STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125026	A. BUILDING: _____ B. WING _____	12/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUAKINI GERIATRIC CARE, INC	347 NORTH KUAKINI STREET HONOLULU, HI 96817

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 000	Initial Comments A licensure survey was conducted by the Office of Health Care Assurance (OHCA). The facility was found not to be in substantial compliance with 42 CFR 483 Subpart B. Two Facility Reported Incidents (FRI) from the Aspen Complaints/Incidents Tracking System (ACTS) #9221 and #9203 were found to be un/substantiated. Two complaints, ACTS #8791 and #9235 (unsubstantiated) were found to be un/substantiated. Survey Dates: December 09, 2021, to December 14, 2021 Survey Census: 140 Sample Size: 28	4 000		
4 113	11-94.1-27(2) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (2) The right to be free of interference, coercion, discrimination, and reprisal from the facility that shall include the right to be free of chemical or physical restraints not medically indicated; This Statute is not met as evidenced by: Based on observations, interviews, and record	4 113	Corrective Action:	1/28/22

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4 113	Continued From page 1 reviews, the facility failed to ensure the resident's right to be treated 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 for 5 of X (Resident (R)52, R234, R84, R20, R97, and R334) residents sampled. This deficiency has the potential to affect the resident's psychosocial health and affect their quality of life. Findings include: 1) R52 is a 93-year-old male who was admitted to the facility on 09/24/21 with diagnosis that include high blood pressure, gastroesophageal Reflux Disease (GERD), benign prostatic hyperplasia (an enlarged prostate that makes it difficult for the resident to urinate), pneumonia due to aspiration (breathing in a foreign substance/particle into the lungs), malnutrition, failure to thrive, and a urinary tract infection. R52 was admitted with a Foley catheter. Review of R52's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/30/21 documented a Brief Interview for Mental Status (BIMS) score of 13, indicating he is cognitively intact. On 12/09/21 at 08:40 AM, observed R52 seated in a wheelchair, in the hallway, with his catheter tubing exposed. Dark yellow urine was observed in the catheter tubing and two (2) female residents were within approximately 6 feet of him. At 09:30 AM, inquired with R52 regarding being in the hallway with the catheter tubing exposed. R52 stated initially when he came out of the room, he had a blanket over his lap. Staff removed the blanket to put lotion on his legs and did not place the blanket back on him. R52 reported feeling badly that he needs a catheter to	4 113	" Catheter bag covers were provided for Residents (R) 52, (R) 234, and (R) 84 Completed 12/14/2021 " The therapeutic recreation staff TRS1 was educated on (1) the correct approach to addressing Resident (R) 20□s requests for assistance to ensure that residents□ requests are communicated timely to the nursing staff Completed 01/28/2022 " Resident (R) 97□s Assessment was completed, and Resident (R) 97□s Comprehensive Care Plan was reviewed and updated to reflect the required individualized care including the language barrier and behavioral needs. Completed 12/22/2021 " Resident (R) 334□s Occupational Therapy screen was completed for all activities of daily living (ADL) and transfer care and there were no new recommendations for the services to provide to the Resident (R) 334. Resident (R) 334 continues to require total assist with use of the Hoyer lift for all transfers and is not recommended for transfer via Hoyer lift to toilet or bed side commode due to safety. Resident (R) 334 was given education to request and use a bed pan for toileting needs. Completed 12/14/2021	

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4 113	Continued From page 2 help empty his bladder. 2) R234 was admitted to the facility on 11/04/21 with diagnosis that included a stage 4 pressure ulcer with underlying cellulitis, multiple pressure wounds, vascular Dementia, contractures, and left sided weakness due to a stroke. He was admitted to the facility with a Foley catheter. On 12/09/21 at 3:20 PM, from the hallway, this surveyor observed the resident's uncovered catheter bag hanging from the side of his bed closest to the door. Inquired with Licensed Staff (LS)10 regarding the visibility of R234's uncovered catheter bag from the hallway. LS10 acknowledged if his catheter bag is visible from the hallway, then it should have been covered or placed on the other side of his bed to conceal it from other residents and visitors that pass by R234's room. 3) R84 was admitted to the facility on 11/8/21 with diagnosis that include sepsis (a life-threatening complication of an infection in the blood stream), urinary retention, Dementia, renal (kidney) failure, low blood pressure, and a stage 4 pressure ulcer on sacrum (the bottom portion of the spine). R84 was admitted with a Foley catheter. On 12/09/21 at 10:15 AM, while standing in the hallway, this surveyor observed R84's uncovered catheter bag hanging from her bedside closest to the doorway. The uncovered catheter bag was filled (approximately a third full) of yellow colored urine. 4) On 12/10/21 at 07:10 AM, R20 was observed to be awake and lying-in bed with the front of his brief rolled down and tucked under his behind, exposing his genitals. R20 quickly tried to cover	4 113	Systemic changes: " The KGC Director of Nursing (DON) or designee identified all residents who have orders for Foley catheters and ensured that these residents were provided with catheter bags covers. Completed 12/14/2021 " The Nursing Home Administrator educated the Therapeutic Recreational Activity Staff to notify the nursing staff of any resident needs that are brought to their attention by the residents including requests to use the restroom. Completed 01/28/2022 " The Patient Care Coordinators (PCC) or designee reviewed the mood and behavior of all the residents in order to identify unwanted behavior. All identified unwanted behaviors were properly addressed in the residents Comprehensive Care Plans with specific interventions. A behavior log was developed to monitor behavior the residents and interventions in order to improve the management of the unwanted behavior. Completed 12/22/2021 and ongoing " The PCC or designee reviewed all the residents with any communication and/or language barriers and concerns. All the identified communication needs and/or language barriers are properly addressed in the updated individualized residents	

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4 113	Continued From page 3 himself after surveyor knocked and entered his room. At 09:06 AM, R20 was observed to be lying in bed with a napkin and towel around his neck, there was no breakfast tray at his bedside. At 10:23 AM, R20 was sitting up in his wheelchair in the solarium participating in an activity. At 11:13 AM, R20 was observed to be sitting up in his wheelchair in the hallway fronting the nursing station. The therapeutic recreation staff (TRS)1 asked R20 if he wanted to go into the solarium for activities, unlocked his wheelchair and started to wheel him towards the solarium. R20 responded by saying that he wanted to go to the restroom. TRS1 stated, "Oh!" parked him back into the hallway, locked the wheels of the wheelchair and left. At 11:24 AM, patient care coordinator (PCC)5 wheeled R20 into the television room. At 11:37 AM, R20 was observed in the solarium doing a coloring activity. R20 told TRS1 loudly that he needed to use the restroom. R20's request was again ignored by TRS1 as she told him that lunch was being served. On 12/14/21 at 07:51 AM, R20's health record was reviewed. The "Queens University Medical Group Nursing Home Progress Note," dated 11/15/21, revealed that R20 was a 78-year-old resident initially admitted to the facility on 08/09/21. He receives hemodialysis for kidney failure and suffers from bipolar disorder (mental illness characterized by extreme mood swings) and depression treated with medications. On 12/14/21 at 1:00 PM, query was done with certified nurses' aide (CNA)5 in the hallway in front of the nursing station about what should be done if a resident asks a TRS to use the restroom and she stated that the TRS should notify the nurse.	4 113	Comprehensive Care Plans with specific communication techniques and available options to address the language barriers. Completed 12/22/2021 " The PCC or designee conducted an audit of all residents with Hoyer lift transfers to verify that the resident□s mode of transfer technique continues to be current and accurate based on the individualized resident□s preference and transfer status and recommendations from the residents Occupational Therapy screening. Completed 01/28/2022 and ongoing " The KGC DON or designee provided education to all KGC employees on the Resident□s Rights and Responsibilities. Completed 01/28/2022 Monitoring and corrective action: " The Patient Care Coordinators (PCCs) or designee will conduct monthly audits of residents with Foley catheters to ensure these residents are provided catheter bag covers. The audit result will be reported to the Interdisciplinary team (IDT) meetings and the Performance Improvement (PI) Committee meetings. Completed 01/28/2022 and ongoing	

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4 113	Continued From page 4	4 113		

5) An initial record review for R97 was done on 12/09/21 at 12:42 PM. He is a 57-year-old resident receiving hemodialysis for kidney failure, admitted on 10/25/21. The facility's Minimum Data Set (MDS) report "updated: 10/19/2021" (a recent MDS report was requested of the facility but was never provided) revealed that he is receiving antianxiety and antidepressant medications.

On 12/13/21 at 08:27 AM, R97 was observed to be occasionally yelling out from his room. A concurrent query was made to RN2 who was preparing resident medications at her medication cart in the hallway. She stated that R97 occasionally yells out, but it is difficult to assess his needs because of a language barrier.

At 09:15 AM, a CNA entered R97's room, who was still occasionally yelling out. R97 stopped yelling and surveyor observed that he looked distressed, lying sideways in his bed and he stated, "Phone!"

At 10:04 AM, R97 had still been yelling out and a concurrent query was made with LPN4 at the nursing station. She stated that R97 does not usually yell out, but she had already called her son and was informed that R97's wife was out of town. She continued to say that she will call his brother, but she continued doing her task at the nursing station.

At 10:22 AM, the nursing home administrator (NHA) went to visit R97. R97 had still been yelling out. Surveyor noted that when the nursing station phone rang, R97 would yell, "Phone!"

At 10:23 AM, a CNA was in R97's room and he was no longer yelling out. After she left the room,

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4 113	Continued From page 5 R97 started yelling out again. On 12/15/21 at 10:00 AM, R97's care plan, received from the DON on 12/14/21 at 08:00 AM, was reviewed. R97's identified needs for his language barrier and his yelling out behavior were not addressed, therefore there were no individualized interventions for their management. 6) Resident (R)334 is a 74-year-old female admitted to the facility on 10/28/21 for long-term care (LTC). R334's admitting diagnoses included ischemic stroke (when a vessel supplying blood to the brain is blocked, causing brain tissue to die), with resulting left-sided weakness, high blood pressure, diabetes, and a history of breast cancer. On 12/10/21 at 08:43 AM, observations and a concurrent interview was done with R334 in her room on the fifth floor. Certified Nurse Aide (CNA)4 had just entered the room and R334 asked to "go to the bathroom." CNA4 stated "I will get you the bedpan," to which R334 emphatically and repeatedly refused asking "why, I don't want to use the bedpan, I want to go to the bathroom!" Instead of answering her, CNA4 looked at me and asked, "what should I do, she cannot walk to the bathroom." After CNA4 left the room to find a second CNA to assist her with transferring, R334 stated that staff are "very rude," but that she does not complain or she "get[s] oogie treatment." When asked what she meant by that, R334 stated, "they just plop my food on the table, and they don't listen to me." When CNA4 returned with help, R334 stated "I couldn't hold it anymore, you guys took so long." On 12/13/21 at 08:06 AM, it was observed that R334 had turned her call light on. Registered	4 113		

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4 113	Continued From page 6 Nurse (RN)3 entered R334's room to take her blood pressure prior to preparing her morning medications. As soon as RN3 entered, R334 stated "I need to go to the bathroom." RN3 turned off the call light, and told R334 "you cannot walk, let me go get you a bedpan." R334 became upset and loudly asked, "What? Why? I want to go to the bathroom," then she shouted, "I DON'T WANT A BEDPAN!" RN3 turned his back on R334 so that he was facing the surveyor and began explaining that R334 could not walk. Surveyor instructed RN3 that he should be addressing the distressed resident behind him, not the surveyor. R334 had begun making movements towards the right side of the bed, trying to position herself to get out of bed. RN3 turned to her and said he would find someone to help her. Surveyor followed RN3 out of the room, where he turned to his medication cart in the doorway of the next room and began preparing medication for another resident. Surveyor asked RN3 why he turned R334's call light off if he did not help her, and he did not alert another staff member that she needed help. RN3 re-entered R334's room, stated to resident that she could not walk and again told her he would get a bedpan. R334 became upset, yelling, "no, no, I DON'T WANT A BEDPAN, how many times do I have to tell you!" RN3 told the resident he was going to find help and left the room. After RN3 left, R334 turned to me and stated, "he is a jerk, he never listens to me." Based on observations, interviews, and record reviews, the facility failed to ensure the resident's right to be treated with respect and dignity and	4 113		

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4 113	Continued From page 7	4 113		

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 for 5 of X (Resident (R)52, R234, R84, R20, R97, and R334) residents sampled. This deficiency has the potential to affect the resident's psychosocial health and affect their quality of life.

Findings include:

1) R52 is a 93-year-old male who was admitted to the facility on 09/24/21 with diagnosis that include high blood pressure, gastroesophageal Reflux Disease (GERD), benign prostatic hyperplasia (an enlarged prostate that makes it difficult for the resident to urinate), pneumonia due to aspiration (breathing in a foreign substance/particle into the lungs), malnutrition, failure to thrive, and a urinary tract infection. R52 was admitted with a Foley catheter. Review of R52's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/30/21 documented a Brief Interview for Mental Status (BIMS) score of 13, indicating he is cognitively intact.

On 12/09/21 at 08:40 AM, observed R52 seated in a wheelchair, in the hallway, with his catheter tubing exposed. Dark yellow urine was observed in the catheter tubing and two (2) female residents were within approximately 6 feet of him. At 09:30 AM, inquired with R52 regarding being in the hallway with the catheter tubing exposed. R52 stated initially when he came out of the room, he had a blanket over his lap. Staff removed the blanket to put lotion on his legs and did not place the blanket back on him. R52 reported feeling badly that he needs a catheter to help empty his bladder.

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4 113	Continued From page 8 2) R234 was admitted to the facility on 11/04/21 with diagnosis that included a stage 4 pressure ulcer with underlying cellulitis, multiple pressure wounds, vascular Dementia, contractures, and left sided weakness due to a stroke. He was admitted to the facility with a Foley catheter. On 12/09/21 at 3:20 PM, from the hallway, this surveyor observed the resident's uncovered catheter bag hanging from the side of his bed closest to the door. Inquired with Licensed Staff (LS)10 regarding the visibility of R234's uncovered catheter bag from the hallway. LS10 acknowledged if his catheter bag is visible from the hallway, then it should have been covered or placed on the other side of his bed to conceal it from other residents and visitors that pass by R234's room. 3) R84 was admitted to the facility on 11/8/21 with diagnosis that include sepsis (a life-threatening complication of an infection in the blood stream), urinary retention, Dementia, renal (kidney) failure, low blood pressure, and a stage 4 pressure ulcer on sacrum (the bottom portion of the spine). R84 was admitted with a Foley catheter. On 12/09/21 at 10:15 AM, while standing in the hallway, this surveyor observed R84's uncovered catheter bag hanging from her bedside closest to the doorway. The uncovered catheter bag was filled (approximately a third full) of yellow colored urine. 4) On 12/10/21 at 07:10 AM, R20 was observed to be awake and lying-in bed with the front of his brief rolled down and tucked under his behind, exposing his genitals. R20 quickly tried to cover himself after surveyor knocked and entered his	4 113		

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4 113	Continued From page 9	4 113		

room. At 09:06 AM, R20 was observed to be lying in bed with a napkin and towel around his neck, there was no breakfast tray at his bedside. At 10:23 AM, R20 was sitting up in his wheelchair in the solarium participating in an activity. At 11:13 AM, R20 was observed to be sitting up in his wheelchair in the hallway fronting the nursing station. The therapeutic recreation staff (TRS)1 asked R20 if he wanted to go into the solarium for activities, unlocked his wheelchair and started to wheel him towards the solarium. R20 responded by saying that he wanted to go to the restroom. TRS1 stated, "Oh!" parked him back into the hallway, locked the wheels of the wheelchair and left. At 11:24 AM, patient care coordinator (PCC)5 wheeled R20 into the television room. At 11:37 AM, R20 was observed in the solarium doing a coloring activity. R20 told TRS1 loudly that he needed to use the restroom. R20's request was again ignored by TRS1 as she told him that lunch was being served.

On 12/14/21 at 07:51 AM, R20's health record was reviewed. The "Queens University Medical Group Nursing Home Progress Note," dated 11/15/21, revealed that R20 was a 78-year-old resident initially admitted to the facility on 08/09/21. He receives hemodialysis for kidney failure and suffers from bipolar disorder (mental illness characterized by extreme mood swings) and depression treated with medications.

On 12/14/21 at 1:00 PM, query was done with certified nurses' aide (CNA)5 in the hallway in front of the nursing station about what should be done if a resident asks a TRS to use the restroom and she stated that the TRS should notify the nurse.

5) An initial record review for R97 was done on

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4 113	Continued From page 10 12/09/21 at 12:42 PM. He is a 57-year-old resident receiving hemodialysis for kidney failure, admitted on 10/25/21. The facility's Minimum Data Set (MDS) report "updated: 10/19/2021" (a recent MDS report was requested of the facility but was never provided) revealed that he is receiving antianxiety and antidepressant medications. On 12/13/21 at 08:27 AM, R97 was observed to be occasionally yelling out from his room. A concurrent query was made to RN2 who was preparing resident medications at her medication cart in the hallway. She stated that R97 occasionally yells out, but it is difficult to assess his needs because of a language barrier. At 09:15 AM, a CNA entered R97's room, who was still occasionally yelling out. R97 stopped yelling and surveyor observed that he looked distressed, lying sideways in his bed and he stated, "Phone!" At 10:04 AM, R97 had still been yelling out and a concurrent query was made with LPN4 at the nursing station. She stated that R97 does not usually yell out, but she had already called her son and was informed that R97's wife was out of town. She continued to say that she will call his brother, but she continued doing her task at the nursing station. At 10:22 AM, the nursing home administrator (NHA) went to visit R97. R97 had still been yelling out. Surveyor noted that when the nursing station phone rang, R97 would yell, "Phone!" At 10:23 AM, a CNA was in R97's room and he was no longer yelling out. After she left the room, R97 started yelling out again.	4 113		

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4 113	Continued From page 11 On 12/15/21 at 10:00 AM, R97's care plan, received from the DON on 12/14/21 at 08:00 AM, was reviewed. R97's identified needs for his language barrier and his yelling out behavior were not addressed, therefore there were no individualized interventions for their management. 6) Resident (R)334 is a 74-year-old female admitted to the facility on 10/28/21 for long-term care (LTC). R334's admitting diagnoses included ischemic stroke (when a vessel supplying blood to the brain is blocked, causing brain tissue to die), with resulting left-sided weakness, high blood pressure, diabetes, and a history of breast cancer. On 12/10/21 at 08:43 AM, observations and a concurrent interview was done with R334 in her room on the fifth floor. Certified Nurse Aide (CNA)4 had just entered the room and R334 asked to "go to the bathroom." CNA4 stated "I will get you the bedpan," to which R334 emphatically and repeatedly refused asking "why, I don't want to use the bedpan, I want to go to the bathroom!" Instead of answering her, CNA4 looked at me and asked, "what should I do, she cannot walk to the bathroom." After CNA4 left the room to find a second CNA to assist her with transferring, R334 stated that staff are "very rude," but that she does not complain or she "get[s] oogie treatment." When asked what she meant by that, R334 stated, "they just plop my food on the table, and they don't listen to me." When CNA4 returned with help, R334 stated "I couldn't hold it anymore, you guys took so long." On 12/13/21 at 08:06 AM, it was observed that R334 had turned her call light on. Registered Nurse (RN)3 entered R334's room to take her	4 113		

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	125026	A. BUILDING: _____ B. WING _____	12/14/2021

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4 113	Continued From page 12 blood pressure prior to preparing her morning medications. As soon as RN3 entered, R334 stated "I need to go to the bathroom." RN3 turned off the call light, and told R334 "you cannot walk, let me go get you a bedpan." R334 became upset and loudly asked, "What? Why? I want to go to the bathroom," then she shouted, "I DON'T WANT A BEDPAN!" RN3 turned his back on R334 so that he was facing the surveyor and began explaining that R334 could not walk. Surveyor instructed RN3 that he should be addressing the distressed resident behind him, not the surveyor. R334 had begun making movements towards the right side of the bed, trying to position herself to get out of bed. RN3 turned to her and said he would find someone to help her. Surveyor followed RN3 out of the room, where he turned to his medication cart in the doorway of the next room and began preparing medication for another resident. Surveyor asked RN3 why he turned R334's call light off if he did not help her, and he did not alert another staff member that she needed help. RN3 re-entered R334's room, stated to resident that she could not walk and again told her he would get a bedpan. R334 became upset, yelling, "no, no, I DON'T WANT A BEDPAN, how many times do I have to tell you!" RN3 told the resident he was going to find help and left the room. After RN3 left, R334 turned to me and stated, "he is a jerk, he never listens to me."	4 113		

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4 113	Continued From page 13	4 113		

Based on observations, interviews, and record reviews, the facility failed to ensure the resident's right to be treated 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 for 5 of X (Resident (R)52, R234, R84, R20, R97, and R334) residents sampled. This deficiency has the potential to affect the resident's psychosocial health and affect their quality of life.

Findings include:

1) R52 is a 93-year-old male who was admitted to the facility on 09/24/21 with diagnosis that include high blood pressure, gastroesophageal Reflux Disease (GERD), benign prostatic hyperplasia (an enlarged prostate that makes it difficult for the resident to urinate), pneumonia due to aspiration (breathing in a foreign substance/particle into the lungs), malnutrition, failure to thrive, and a urinary tract infection. R52 was admitted with a Foley catheter. Review of R52's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/30/21 documented a Brief Interview for Mental Status (BIMS) score of 13, indicating he is cognitively intact.

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4 113	Continued From page 14 On 12/09/21 at 08:40 AM, observed R52 seated in a wheelchair, in the hallway, with his catheter tubing exposed. Dark yellow urine was observed in the catheter tubing and two (2) female residents were within approximately 6 feet of him. At 09:30 AM, inquired with R52 regarding being in the hallway with the catheter tubing exposed. R52 stated initially when he came out of the room, he had a blanket over his lap. Staff removed the blanket to put lotion on his legs and did not place the blanket back on him. R52 reported feeling badly that he needs a catheter to help empty his bladder. 2) R234 was admitted to the facility on 11/04/21 with diagnosis that included a stage 4 pressure ulcer with underlying cellulitis, multiple pressure wounds, vascular Dementia, contractures, and left sided weakness due to a stroke. He was admitted to the facility with a Foley catheter. On 12/09/21 at 3:20 PM, from the hallway, this surveyor observed the resident's uncovered catheter bag hanging from the side of his bed closest to the door. Inquired with Licensed Staff (LS)10 regarding the visibility of R234's uncovered catheter bag from the hallway. LS10 acknowledged if his catheter bag is visible from the hallway, then it should have been covered or placed on the other side of his bed to conceal it from other residents and visitors that pass by R234's room. 3) R84 was admitted to the facility on 11/8/21 with diagnosis that include sepsis (a life-threatening complication of an infection in the blood stream), urinary retention, Dementia, renal (kidney) failure, low blood pressure, and a stage 4 pressure ulcer on sacrum (the bottom portion of the spine). R84	4 113		

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4 113	Continued From page 15 was admitted with a Foley catheter. On 12/09/21 at 10:15 AM, while standing in the hallway, this surveyor observed R84's uncovered catheter bag hanging from her bedside closest to the doorway. The uncovered catheter bag was filled (approximately a third full) of yellow colored urine. 4) On 12/10/21 at 07:10 AM, R20 was observed to be awake and lying-in bed with the front of his brief rolled down and tucked under his behind, exposing his genitals. R20 quickly tried to cover himself after surveyor knocked and entered his room. At 09:06 AM, R20 was observed to be lying in bed with a napkin and towel around his neck, there was no breakfast tray at his bedside. At 10:23 AM, R20 was sitting up in his wheelchair in the solarium participating in an activity. At 11:13 AM, R20 was observed to be sitting up in his wheelchair in the hallway fronting the nursing station. The therapeutic recreation staff (TRS)1 asked R20 if he wanted to go into the solarium for activities, unlocked his wheelchair and started to wheel him towards the solarium. R20 responded by saying that he wanted to go to the restroom. TRS1 stated, "Oh!" parked him back into the hallway, locked the wheels of the wheelchair and left. At 11:24 AM, patient care coordinator (PCC)5 wheeled R20 into the television room. At 11:37 AM, R20 was observed in the solarium doing a coloring activity. R20 told TRS1 loudly that he needed to use the restroom. R20's request was again ignored by TRS1 as she told him that lunch was being served. On 12/14/21 at 07:51 AM, R20's health record was reviewed. The "Queens University Medical Group Nursing Home Progress Note," dated	4 113		

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4 113	Continued From page 16 11/15/21, revealed that R20 was a 78-year-old resident initially admitted to the facility on 08/09/21. He receives hemodialysis for kidney failure and suffers from bipolar disorder (mental illness characterized by extreme mood swings) and depression treated with medications. On 12/14/21 at 1:00 PM, query was done with certified nurses' aide (CNA)5 in the hallway in front of the nursing station about what should be done if a resident asks a TRS to use the restroom and she stated that the TRS should notify the nurse. 5) An initial record review for R97 was done on 12/09/21 at 12:42 PM. He is a 57-year-old resident receiving hemodialysis for kidney failure, admitted on 10/25/21. The facility's Minimum Data Set (MDS) report "updated: 10/19/2021" (a recent MDS report was requested of the facility but was never provided) revealed that he is receiving antianxiety and antidepressant medications. On 12/13/21 at 08:27 AM, R97 was observed to be occasionally yelling out from his room. A concurrent query was made to RN2 who was preparing resident medications at her medication cart in the hallway. She stated that R97 occasionally yells out, but it is difficult to assess his needs because of a language barrier. At 09:15 AM, a CNA entered R97's room, who was still occasionally yelling out. R97 stopped yelling and surveyor observed that he looked distressed, lying sideways in his bed and he stated, "Phone!" At 10:04 AM, R97 had still been yelling out and a concurrent query was made with LPN4 at the	4 113		

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4 113	Continued From page 17	4 113		

nursing station. She stated that R97 does not usually yell out, but she had already called her son and was informed that R97's wife was out of town. She continued to say that she will call his brother, but she continued doing her task at the nursing station.

At 10:22 AM, the nursing home administrator (NHA) went to visit R97. R97 had still been yelling out. Surveyor noted that when the nursing station phone rang, R97 would yell, "Phone!"

At 10:23 AM, a CNA was in R97's room and he was no longer yelling out. After she left the room, R97 started yelling out again.

On 12/15/21 at 10:00 AM, R97's care plan, received from the DON on 12/14/21 at 08:00 AM, was reviewed. R97's identified needs for his language barrier and his yelling out behavior were not addressed, therefore there were no individualized interventions for their management.

6) Resident (R)334 is a 74-year-old female admitted to the facility on 10/28/21 for long-term care (LTC). R334's admitting diagnoses included ischemic stroke (when a vessel supplying blood to the brain is blocked, causing brain tissue to die), with resulting left-sided weakness, high blood pressure, diabetes, and a history of breast cancer.

On 12/10/21 at 08:43 AM, observations and a concurrent interview was done with R334 in her room on the fifth floor. Certified Nurse Aide (CNA)4 had just entered the room and R334 asked to "go to the bathroom." CNA4 stated "I will get you the bedpan," to which R334 emphatically and repeatedly refused asking "why, I don't want to use the bedpan, I want to go to the

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4 113	Continued From page 18 bathroom!" Instead of answering her, CNA4 looked at me and asked, "what should I do, she cannot walk to the bathroom." After CNA4 left the room to find a second CNA to assist her with transferring, R334 stated that staff are "very rude," but that she does not complain or she "get[s] oogie treatment." When asked what she meant by that, R334 stated, "they just plop my food on the table, and they don't listen to me." When CNA4 returned with help, R334 stated "I couldn't hold it anymore, you guys took so long." On 12/13/21 at 08:06 AM, it was observed that R334 had turned her call light on. Registered Nurse (RN)3 entered R334's room to take her blood pressure prior to preparing her morning medications. As soon as RN3 entered, R334 stated "I need to go to the bathroom." RN3 turned off the call light, and told R334 "you cannot walk, let me go get you a bedpan." R334 became upset and loudly asked, "What? Why? I want to go to the bathroom," then she shouted, "I DON'T WANT A BEDPAN!" RN3 turned his back on R334 so that he was facing the surveyor and began explaining that R334 could not walk. Surveyor instructed RN3 that he should be addressing the distressed resident behind him, not the surveyor. R334 had begun making movements towards the right side of the bed, trying to position herself to get out of bed. RN3 turned to her and said he would find someone to help her. Surveyor followed RN3 out of the room, where he turned to his medication cart in the doorway of the next room and began preparing medication for another resident. Surveyor asked RN3 why he turned R334's call light off if he did not help her, and he did not alert another staff member that she needed help. RN3 re-entered R334's room, stated to resident that she could not walk and again told her he would get a bedpan.	4 113		

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4 113	Continued From page 19 R334 became upset, yelling, "no, no, I DON'T WANT A BEDPAN, how many times do I have to tell you!" RN3 told the resident he was going to find help and left the room. After RN3 left, R334 turned to me and stated, "he is a jerk, he never listens to me."	4 113		
4 153	11-94.1-40(a) Dietary services (a) The food and nutritional needs of the residents shall be met through a nourishing, well-balanced diet in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, and shall be adjusted for age, sex, activity, and disability. (1) At least three meals shall be served daily at regular times with not more than a fourteen hour span between a substantial evening meal and breakfast on the following day; (2) Between meals nourishment that is consistent with the resident's needs shall be offered routinely and shall include a regular schedule of hydration to meet each resident's needs; (3) Appropriate substitution of foods shall be promptly offered to all residents as necessary; (4) Food shall be served in a form consistent with the needs of the resident and the resident's ability to consume it; (5) Food shall be served with appropriate utensils; (6) Residents needing special equipment,	4 153		1/28/22

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4 153	Continued From page 20 implements, or utensils to assist them when eating shall have the items provided by the facility; and (7) There shall be a sufficient number of competent personnel to fulfill the food and nutrition needs of residents. Paid feeding attendants shall be trained as per the facility's state-approved training protocol. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to provide care and services to prevent significant weight loss or to identify the need for dietary evaluation and intervention for two residents (Resident 334 and Resident 40), as evidenced by an unrecognized significant weight loss of 15.04 pounds (lbs.) or 8.97% in six (6) weeks for Resident (R)334, R40. As a result of this deficient practice, the facility placed these residents at risk for avoidable declines and injuries. This deficient practice has the potential to affect all residents at the facility. Findings include: 1) On 12/10/21 at 08:28 AM, while reviewing the weight log binder for fifth-floor residents at the nurses' station, no weight log could be found for resident (R)334, who had been admitted on 10/28/21 for long-term care. The weight documented on her admission assessment was 76.2 kg [kilograms] or 167.64 lbs. [pounds]. A review of R334's electronic health record (EHR) revealed one weight documented on 12/08/21 at 03:08 AM by licensed practical nurse (LPN)3 of 152.6 lbs. No other weights were found documented under "weights" in the EHR.	4 153	Corrective Actions: " The weight record for Resident (R) 334 indicated an admission weight of 167.74 lbs. and a current weight of 161.8 lbs. on 01/02/2022 and 160.8 lbs. on 01/25/2022. The Registered Dietician (RD) completed a review on 12/13/2021 and the Comprehensive Care Plan was updated. The accuracy of the 11/08/2021 weight of 157.52 lbs. is questionable. Completed 01/28/2022 " A Comprehensive Review was completed for Resident (R) 40 the new Assessment Reference Date (ARD) was changed and scheduled on 12/16/2021. The assessment included a decline on MDS section K Nutritional Status. The Registered Dietician (RD) evaluation was completed and found no change on Resident (R) 40□s meal and fluid intake at 100%. A complete metabolic Panel was completed on 12/15/2021 and found to be nutritionally stable with electrolytes, BUN, albumin, and protein levels within normal ranges. The Nutrition Care Plans were	

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4 153	Continued From page 21 On 12/10/21 at 08:51 AM, during an interview with R334 in her room, R334 stated she "thinks" she lost weight since she was admitted but does not remember being weighed. On 12/13/21 at 09:30 AM, during an interview with licensed practical nurse (LPN)4 and Unit Clerk (UC)5, and a concurrent record review of R334's hard chart, Kardex, and EHR, at the fifth-floor nurses' station, LPN4 and UC5 confirmed that there were no weights found in the weight log binder for R334, no documentation of routine weights in her EHR except for the one weight on 12/08/21, and no dietary assessment found in R334's hard chart. LPN4 expressed confusion why they could not be found, stating "they should all be there." UC5 stated that the standing orders for routine weight checks [following admission] is "once a day for three (3) days, then once a week for four (4) weeks, then once a month after that." UC5 also expressed confusion as to why the documentations could not be located. A review of R334's nurse progress notes found no documentation of any weight loss being documented, reported, or referred to dietary. On 12/13/21 at 11:20 AM, UC5 presented the surveyor with a copy of R334's weight log, stating, "it was found on the sixth floor, it should have been transferred down here with the rest of her records, but somehow they missed it." A review of the weight log documented the following weights: 10/29/21 [admission] 76.2 kg [167.74 lbs.] 10/30/21 76.5 kg [168.3 lbs.] 10/31/21 74.2 kg [163.24 lbs.] 11/01/21 74.6 kg [164.12 lbs.] 11/08/21 71.6 kg [157.52 lbs.]	4 153	reviewed and updated on 12/16/2021 Completed 01/28/2022 Systemic Change: " The Patient Care Coordinators (PCC) or designee reviewed all the residents weight records in each resident care unit to ensure that the weight records are complete, and the RD notifications are forwarded for all weight deviations of 3% or more. The residents Comprehensive Care Plans were reviewed and updated as appropriate. Completed 01/28/2022 and ongoing Monitoring of Corrective Actions: " The PCC or designee will conduct a monthly audit of all residents weight records, RD referral for weight deviations of 3% or more, and Nutrition Care Plans for accuracy. The audit results will be reported at the Interdisciplinary Team (IDT) meetings and the Performance Improvement Committee meetings. Completed 01/28/2022 and ongoing	

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4 153	Continued From page 22 11/13/21 73.7 kg [162.14 lbs.] The weight log also documented the following procedure: " ...5. Notify RD [Registered Dietician] using RD referral form if 3% or more weight loss/gain ..." A review of R334's Nurse's Admission Record, dated 11/16/21, from when R334 transferred down to the fifth floor revealed no "admission" weight documented. LPN4 stated the nurse who admitted R334 to the floor should have weighed her and documented it on the Admission Record. No other weights were found documented until the 12/08/21 EHR documentation of 152.6 lbs. On 12/13/21 at 11:40 AM an interview was done with the Registered Dietician (RD) at the fifth-floor nurses' station. The RD stated she had received no dietary referral regarding R334's weight loss prior to "today." 2) Record review (RR) on 12/13/21 at 10:20 revealed a family medicine note dated 11/22/2021 with notation of a change in R40's personality. R40 was quieter than usual and dysphagic. Speech therapy was ordered. Diet was downgraded to diced solid. Four days later, on 11/26/21, a care conference was documented to evaluate for a significant change of condition. R40's weight was documented at 130.0 with no weight loss. Fifteen days later, on 12/06/21, a significant weight loss of approximately 11 lbs. (119.3) was documented. (Ref F657) RR did not show the care plan for nutrition updated or revised to accommodate for a significant change in nutrition. During a confidential interview on 12/13/21 at	4 153		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUAKINI GERIATRIC CARE, INC	347 NORTH KUAKINI STREET HONOLULU, HI 96817

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 153	Continued From page 23 12:30 PM with staff who preferred to remain anonymous, staff stated that their charge nurse had retired, and she used to take care of all the care plans. She kept them up to date, revised, created them. (Ref F657)	4 153		