a lesser frequency is deemed appropriate.

Date of Compliance: 7/29/2021
DON is responsible for on-going compliance.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/28/2021

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

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K 342 SS=C	Fire Alarm System - Initiation CFR(s): NFPA 101 Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 This REQUIREMENT is not met as evidenced by: K342 Fire Alarm Installation This standard is not met by: Based on observation and staff interview, the facility failed to provide a fire alarm system that meets the requirements of section 19.3.4.2.1 of the 2012 edition of the NFPA 101 Life Safety Code. Several manual fire alarm boxes were found to be mounted higher than the prescribed height of a minimum of 42" and maximum of 48" of the operating section off the floor. For example, fire alarm boxes located in Lewalani ground floor exit was measured at 59", Lewalani stairwell number 2 was measured at 60 ½", and the Pensacola 3rd floor exit was measured at 66". Findings include: Observations on 9/29 and 9/30/21 during the survey revealed that multiple fire alarm boxes were mounted above the prescribed height as required by the 2010 edition of the NFPA 72, National Fire Alarm Code, section 17.14.4. These finding does not affect the welfare of	K 342	1. Maintenance Director has scheduled repair work with System Service Specialists to lower fire alarm system boxes to between 42" to 48". 2. Residents have the potential to be affected by this practice. 3. The administrator re-educated maintenance staff on 10/7/2021 about the installation requirements for fire alarm system boxes. 4. Administrator/Designee will validate fire alarm box heights are within compliance after repair has been completed and report findings to the QAPI committee for evaluation of the effectiveness of the plan and further recommendations as appropriate.	11/15/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 10/15/2021

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

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K 342	Continued From page 1 residents, staff or visitors because the fire alarm is operable as designed when the fire drill was conducted on 9/30/21 at approximately 1120am. These findings were verified by staff and the Administrator on 9/30/21 at 115pm.	K 342	5. Compliance to be achieved by 11/15/2021	
K 345 SS=C	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: K345 Fire Alarm-Testing and Maintenance This standard is not met by: Based on record review and staff interview, the facility failed to provide the proper documentation to prove that the fire alarm system was inspected and tested at the proper frequency as required by section 9.6.1.3 of the 2012 edition of the NFPA 101 Life Safety Code. This finding would not affect the residents, staff, and visitors because the fire alarm is operable as designed as verified when a fire drill was conducted on 9/30/21 at approximately 1120am. Findings include: On 9/29/21 at approximately 1130 am during record review, it was indicated that the fire alarm system could not be tested due to an inoperable fire sprinkler tamper switch. The sprinkler tamper switch has been repaired; however, the fire alarm annual inspection and testing was not completed	K 345	1. Maintenance Director has scheduled a fire alarm inspection with System Service Specialists. 2. Residents residing in the facility have the potential to be affected. 3. Administrator re-educated Maintenance Director on 10/7/2021 about ensuring the fire alarm system is inspected as required by section 9.6.1.3 of the 2012 edition of the NFPA 101 Life Safety Code. 4. Administrator/Designee will validate fire alarm testing frequency one a week x 8 weeks. Administrator will report findings to the QAPI committee for evaluation of the effectiveness of the plan and further recommendations as appropriate. 5. Compliance will be achieved by 11/15/2021	11/15/21

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K 345	Continued From page 2 at the time of the survey as found during the exit interview with staff and the Administrator on 9/30/21 at approximately 115pm.	K 345		
K 531 SS=C	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: K531 Elevators The standard is not met by: Based on both record review and staff interview, the facility failed to produce a satisfactory elevator inspection report as required by section 9.4.6.3 of the 2012 edition of NFPA 101, Life Safety Code. This deficiency could affect all residents, staff, and visitors if the Firefighter's Service feature does not work during an emergency. Findings include:	K 531	1. Maintenance Director has scheduled necessary elevator repairs with Thyssenkrupp. 2. Residents residing in the facility have the potential to be affected. 3. Administrator re-educated the Maintenance Director on 10/7/21 regarding elevator inspection requirements per section 9.4.6.3 of 2012 edition of NFPA 101, Life Safety Code.	11/15/21

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K 531	Continued From page 3 On September 29th at approximately 1130am, during record review and staff interview, inspection reports indicate discrepancies on the most recent elevator testing by the vendor. On September 30th at approximately 115pm during the exit interview with staff and the Administrator, these findings were ascertained and also indicated that a work order with the vendor was in place.	K 531	4. Administrator/Designee will validate that elevator operation is compliant once a week x 8 weeks. Administrator will report findings to the QAPI committee for evaluation of the effectiveness of the plan and further recommendations as appropriate. 5. Compliance will be achieved by 11/15/2021	
K 918 SS=C	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and	K 918		11/15/21

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HALE NANI REHABILITATION AND NURSING CENTER	**1677 PENSACOLA STREET** **HONOLULU, HI 96822**

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K 918	Continued From page 4 readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: K918 Electrical Systems-Essential Electric System Maintenance and Testing This standard is not met as evidenced by: Based on record review and staff interview on September 30th at approximately 1245 pm, the facility failed to produce documentation of a satisfactory annual diesel fuel quality test as required by section 8.3.8 of the 2010 edition of NFPA 110, Standard for Emergency and Standby Power Systems. This deficiency could affect all residents, staff, and visitors during a power outage if the fuel system is contaminated. However, weekly and monthly emergency generator tests conducted by staff has been conducted as evidenced by facility documentation. Findings include: Record review on 9/30/21 at approximately 1245 pm and during exit interview at 115pm, the facility could not produce documentation to support the required annual testing of the diesel fuel, serving the emergency generator. This finding was verified during exit interview with staff and the Administrator at 115pm on 9/30/21.	K 918	1. Maintenance Director has scheduled Cummins Sales and Service to complete the annual test for generator and diesel fuel quality testing. Maintenance staff has conducted required emergency generator tests. 2. Residents residing in the facility have the potential to be affected. 3. The Administrator re-educated the Maintenance Director on 10/7/2021 regarding emergency generator tests to be conducted by staff and having documentation of annual fuel quality test as required by section 9.4.6.3 of 2012 edition of NFPA 101, Life Safety Code. 4. Administrator/Designee will validate emergency generator testing and annual diesel fuel quality testing is compliant once a week x 8 weeks. Maintenance Director will report findings to the QAPI committee for evaluation of the effectiveness of the plan and further recommendations as appropriate. 5. Compliance will be achieved by 11/15/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING ______ B. WING ______	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 000	Initial Comments THIS FACILITY MET THE LIFE SAFETY REQUIREMENTS OF APPENDIX "Z"; IN ACCORDANCE WITH CFR 483.73, REQUIREMENT FOR LONG-TERM CARE (LTC) FACILITIES	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/15/2021

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.