STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING _____ B. WING _____	09/20/2021

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LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA). The facility was found not to be in substantial compliance with 42 CFR 483 Subpart B. Two hospital rooms were converted to SNF/NF rooms in preparation for the facility's COVID-19 resident dedicated unit. These rooms meet the requirements at §483.90 Physical Environment. Three complaints, #8609, #9026, and #9090, from the Aspen Complaints Tracking System (ACTS) were found to be substantiated. One facility reported incident (FRI), #8479, was found to be unsubstantiated. Survey Dates: September 14 to September 20, 2021 Survey Census: 88 Sample Size: 19	F 000		
F 552 SS=G	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in	F 552		11/3/21

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

Electronically Signed | 10/21/2021

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F 552	Continued From page 1 advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the resident's right to be informed of and participate in his/her care in a manner the resident can understand for one (1) resident, (R)335, sampled. Staff did not use auxiliary aids or written communication to inform R335, who has impaired hearing, that a medication would be administered rectally and was not informed of options and/or alternatives prior to staff administering the medication. As a result of not understanding medications would be administered rectally, R335 reported an allegation of sexual abuse to a family member (FM). As a result of this deficiency, R335's blood pressure elevated and required intervention, the resident has experienced feelings of being physically violated, fear of the staff member, difficulty sleeping at night, and sadness indicating psychosocial harm. Findings include: R335 is a 97-year-old resident who was admitted to the facility on 09/07/21, for rehabilitation, after falling at home and fracturing his/her pelvis. At the time of the survey, the Minimum Data Set (MDS) assessment was in progress and a baseline care plan was documented. On 09/14/21 at 09:29 AM, this surveyor knocked on R335's room door then proceeded to enter the room. R335 was lying in bed, resting, and the	F 552	Part of the current admission process documented on the Nursing Admission Assessment form, Part B is to assess and document any communication/sensory deficits. These deficits may be sensory (including hearing and visual) and/or language barriers. To ensure all future residents are assessed for communication/Sensory deficits on admission in a timely manner, licensed nursing staff will be required to complete section B within 30 minutes of arrival to the unit. Assessments to include an interview with resident to determine any visual, hearing or verbal comprehension deficits. An allocated space to document the time reviewed will be added to section B on the Nursing Admission Assessment Form. The Head nurse will be responsible for auditing all new admissions within 24 hours to ensure completion of the Sensory Assessment was done within 30 minutes after admission. Head nurses will submit any reported communication and/or sensory deficits identified to the DON who will audit these reports and report them to QAPI and QACC. Ongoing assessment of all residents will occur at least annually and/or if resident has a significant change in condition, during IDT meetings and when any resident has a significant change in condition. Nursing	

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F 552	Continued From page 2 resident's eyes were closed. Surveyor stood approximately 2 feet from the resident's bed and called the resident by name. The resident's eyes did not open and remained resting. On 09/14/21 at 12:05 PM, surveyor knocked on the resident's door and announced her presence, however, the resident did not open his/her eyes and remained resting. On 09/15/21 at 10:50 AM, this surveyor proceeded to enter the resident's room again in the same manner (knocking and announcing her presence). As surveyor entered the room, the Nurse Manager (NM)9 stated the resident cannot hear and directed surveyor to the erasable whiteboard and/or an amplifier, located in the room, to communicate with R335. R335 had just had an interview with the Ombudsman and appeared to have been crying. This surveyor sat at the resident's bedside (approximately 1 foot from the bedside) and verbally introduced herself. R335 stated "What?! I cannot hear you. I cannot tell what you're saying, you have to use the whiteboard and write it down cause I have bad hearing." Inquired with R335 (using the whiteboard to write questions and the resident verbally replied) regarding the allegation of sexual abuse reported by the resident's FM. R335 stated on the day the resident was admitted, the "nurse put something up the resident's ass and in the resident's vagina. They (the facility staff) said that the nurse said she told me and showed me the medicine, but she didn't. If they asked me, I would have told them NO! I don't want anything up my ass. It feels like they raped me. I feel so violated." R335 confirmed the Registered Nurse (RN)10 worked the remainder of the shift and provided care to the resident after the Nursing Supervisor (NS)4 became aware of the allegation of sexual abuse. R335 stated that she felt afraid all night and could not sleep. The resident	F 552	Education to provide at initial Orientation and annual on-going Competency Skills Training, adding a Sensory Assessment Component. This will be implemented by 10/29/2021. All residents and new admissions will be assessed for any communication barriers and/or sensory deficits. Any communication or sensory deficit that is identified for any residents and new admission will be care planned for in both baseline care plan and comprehensive care plan. Resources and tools to be utilized will be identified to aid the resident□s communication/sensory deficits. The resources and tools to be implemented will be used to promote and assist in fostering clear communication for all residents identified with a communication or sensory deficient at all times. Compliance will be audited by the Head Nurse on the admitting unit within 24 hours after admission. This will be implemented by 10/29/2021. For new admissions, identification of any communication barriers and/or sensory deficits will be screened for prior to admission. If any communication or sensory deficit is identified in admission pre- screening, information will be sought if person currently uses and communication or sensory aids, and if they have been previously assessed for assistive aids. If no aids are being used for their communicaton or sensory deficits, information will be sought through pre-screening on how the person communicates effectively with others. This will be added to the admission screening	

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F 552	Continued From page 3 reported to this surveyor feelings of being scared (especially at night), difficulty sleeping, sadness, scared, and fearful due to RN10 administering the rectal suppository without the resident understanding the route of administration. Throughout the interview with this surveyor, R335 was alert and oriented to person, place, time, and situation. The resident responded to questions in a coherent and manner, appropriately. R335 cried periodically throughout the interview and reported feeling emotionally upset and traumatized regarding the incident. This surveyor offered to stop the interview due to the emotional response by R335, but the resident declined and stated she did not want this to happen to anyone else. During an interview with RN10 on 09/17/21 at 3:21 PM, RN10 confirmed staff only verbally communicated with R335 and did not use any auxiliary devices or other means of communication to ensure the resident understood what staff was saying and reported working the entirety of the shift after R335 reported the allegation of sexual abuse to the Nursing Supervisor (NS) 4. RN10 stated the resident had just been admitted around the change or shift. The day shift nurses endorsed during transfer communication with the nurses from the transferring facility, they were informed that the resident had not had a bowel movement and had an order for a rectally suppository due to constipation. RN10 explained while assessing R335's skin as part of the facility's admission process, he/she decided to administer the rectal suppository because the resident has pain upon turning (R335 cannot turn without staff assistance) and it made sense to administer to the resident while conducting a skin check. RN10	F 552	form to be completed by 10/22/2021. For all cognizant residents, licensed nursing staff will be trained to thoroughly explain any procedure and any additional medication administration different from their regular medication regiment, regardless of the route to be given. To ascertain that the resident understands, the licensed nursing staff will ask the cognizant resident to verbally repeat what is about to occur, and listen for acknowledgement that they understand and agree to the procedure or for the medication administration to proceed. For those residents with cognitive deficits, the POA will be contacted to explain the procedure and/or medication administration and obtain verbal agreement/consent from the POA for the procedure or medication administration to proceed. This will be documented by the licensed nursing staff in the progress notes in the EMR of the resident. This will be implemented by 11/03/2021. After FM of R335 expressed her concerns to NS4 on 09/07/2021 at 6:36 PM, in regards to administration of a suppository that was administered at 4:19 PM by RN10, it was identified that R335 benefited from the use of a communication board. Use of the communication board was implemented immediately thereafter. On 09/10/2021 an amplifier was provided at R335□s bedside to further assist with her hearing deificiet. Care plan was initiated on 09/09/2021 to identify problem of hearing deficit. Intervention for R335 to receive clear communication and confirm with staff	

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F 552	Continued From page 4	F 552		

confirmed R335 did have pain but declined pain medication stating it made the resident feel "sick." RN10 stated after the medication was administered, the resident asked to call FM and was assisted in making the call. RN10 reported he/she became aware of the allegation when FM later spoke with NS4 on the unit.

Conducted a record review of R335's medical record (MR) on 09/15/21 at 11:59 AM. Review of an acute facility's Hospitalist Discharge Summary, date of service on 09/07/21 at 10:50 AM, the physical exam on discharge documented R335's abdomen was soft, nontender, non-distended, with normal bowel sound. Review of R335's MR and facility investigation documented the following timeline of the sequence of events on 09/07/21:

At 2:30 PM: R335's Nursing Assessment documented R335 arrived to the facility at 2:30 PM. Upon admission, R335's blood pressure (BP) was 128/65, System Assessment of Communication/Sensory documented; No problems, difficulty with: hearing, slightly impaired (RN10 wrote in slightly impaired).

At 4:19 PM: RN10 administered Dulcolax (medication to treat constipation) Suppository 10 mg, rectally.

At 6:06 PM: RN22 spoke with FM regarding R335's medications.

At 6:36 PM: An interoffice email documented; R335 spoke to FM. Crying, R335 reported to FM, he/she had been left unattended, outside by an elevator and feeling violated when the nurse administered the rectal suppository. FM

understanding of any type of care provided was to use a dry erase communication board provided at bedside to be used at every interaction with resident. This continued until the R335 was discharge to home on 10/02/2021.
FM□s concern of R10 laughing at her expressing her concerns was identified by NS4 as an unconscious nervous giggle by RN10. NS4 addressed this concern directly with RN10 on 09/07/2021 by reminding her to try and control her nervous response when she is in an uncomfortable or stressful situation. This was documented by NS4 in the interoffice memo dated 09/07/2021 at 2150 hrs.
The Head nurse will be responsible for auditing all new admissions within 24 hours, to ensure completion of the Sensory Assessment was done within 30 minutes after admission. Head nurses will submit any reported communication and/or sensory deficits identified to the DON who will audit these reports and report them to QAPI quarterly meeting.
The DON/ Designee will conduct a monthly survey in all nursing units, to ensure no resident has been denied of his/her rights to be fully informed of his treatment/medications and the right to participate in the treatment decisions.
The results of this survey will be reported and presented to the quarterly QAPI meeting for further actions/recommendations as necessary.
IDR for this FTag has been sent as an attachment through ePOC.

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F 552	Continued From page 5	F 552		

contacted the Nursing Supervisor (NS)4 and reported the incident. A conversation was held over speaker phone with FM, NS4, and RN10 during which RN10 "chuckled "while FM queried the staff of the incident. FM became upset due to RN10 laughing. NS4 informed FM he/she would check on R335. NS4 documented he/she knocked on the door, but R335 seemed to not hear the knock and proceeded to gently tap the resident on the right upper arm and R335's eyes immediately opened. R335 did not understand NS4 when the staff verbally introduced themselves to the resident. NS4 exited the room and got a sharpie and paper to communicate with R335. NS4 wrote to the resident and introduced himself/herself and inquired how the resident was feeling and if the resident needed assistance with dinner. R335 stated, "I can't eat, I feel so bad and sad. She (RN10) put her finger in my ass (made a swirling motion with her left finger), in my vagina too." NS4 apologized and explained to R335 that she needed the suppository to have a bowel movement (BM) and it's been 4 days since the resident had a BM. R335 got tearful, asked if FM was going to pick the resident up, and reported having a headache. FM was on the phone during NS4 interaction with R335. NS4 told FM the conversation was going to end and would be tending to R335. FM replied that staff should check the resident's blood pressure due to high blood pressure which was the result of RN10 administering the rectal suppository and the resident could have a stroke.

At 7:30 PM: R335's BP was 178/122, all other vital signs were stable. NS4 instructed RN10 to call the physician. The resident denied chest pains and shortness of breath but had expiratory wheezing while saying "I just feel so bad", holding

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F 552	Continued From page 6	F 552		

his/her chest with facial grimacing.

At 8:29 PM: The Medication Administration Record (MAR) documented R335 received 1 inch of Nitro-Bid Ointment 2% (Nitroglycerin) transdermal (topical, medication is absorbed through the skin) for BP greater than 170 for elevated blood pressure. Staff documented R335's BP was 180/98.

At 11:01 PM: RN10 documented in a progress note a summarized the resident received Bisacodyl (medication to treat constipation) suppository (endorsed by the day shift) with good results.

On the morning of 09/17/21, conducted an interview with anonymous staff. Staff confirmed R335 is alert and oriented to person, place, and time and is reliable. Staff reported R335 was deeply affected by the incident with the suppository as evidenced by the resident reported being scared especially at night, R335 appears to be depressed, observed the resident crying. Additionally, staff verbalized this incident negatively impacted the resident's emotional and psychological well-being.

On 09/17/21 at 3:00 PM, conducted a review of the facility's investigation. Review of interoffice communication confirmed R335 has impaired hearing, was coherent and able to make a choice, and RN10 did not confirm R335 heard or understand staff was going to administer a rectal suppository which was a violation of the resident's rights.

(Refer to F585 Grievances, F600 Free from Neglect, F609 Reporting Alleged Violations, F610

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F 552	Continued From page 7 Failure to Prevent Further Abuse, F641 Accuracy of Assessment)	F 552		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, observation, and record review, the facility failed to allow R60 the right to choose a sleeping schedule and pursue	F 561	" License Nurse and Unit Manager interviewed R60, and other residents that may be affected by the deficient practice	11/4/21

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F 561	Continued From page 8 activities as evidenced by the facility turning off the lights and television and requiring R60 to sleep. This deficient practice prevents the resident from exercising her autonomy for things that are important in her life. Findings include: R60 is a 62 year old admitted on 02/19/20 with diagnoses of spastic quadriplegic cerebral palsy (inability to control and use the legs, arms and body), hearing loss, dysphagia (difficulty swallowing), osteoporosis without current pathological fracture (weakened bone strength that is susceptible to fracture), apraxia (impaired motor skills), myalgia unspecified site (pain in a muscle or groups of muscle), contracture of muscle of multiple sites, and gastro-esophageal reflux disease (acid from stomach flows backward into the throat causing heartburn). In an observation on 09/14/21 at 08:34 AM in R60's room, R60 was found to be alert and oriented to self, place, time, and situation. R60 answered questions appropriately when asked. In an interview in R60's room on 09/14/21 at 8:34 AM, R60 stated "I have to go to bed at 10 PM. I want to sleep at 1 AM. I am a night owl. I told staff I want to sleep later than 10 PM." In another interview in R60's room on 09/17/21 at 11:37 AM, R60 stated "Staff tells me to go sleep. They turn off the TV and lights. I want to continue watching tv or reading. They tell me we have to turn everything off because everyone is sleeping." On 09/17/21 at 11:34 AM, R60's electronic medical record (EMR) was reviewed. The	F 561	identified regarding preferences with sleeping pattern that includes preferred activity, lights, music and appliance while awake. R60 preferred to be assisted in bed at 12 Midnight. R60 preferred to have lights on, reading and TV on with music. Care plan updated and updates implemented. Completion date 10/12/21 and ongoing for R60 and other identified residents. A) The Licensed Nurse (LN) / Head Nurse (HN) and Nursing Supervisors will check with all residents in each unit, to ensure their preferences are addressed and care planned. In- serviced staff regarding recent updates on resident□s preference and individualized updated care plan. Completion by 10/12/21 and updates ongoing as needed. B) Staff will be educated on the importance of communicating to the team when resident verbalized their preferences. Any issues that needed changes must be reported immediately to the Licensed Nurse/ Head Nurses/ Supervisors as appropriate. Implemented on by 10/12/21 and ongoing. " Upon admission, License Nurse completing the Baseline Care plan on section D (Daily Preferences that Resident Prefers) must include resident preference in sleeping pattern, activities and addressed in the care plan. If resident unable to verbalized preferences, consider family input. Implemented 10/12/2021 and ongoing. " Admitting Unit Manager to monitor Baseline Care plan within 48 hours, and	

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F 561	Continued From page 9 Minimum Data Set (MDS) quarterly assessment with Assessment Reference Date (ARD) of 08/10/21 indicated R60 had a Brief Interview for Mental Status (BIMS) score of 15. This indicates that R60 is cognitively intact.	F 561	compliance with the new admission guidelines on resident preference information within 72 hours. Monthly audit will be reported to DON. " Review of Policy and Procedure on Resident Rights and Responsibilities (Policy # LPAT0001) is also being undertaken to target all staff via Section Heads under the direction of the DON, SW, and Education Director. This will be implemented by 10/12/2021 and ongoing. " Quality of Life Surveys implemented on 10/10/2021, based on data collected via Department of Health Interview was conducted by Social Worker with resident R60 on 10/12/2021. " Social Worker will also review Resident□s Rights with resident□s with BIMS Scores 13 and above and conduct Quality of Life Survey. Resident Quality of Life Survey to be conducted on Assessment Reference Dates (ARD) in preparation for care plan meeting by Social Services. Participants include those who are verbal and willing to participate. Participants that are non-verbal can participate via staff observation, or via resident representative. Responses that do not meet the satisfaction of the resident□s right to self-determination will be recorded in quarterly interdisciplinary notes of the Social Services section. These responses will be discussed in the IDT meeting for further action and recommendation. Implemented on 10/12/2021 and ongoing. " Staff Training on Resident Centered Approach acre planning, and Resident Rights to be carried through beginning	

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F 561	Continued From page 10	F 561	10/10/2021-11/04/2021 with an in-service posttest to show staff□s level of competency and understanding.	
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the	F 565		10/29/21

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F 565	Continued From page 11 families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to protect their residents' right to have regularly scheduled Resident Council (RC) meetings or a regular platform for residents to meet either virtually or in person. This deficient practice impedes the residents from providing emotional support to each other, especially during the COVID-19 pandemic, provide one voice needed to iterate improvements in the facility without fear of retaliation by the staff and overall enhancing their quality of life. Findings include: 1) An online RC meeting was done via Zoom on 09/15/21 at 09:56 AM in a nursing unit's conference room. Five residents were in attendance and Social Worker (SW)1 facilitated the meeting. According to the SW1, the last formal RC meeting was held in November 2020. The former president and vice president both expired in July 2021. The new president and vice president for the RC were voted for at the 09/15/21 meeting. One of the residents asked if a suggestion box was available in the facility and the results of the "September 2021 COVID 19 Resident Council Satisfaction Survey" were shared. After the RC meeting at 10:44 AM, SW1 was interviewed via teleconference. She stated that resident satisfaction surveys were being done in place of RC meetings because of restrictions enforced during the COVID-19 pandemic.	F 565	Because the resident was anonymous, the Social Work department will assess all residents, who may have had been affected by this deficient practice. " These residents will be provided by SW with information of the Resident Council (RC) meeting and its bylaws and asked if they would like to participate. If they are not able to participate, SW will document on resident□s chart. (by 10/18/21) " The Chief Social worker will re-educate Social work staff, Recreational therapy staff, and licensed nursing staff, of the importance of the resident council meetings. The Social Work will identify other resident having the potential to be affected by this deficient practice, including " All residents will be informed one month in advance and one day prior to meetings verbally, and advertised RC meetings on RT calendars, and resident□s billboards. (by 10/17/21 and ongoing) " Upon admission, the Resident Access Representative will hand resident/family members/responsible parties, a Leahi Admission Handbook which will contain information of resident council, and SW phone number to call if they would like to get more information. (by 10/12/21 and ongoing) " SW will provide information on	

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F 565	Continued From page 12 On 09/16/21 at 11:25 AM an email communication was sent to SW1 asking about previous resident council surveys covering the period of December 2020 to August 2021. At 12:11 PM, SW1 sent a reply email stating that an RC survey was never done prior to this latest one in September, but a "resident satisfaction survey" was done that covered the period of December 2020 to January 2021. The document was attached to the email. On 09/16/21 at 2:07 PM, R47, who was the newly voted RC president, was interviewed in her room. She stated that there was no RC meeting for a year and a half. On 09/17/21 at 10:34 AM, an interview was conducted in the resident's room with a resident who wishes to remain anonymous. The resident stated that he had been at the facility for two years and has had no knowledge about RC meetings occurring in the facility. A record review of the anonymous resident's EMR was done on 09/17/21 at 11:19 AM. BIMS score on the resident's quarterly MDS assessment of 08/03/21 was "15" (range is 00-15) revealing that the resident is cognitively intact. 2) Surveyor interviewed a resident who wished to remain anonymous on 09/16/21 at 1:38 PM. Initially the resident stated that she was afraid to talk to the surveyor because she might be retaliated against by the facility staff. Resident stated, I'm not a piece of meat, I'm not a pile of dirt. I have rights. Surveyor asked if she ever filed a grievance with the facility about her concerns. The resident responded that in all the	F 565	Resident Council meetings and post on resident□s billboard information about the RC and the text of this law with the heading Rights of Resident Council (by 10/17/21 and ongoing) The Chief Social Worker will implement measures to ensure that this deficient practice does not recur including: " During COVID 19 restrictions, Resident Council meetings will be held on Zoom: SW and RT staff will make sure there is sufficient amount of IPads and they are in working condition so that residents are able to participate with RC meetings. SW will make sure there is a designated space for privacy for meetings to take place and staff support. (10/18/21 and ongoing) " Staff will be re-educated that they are prohibited from willfully interfering with the formation, maintenance or promotion of a RC. Willful interference includes discrimination or retaliation for participating in a resident council, refusal to publicize meetings or provide appropriate space for meetings, or failure to respond to written requests in a timely manner.(10/29/21) " Re-education on the Resident□s rights policy and procedure, and the right for residents to organize and participate in a resident council meeting with SWs, licensed nursing staff, and admission counselor will be conducted to all staff. (10/29/21) " A resident council satisfaction survey will be done in preparation to resident council meeting and it will include	

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F 565	Continued From page 13 time she has been at the facility they never told her how to file a grievance and that she didn't know there was a RC (meeting) until yesterday when she was asked if she wanted to go to the meeting.	F 565	questions regarding resident rights to self-determination, Ombudsman, and quality of life. Responses will be recorded in RC minutes and resident□s own interdisciplinary note of Social Service section. (10/29/21) " Patient Access Representative will provide newly admitted residents Leahi Admission Handbook, which provides information on resident council meetings and have resident/family member/responsible parties initial on admission paperwork, that they have received the Handbook. (9/21/21 and ongoing) " SW will inform each resident of the RC meetings one month and one day prior to meeting and document on chart if the resident refuses or agree to participate. The Chief Social Worker will monitor corrective actions to ensure effectiveness of these actions, including: " QA audits of all RC meetings and assess the rights of residents to organize and participate in resident groups in the facility. " Findings of QA audits and measurements will be shared in the quarterly QAPI meeting for actions and recommendations to improve this practice. (10/29/21 and ongoing)	
F 574 SS=E	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a	F 574		10/29/21

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F 574	Continued From page 14	F 574		

language he or she understands, including:
(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -
(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;
(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.
(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and
(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.
(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older

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F 574	Continued From page 15 Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to protect their residents' right to have the ability to file a complaint with outside advocacy agencies. This deficient practice has the potential to place the resident at risk for feeling vulnerable and fear retaliation by staff if a complaint against staff was made within the facility. Finding includes: An online RC meeting was done via Zoom on 09/15/21 at 09:56 AM with five residents and the SW1 facilitated. Results from the "September	F 574	To address how the corrective action will be accomplished to all residents that have been affected by the deficient practice, " Social works will provide all current residents, family members and responsible parties, Ombudsman information and contact information for all the state agencies that are advocates for LTC residents, in the language they are familiar with. (10/29/21) SW department will address how the facility will identify other residents having the potential to be affected by the same deficient practice	

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F 574	Continued From page 16 2021 COVID 19 Resident Council Satisfaction Survey" were discussed. The following was revealed: "Question 8. Do you know where the ombudsman's contact information is posted?" "Yes" responses were "42.9%" and "No" responses were "57.1%." An interview was conducted with R82 on 09/17/21 at 09:15 AM in her room. R82 had been at the facility for four years and does not like to go to the RC meetings. Surveyor asked her if she knows how to file a complaint with entities outside of the facility and she stated, "no." She had no knowledge of a long-term care (LTC) ombudsman and of a state agency being advocates for LTC residents and of her ability to report complaints to them. A follow up record review of R82's EMR was done on 09/17/21 at 11:29 AM. She is 40 years old with paralysis of her lower extremities. Her annual assessment on her MDS dated 09/09/21 revealed her BIMS score for cognition is "15." Review of R82's progress notes also revealed that she is alert and oriented to self, place, time and situation. On 09/17/21 at 10:34 AM, an interview was conducted in the resident's room with a resident who wishes to remain anonymous. The resident had been at the facility for two years and had had no knowledge about RC meetings occurring in the facility. The resident also had no knowledge about the LTC ombudsman and state agency being LTC advocates outside of the facility who could be contacted for complaints. A record review of the anonymous resident's EMR was done on 09/17/21 at 11:19 AM. BIMS	F 574	" All residents, family members, and responsible parties will be given a list of state agencies who advocates for LTC residents. (10/29/21 and ongoing) " Upon admission, the patient access representative will hand the resident/family members/responsible parties a Leahi Information Handbook which will contain the LTC Ombudsman address and phone number and the Office of Healthcare Assurance phone number and address. (10/12/21 and ongoing) " SW will post on resident bulletin boards information of LTC Ombudsman and all state agencies that they can call if there is any allegation of abuse or concerns regarding their care. (9/29/21) The measures that SW will put in place and systemic changes will ensure that deficient practice does not recur. " The Leahi Admission Handbook that is given by the admission department to resident/family member/responsible party will need to be initialed on the admission paperwork that they have received handbook and understand all the context. " When resident is educated and given information of the LTC Ombudsman and other state agencies that they can call in case of abuse, SW will document on chart that the action has taken place. (10/18/21) " During Resident Council meetings, SW will address the resident□s right to be protected from abuse and mistreatment, and ensure residents that the facility will investigate any reports of mistreatment immediately. (10/12/21 and ongoing) " During Resident Council meetings,	

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F 574	Continued From page 17 score on the resident's quarterly assessment of 08/03/21 was "15."	F 574	information that was given to council members will be documented in the minutes by SW. (10/12/21 and ongoing) " A resident council satisfaction survey will be done in preparation to resident council meeting which includes questions regarding resident□s rights to self-determination, Ombudsman, and quality of life. Responses will be recorded in minutes and resident□s own interdisciplinary note on the Social Service section.(10/18/21) " When retraining staff of Abuse and Neglect, and Resident□s Rights, and regarding LTC Ombudsman and state agencies that are able to help when there are allegations of abuse, staff□s attendance are being documented by their signatures. (10/29/21 and ongoing) Monitoring to Ensure Effectiveness of Corrective Actions to Avoid Recurrence: " The QA Coordinator/ Designee, will audit quarterly, all information posted in the bulletin boards and information given to the residents, pertaining to the LTC Ombudsman and all state agencies, that the residents may call if there is an abuse allegations or violations of their resident□s rights. The QA coordinator will also audit to ensure the residents can locate that information in the bulletin boards. (10/18/21 and ongoing) " Findings of QA audits will be shared in the quarterly QAPI meetings for discussion and for further actions and recommendations as necessary.	
F 585 SS=D	Grievances	F 585		10/29/21

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F 585	Continued From page 18 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 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	F 585		

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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 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

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F 585	Continued From page 20 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 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 staff interview and review of policy, the facility failed to identify and follow the grievance process for R335. Findings include: During an interview with SW1 on 09/17/21 at 1:30 PM, SW1 stated that the facility was dealing with a complaint for R335 and that the complaint was referred to an outside source for further investigation. SW1 said that communication with the complainant/s continued and the final results were pending. However, the facility did not file a formal grievance and thus, was not able to provide any further information such as a timeframe when the complainant/s could expect a completed review. SW1 acknowledged that the complaint for R335 met the criteria as a grievance and should have been treated as such. SW1 was also not sure who was responsible for overseeing their grievance process and reported that the facility did not have any grievances filed	F 585	Corrective action for R335 for this deficient practice: " Chief SW offered the resident R335□s advocate the option to submit a formal written grievance pertaining to her complaints. (9/22/21) Resident R335 was discharged on 10/01/21. SW1 will be addressed by this corrective action by: " Having the SW1 retrained on the Policy and Procedure of Grievance process (#ORPAT0006) by the facility□s QA Nurse. (9/22/21) The facility will identify other resident having the potential to be affected by the same deficient practice by: " SW will provide all residents/family members/responsible parties with information about the grievance process-	

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F 585	Continued From page 21 for this year. A review of facility policy on Complaint and Grievance Process stated the following: Purpose; to provide residents, participants and patients a process for expressing dissatisfaction with services provided by Oahu Region facilities and allow for orderly resolution to any complaint or grievance ... Policy; all staff members should take responsible action(s) whenever a complaint or grievance is expressed by any resident and advocate at any time. The staff member receiving the complaint or grievance is empowered to correct the concern, if able to, and will forward the information to their supervisor soon after the complaint is made for follow-up, the complaint, grievance will be managed in a timely manner to ensure that prompt feedback is provided to the complainant ... Definitions; complaint, a verbal expression of dissatisfaction regarding the response or action taken by staff to resolve an initial concern expressed by the resident/ advocate. Grievance; a written expression of dissatisfaction, expressing dissatisfaction with service delivery or the quality of care furnished expressed by the resident/ advocate; or a verbal complaint which was not resolved satisfactorily. Procedure for managing a grievance; If a verbal concern/complaint cannot be satisfactorily resolved within 72 hours and the complainant is not satisfied with the progress made to resolve the complaint, the Nurse Manager or Department Manager will offer the resident/advocate the option to submit a formal written grievance ... All formal written complaints/grievances will be reviewed by the Grievance Committee which will include, but is not limited to, the Director of Social Services, Director of Nursing, and the Quality Manager or	F 585	how to file a grievance, how to contact the grievance official, a time frame for complaint review, a written decision, and information about other entities with which grievances can be filed. All information will be given in a language they are familiar with. (1018/21 and ongoing) " Upon admission, the Resident access representative will hand the resident/family members/responsible parties a Leahi Admission Handbook which will contain information on the grievance process and grievance form, the address and phone number and the Office of Healthcare Assurance, LTC Ombudsman and the other state agencies that they are able to contact if there are any allegations of abuse or complaints about their care. (10/12/21 and ongoing) The measures that will put in place and systemic changes, SW will ensure that deficient practice does not recur. " During Resident Council meetings, SW will review information of the Complaint and Grievance Process to all residents and reiterate to them, the resident□s right to be protected from abuse and mistreatment, and to be able to report mistreatment or safety concerns without fear of retaliation. (10/29/21) " Review of Policy and Procedure on Complaint and Grievance Process (Policy # ORPAT006) is also being conducted to all staff by the SW and Education Director. (10/29/21) " SW will assist any resident with unresolved complaints, unsatisfactory	

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F 585	Continued From page 22 designees. Formal Written Grievance Process; the formal grievance will be forwarded to the Administrator for assignment as needed. As appropriate, the Administrator will assign the grievance to the supervisor of the unit/section that the grievance is directed and informs the Grievance Committee. All other reasonable resolution attempts to be taken are considered top priority and should be implemented at least within 72 working hours of the formal grievance notification by the Administrator. The resident/advocate shall be promptly advised by the social worker of the final (and interim) solutions being taken with verbal updates every seven (7) working days thereafter until a final resolution is reached. The resident/ advocate will be notified in writing once the final recommendations are made by the Grievance Committee. The letter will include the name of the facility's contact person, investigation findings, actions taken to resolve the grievance, the date of completion, and the notice of appeal. The body of the letter shall also address any recommendations made by the resident/advocate to address the grievance. It will also include further appeals provided if the resident/advocate remains dissatisfied. A copy of the letter will also be forwarded to the Grievance Committee. All completed Grievance Forms and written complaints/grievances accompanied by their written responses/ resolutions will be forwarded to the Oahu Region Risk Manager through each Oahu Region Facility's Administration. All grievances will be reported to each facility's Quality Assurance Performance Improvement Committee (QAPI) and the Oahu Region QACCC on a quarterly basis ...	F 585	handling of reports of abuse or mistreatment, and will guide and explain the grievance process to the resident/family/responsible party. This will be documented in the resident□s chart. (10/12/21 and ongoing) " During RC meetings, information that was given to council members will be documented in the minutes by SW. (10/29/21 and ongoing) Monitoring to Ensure Effectiveness of the Corrective Actions and to Ensure no Recurrence of this Deficient Practice: " All residents will be surveyed by the SW department quarterly, with questionnaires pertaining to Grievance process to find out if the resident is aware/ or able to recall what had been introduced and discussed with them. (10/29/21 and ongoing) " The SW will create a complaints log, and reviews the log weekly and monthly, to ensure no complaints are missed, and follow-up each complaint to ensure the resident/family member/responsible party is satisfied with the interventions, and complaint is resolved, or if a grievance process is necessary. " Results of all this monitoring will be reported to the quarterly QAPI meeting for further actions and recommendations as indicated.	
F 609 SS=D	Reporting of Alleged Violations	F 609		10/29/21

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F 609	Continued From page 23 CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and review of the facility's policy and procedures, the facility failed to immediately report an allegation of abuse immediately, but not later than two hours after the allegation is made to the administrator of the facility, SA, and APS in accordance with Federal and State law for purposes of this	F 609	All licensed Staff are currently undergoing review and acknowledgement of understanding of Policy LPAT0003-Prevention of Resident Abuse, Neglect, Involuntary Seclusion and Misappropriation of Property that outlines the Reporting Responsibilities both	

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F 609	Continued From page 24 regulation. R335 reported an allegation of sexual abuse to a family member, who then notified NS4 on 09/07/21 at 6:36 PM. R335 reported feeling bad, sad, and violated when RN10 inserted a finger in the resident's rectum and vagina when administering a rectal suppository. The allegation was not reported to the Administrator or the SA within the required timeframe. Findings include: On 09/17/21 at 10:36 AM, conducted an interview with the DON regarding the allegation of SA. Requested to review the facility's investigation and documentation. The DON confirmed herself as the Designee and reportedly did not find out about the allegation until the following day (09/08/21). According to the facility's "Event Report", the following timeline of notifications confirms the facility did not report the allegation of SA immediately or within a two-hour timeframe to the State Agency or the Administrator/Designee. -Date of the event- 09/07/21 at 6:36 PM -Initial Date reported to the Office of Health Care Assurance- 09/8/21 at 7:26 PM via fax -Date reported to APS- 09/09/21 at 08:27 AM (according to SA's Complaints Tracking System) -Notification of Physician- 09/08/21 at 6:00 PM -Notification of Family Member- 09/07/21 at 6:36 PM (R335's FM reported the allegation to NS4) -Notification of Administrator/Designee- 09/08/21 at 3:00 PM On 09/17/21 at 10:36 AM, conducted an interview with SW1. SW1 could not provide documentation indicating the facility reported the allegation of SA immediately to the Administrator/Designee or State Agency within two hours of R335's FM	F 609	internally and externally with attention to the required timelines stipulated. Licensed staff are asked to sign to acknowledged that they have read and understood this policy. This will be completed by 10/29/2021. NS4 was counseled and re-educated on the reporting requirements, both internally and externally to ensure an investigation is initiated immediately into any abuse allegation on 09/08/2021 by the DON. As corrective action for the deficient practice in this citation, NS4 was further counselled about the required reporting times to outside agencies including SA, APS, HPD and notifying her supervisors immediately whenever any abuse or alleged abuse occurs on 9/21/2021. Attempts were made on 09/08/2021 to contact RN 10 by telephone to inform her verbally that she was being placed on administrative leave pending investigation into allegation made by FM of R335. On both occasions the phone was not answered and a message to call DON immediately. At 6:30 AM on 09/09/2021 DON and NS called RN10, and she answered the phone. She was verbally notified of being placed on administrative leave pending investigation into allegation made by FM of R335. RN10 was also informed that she would be receiving a formal letter. After completing her shift on 09/07/2021, RN10 has not had any contact with R335 or any direct patient care or anywhere in the facility. We have identified the need for the creation of a Staff Checklist Tool that will	

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F 609	Continued From page 25 reporting the incident to NS4. Review of the facility's P&P, "Prevention of Resident Abuse, Neglect, Involuntary Seclusion and Misappropriation of Property" documents in Step 2: Reporting Responsibilities, the supervisor, i.e., charge nurse, shift supervisor, etc, shall immediately notify the DON and Administrator. In addition, if the abuse allegation includes assault, such as physical or sexual, the Honolulu Police Department (HPD) is notified for a police report. The facility did not file a report with HPD until two days after the allegation, on 09/09/21. A report received by OHCA from APS regarding APS's intake of the allegation documented the report date was 09/09/21 at 08:27 AM. The P&P documented the DON or Administrator shall notify APS and the Office of Healthcare Assurance (OHCA) within 24 hours, which the facility did not. (Refer to F552 Right To Be Informed, F600 Free from Neglect, F610 Investigate/prevent/correct Alleged Violations)	F 609	be utilized for use in the unfortunate circumstance that any abuse incident occurs within the facility. This tool will serve as a template for the required reporting time frames for outside agencies including the State Agency, APS, and HPD. This tool will cover: " Immediate removal of alleged abuser from contact with resident and any resident care areas by Nursing Supervisor/DON. " Notifying DON and Administrator immediately once an event of Abuse is identified. " Updating the attending physician and medical director immediately. " Notifying family and/or POA immediately. " Sending initial report of abuse to OHCA within 2 hours of incident occurring. " Sending report to APS within 24 hours. " If a crime is suspect or sexual abuse is alleged, HPD to be notified immediately. (If a crime(such as theft, physical or sexual abuse is reported/alleged, DON/Administrator will notify HPD immediately)). " Complete and document set of vitals on resident and complete a head to toe assessment. " If sexual abuse is alleged, transfer to Kapiolani Women□s Center for a Rape Kit and medical follow up. Refusal of this evaluation will be witnessed by 2 licensed staff and documented. " If physical abuse is reported/alleged - Resident to be transferred to ER for	

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F 609	Continued From page 26	F 609	immediate evaluation. Refusal of this evaluation will be witnessed by 2 licensed staff and documented. " Notify attending social worker to facilitate follow up with resident and complete a psychosocial assessment post incident. " Provide appropriate Trauma informed care services to Resident. Geropshych referral will be offered to resident. " Initiate preliminary investigation to complete OHCA report within 5 days. " Initiation of comprehensive investigation into incident. This may be internal or external. This tool will be implemented by 10/25/2021. The DON/Designee will conduct an audit every end of each shift daily, to ensure no alleged abuse complaints from resident/family/responsible party are missed or unreported during the shift. Each unit will create a log of all alleged abuse/abuse complaints from residents/family/responsible party, with dates, time, staff caring for this resident, and others involved with the complaint, for the DON /Designee to audit. The results of this monitoring will be reported to the quarterly QAPI meeting for further actions/recommendations as necessary.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 610		10/29/21

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F 610	Continued From page 27 §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure an allegation of abuse was thoroughly investigated and immediately put effective measures in place to prevent further or potential abuse for one resident, R335, sampled. After R335's FM reported an allegation of sexual abuse (SA) to NS4 on duty, RN10 was not immediately removed from providing direct care (including incontinent care) and continued to have access to the resident. As a result of this deficiency, the resident was not protected from the potential of further harm and potential coercion by staff. Findings include: On 09/07/21 at 6:36 PM, FM informed NS4 that R335 called FM, crying and reported she felt violated when the nurse administered a rectal suppository without being informed that the medication would be administered rectally. NS4 followed up with R335 during which the resident	F 610	Resident R335 was discharged on 10/01/2021. RN 10 remains on administrative leave pending conclusion of external investigation. An external investigation was instituted due to claim of bias by FM of R335. She will also undergo re-education/counseling regarding her responsibilities in regards to making sure residents are informed and make decisions about the care they receive and steps she needs to take if she is accused of abuse in the future. The other staff that were working on that night also underwent one on one reeducation if this occurs in the future (as more than one person was aware of this incident on the floor). The facility must ensure to pay attention to every resident□s/family/responsible party□s complaint of abuse or neglect, and must ensure to remove the alleged perpetrator immediately from providing	

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F 610	Continued From page 28 stated, "I can't eat, I feel so bad and sad. She (RN10) put her finger in my ass (made a swirling motion with her left finger), in my vagina too." NS4 apologized and explained to R335 that he/she needed the suppository to have a bowel movement (BM) and it's been 4 days since the resident had a BM. R335 got tearful, asked if FM was going to pick the resident up. On 09/17/21 at 3:21 PM, conducted a telephone interview with RN10. RN10 confirmed he/she was not sent home, reassigned to another unit, or was removed from providing direct care to R335 and/or other vulnerable residents. Review of R335's EMR documented a progress written by RN10 on 09/07/21 at 11:01 PM (after the allegation was reported to NS4), "....Resident said that she's upset and mad BP elevated obtained order for nitropaste....(R335) Refused care during HS and last round." Review of the facility's completed investigation into the allegation documented on 09/09/21 RN10 received a letter stated the staff would be placed on administrative leave pending an investigation of a formal complaint by FM, on behalf of R335. R335 felt she "got raped, felt violated and in prison". The incident report alleged RN10 did not explain a rectal suppository was going to be administered to the resident. Refer to F552 Right To Be Informed, F600 Free from Abuse and Neglect, F609 Reporting Allegations)	F 610	direct care to the affected resident and other resident□s care areas, to protect the resident and others from potential further harm or abuse, and an investigation must be initiated immediately. All licensed Staff are currently undergoing review and acknowledgement of understanding of Policy LPAT0003-Prevention of Resident Abuse, Neglect, Involuntary Seclusion and Misappropriation of Property that outlines the Reporting Responsibilities both internally and externally with attention to immediate removal of the alleged abuser from further contact with resident and all resident care areas, and the required timelines stipulated for reporting. Licensed staff are asked to sign to acknowledged that they have read and understood this policy. By undertaking review of this policy staff will be re-educated about the responsibility of taking preventive measures to prevent any resident being put in place of any potential abuse. This will be implemented by 10/29/2021. NS4 was counseled and re-educated on the reporting requirements, both internally and externally to ensure an investigation is initiated immediately into any abuse allegation on 09/08/2021 by the DON. As corrective action for the deficient practice in this citation, NS4 was further counselled about the required reporting times to outside agencies including SA, APS, HPD and notifying her supervisors immediately whenever any abuse or alleged abuse occurs on 9/21/2021. We have identified the need for the	

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F 610	Continued From page 29	F 610	creation of a checklist tool that will be created for use in the unfortunate circumstance should ever any abuse incident occur within the facility. Use of the tool will facilitate immediate initiation of an investigation into any abuse allegation. This tool will cover: " Immediate removal of alleged abuser from contact with resident and any resident care areas by Nursing Supervisor/DON. " Notifying DON and Administrator immediately once an event of Abuse is identified. " Updating the attending physician and medical director immediately. " Notifying family and/or POA immediately. " Sending initial report of abuse to OHCA within 2 hours of incident occurring. " Sending report to APS within 24 hours. " If a crime is suspect or sexual abuse is alleged, HPD to be notified immediately. (If a crime (such as theft, physical or sexual abuse is reported/alleged, DON/Administrator will notify HPD immediately)). " Complete and document set of vitals on resident and complete a head to toe assessment. " If sexual abuse is alleged, transfer to Kapiolani Women□s Center for a Rape Kit and medical follow up. Refusal of this evaluation will be witnessed by 2 licensed staff and documented. " If physical abuse is reported/alleged - Resident to be transferred to ER for	

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F 610	Continued From page 30	F 610	immediate evaluation. Refusal of this evaluation will be witnessed by 2 licensed staff and documented. " Notify attending social worker to facilitate follow up with resident and complete a psychosocial assessment post incident. " Provide appropriate Trauma informed care services to Resident. Geropshych referral will be offered to resident. " Initiate preliminary investigation to complete OHCA report within 5 days. " Initiation of comprehensive investigation into incident. This may be internal or external. This tool will be implemented by 10/25/2021. All allegations of abuse will be reviewed for completion of all immediate steps/reporting required, and initiation and completion of investigation/s undertaken by Admin/DON. All allegations of abuse are currently reported quarterly to QAPI and QACC and this will continue to be an ongoing process of monitoring any abuse or alleged abuse incidents. All allegations of abuse will be reviewed for completion of all immediate steps/reporting required, and initiation and completion of investigation/s undertaken by Admin/DON. All allegations of abuse are currently reported quarterly to QAPI and QACC and this will continue to be an ongoing process of monitoring any abuse or alleged abuse incidents. IDR for this FTag has been sent as an attachment through ePOC.	
F 641 SS=D	Accuracy of Assessments	F 641		11/4/21

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F 641	Continued From page 31 CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the assessment accurately reflected the resident's status for three residents, R56, R336, and R335. R56 was portrayed as delusional, but was not. R336's admission MDS did not document the resident's use of an anticoagulant medication. R335's nursing admission assessment did not accurately document the resident's ability to hear. The deficient practice impedes the resident's plan of care which is not accurately reflected and has the potential to decrease the resident's quality of care. Findings include: Surveyor reviewed the EMR for R56 on 09/15/21 at 01:06 PM who was diagnosed with a delusional disorder. Progress notes document resident refuses treatment, care, vaccinations, etc. MDS was not coded for behaviors (section E). R56's cognitive assessment scores her at a BIMS of 15, (a high score). On 09/16/21 at 10:52 AM, surveyor reviewed the care plan dated 08/10/21. Problem: Resident with accusatory and suspicious behavior. Resident will be calm and cooperative with every care. Assure resident that staff are here to protect her. Staff to ensure document episode of accusatory to the staff and update social worker. Staff to ensure resident is	F 641	" MDS coordinator reviewed EMAR and corrected the R336□s admission MDS to include the use of anticoagulant. Completed 9/21/17. " MDS coordinator/designee will identify current residents on anticoagulants. An initial 6 month look back audit of all current residents on anticoagulants to ensure accuracy of MDS coding. Commenced on 10/13/2021 and will be completed by 11/04/21. " MDS coordinator/designee will identify current residents on anticoagulants. The list of residents identified with anticoagulant use will be audited to ensure accurate coding. o This process was commenced on 10/13/2021 and will be an ongoing for any current resident commenced on anticoagulants and all new admissions. Audits will be conducted monthly and at random. These audits will commence in October 13, 2021 and will be ongoing. Audits will also be included in quarterly reporting to QAPI Coordinator and presented to the QAPI meeting. " MDS Coordinator/Designee will audit the MDS assessments monthly to ensure that correct information is reflected in the assessments. The audits will be reported	

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informed and explained all procedures and activity to be done. The resident has impaired cognitive function/ dementia or impaired thought processes related to impaired decision making. The resident will improve current level of cognitive function through the review date.

Surveyor reviewed a letter dated 08/15/19. The letter was signed by the attending psychiatrist which addressed R56's cognitive capacity. The letter stated that the resident was unable to receive and evaluate information or make or communicate decisions regarding her, to such an extent that this patient lacked the ability to meet essential requirements for her physical health, safety, or self-care, even with appropriate and reasonable available technological assistance. Recommended that the resident has an unlimited guardianship for her needs.

Surveyor reviewed a letter dated 08/29/18 from the primary care physician agreeing with the psychiatrist that the resident is incapacitated and unable to manage property and business affairs effectively because of an impairment in the ability to receive and evaluate information or to make and communicate decisions, even with the appropriate and reasonable available technological assistance. Patient cannot physically handle documents and financial affairs due to her disability.

Surveyor interviewed R56 on 09/16/21 at 01:38 PM in her room, who presented as alert and oriented to person, place, and time. R56 was pleasant and open during the conversation.

On 09/17/21 at 08:09 AM, surveyor interviewed the MDS coordinator in the conference room.

to the quarterly QAPI committee meeting, for further recommendations as necessary. These audits will be implemented and October 13, 2021 and will be ongoing.

" The deficiency in assessing R335□s hearing deficit as slightly impaired in the Nursing Admission Assessment conducted at 2:30 PM on 9/21/2021 was reviewed and updated in the MDS for R335 on 10/12/2021 showed that Section B (Hearing, Speech & Vision) had been coded to reflect Moderate Difficulty (2) in hearing for R335. Care plan was initiated on 09/09/2021 for R335□s hearing deficit and then revised and updated on 09/21/2021. R335 was discharged on 10/01/2021.

" To ensure this deficient practice is rectified for all new admissions to the facility the following interventions and practices will be incorporated into the admission of all new residents. Part of the current admission process documented on the Nursing Admission Assessment form, Part B is to assess and document any communication/sensory deficits. These deficits may be sensory (including hearing and visual) and/or language barriers. To ensure all future residents are assessed for communication/Sensory deficits on admission in a timely manner, licensed nursing staff will be required to complete section B within 30 minutes of arrival to the unit. Assessments to include an interview with resident to determine any visual, hearing or verbal comprehension deficits. An allocated space to document the time reviewed will

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F 641	Continued From page 33 When asked about section E behavioral assessment, and why R56 has a diagnosis of delusional disorder, there is no code? MDS coordinator responded its usually the (SW) who completes sections D and E. She gets the information from the nurse and certified nurse aide (CNA). Surveyors interviewed the fourth-floor charge nurse (CN) on 09/17/21 at 09:09 AM. Surveyor asked if the care plan is based on R56 specific conditions and if the goals and objectives are effective. CN responded that they monitor and assess the resident daily, the psychiatrist that sees and assesses the resident gives recommendations. We usually try to go in with two staff, approach the resident quietly and calmly, most times we can redirect. She knows and reads a lot; she doesn't want to take any medication due to side effects. She's up to date, on everything. There is a few of the staff who she trusts to get a bed bath. Most of the time she's in a good a good mood. She's alert. Surveyor interviewed SW1 on 09/17/21 at 09:30 AM in the conference room and asked why R56 had a diagnosis of delusional disorder and was not coded on the MDS, quarterly assessment. SW1 responded, "because she is not delusional" She refuses a lot of her treatment, and the ombudsman is involved. She wants to be left alone, be on her bed, reading her newspaper, listening to the news radio stations. For bathing, she doesn't want to get out of bed, I think because it hurts her, she will only let PT help her get up. I don't know if it is causing her pain. It's her right to. She understands her rights. She refused to have the COVID-19 testing. She heard really bad things about it. She listens to	F 641	be added to section B on the Nursing Admission Assessment Form. The Head nurse will be responsible for auditing all new admissions within 24 hours to ensure completion of the Sensory Assessment was done within 30 minutes after admission. Head nurses will submit any reported communication and/or sensory deficits identified to the DON who will audit these reports and report them to QAPI and QACC. Ongoing assessment of all residents will occur at least annually and/or if resident has a significant change in condition, during IDT meetings and when any resident has a significant change in condition. Nursing Education to provide at initial Orientation and annual on-going Competency Skills Training, adding a Sensory Assessment Component. This will be implemented by 10/29/2021. " Review of documentation in R56□s Electronic Medical Record (EMR) was done on 10/13/2021 by MDS coordinator, DON and Social Worker. MDS was modified to reflect documented behaviors of refusal of care under Section E (Behavior). Behavioral monitoring by Headnurses will be on-going, to monitor R56□s refusal of care and observations will be reported to IDT team meeting, and care plan updated as necessary. This was commenced 10/13/2021 and on-going. IDR for this FTag has been sent as an attachment through ePOC.	

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the public radio; she has never had one and feels that anything put in her body is poison.
2) On 09/16/21 at 10:59 AM, a review of R336's EMR documented that the resident was admitted to the facility on 09/03/21. Review of the resident's medical diagnosis documented R336 had a cerebral infarction (stroke) and the long-term use of an anticoagulants noted. Medication orders and MAR documented an order for Apixaban (Eliquis) (blood-thinner medication) tablet 2.5 milligrams (mg) by mouth every 12 hours for cerebrovascular accident (CVA, stroke) was ordered on 09/03/21 at 20:00 (8:00 PM) and administered as ordered. Review of the resident's admission MDS documented the assessment was completed on 09/16/21 but had not yet been submitted. In Section N-Medications Received, N0410 E. Anticoagulant, was marked 0 (zero) the resident did not receive any anticoagulant medication during the last 7 days or since admission/entry into the facility.

During an interview and concurrent review of R336's EMR on 09/17/21 08:11 AM, the MDS Coordinator confirmed Eliquis is coded as an anticoagulant and if a resident receives Eliquis, it should be coded and reflected in Section N-Medications Received N.0410. The MDS Coordinator navigated R336's EMR and confirmed the resident's admission MDS had been marked as completed on 09/16/21, the resident was ordered and administered Eliquis as ordered, and the use of Eliquis was not reflected in Section N of the resident's admission MDS. The MDS coordinator further confirmed had this surveyor not pointed out the error, the MDS would have been submitted as completed, stating "How come I missed this one? I just completed this one yesterday, I did not submit it yet so I will correct it

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before submitting it." and proceeded to correct the error in the MDS.

3) While conducting investigation into an allegation of sexual abuse, reviewed R335's EMR and paper medical chart on 09/17/21. Review of the Nursing Admission Assessment of 09/07/21 at 2:30 PM, in the System Assessment B. Communication/Sensory marked a box indicating no problems then marked the box indicating the resident has difficulty with hearing and hand wrote "slightly impaired".

On 09/14/21 at 09:35 AM, surveyor knocked on R335's room door and loudly announced herself. The resident did not turn her head, surveyor approached the resident's bed announced her presence once again. The resident did not react to surveyor's verbal announcements and surveyor left the resident's room. On 09/15/21 at 10:15 AM, as this surveyor approached R335's room, NM9 informed surveyor that R335 is hard of hearing and the resident has a amplifier and to write on the whiteboard to communicate to the resident. Upon entering the room, the resident did not respond to surveyor's knock on the door or verbal announcement when entering the room again. The resident was resting in bed and did not become aware of surveyor's presence until she was within the resident's visual field. Surveyor stood approximately one foot away from the resident and loudly verbally announced herself again. The resident did not reply to the verbal announcement and said, "Who are you?". Surveyor showed the resident her identification card and the resident stated she could not hear the surveyor and stated "you gotta use the whiteboard and write because I cannot hear you."

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F 641	Continued From page 36 Conducted interviews with regular unit staff who wish to remain anonymous throughout the survey regarding R335's hearing ability. Staff confirmed the resident is significantly hearing impaired and requires the use of an amplifier and/or the use of a whiteboard to write as a means of effective communication.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of	F 655		10/29/21

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F 655	Continued From page 37 this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to ensure a baseline care plan was developed which included the instructions needed to provide effective and person-centered care of the resident for R336. R336's care plan did not include the use of resident's regularly scheduled anticoagulant (blood thinner medication) to ensure staff are monitoring R336 for side effects and potential dangers of the use of the medication. As a result of this deficiency, the resident is at an increased risk of bleeding and potential harm. Findings include: On 09/16/21 at 10:59 AM, conducted a record review of R336's EMR. Review of the resident's medical diagnosis documented R336 had a cerebral infarction (stroke) and is on long term use of an anticoagulant. Review of R336's medication orders documented an order for Apixaban (Eliquis) 2.5 milligrams tablet, Give 1 tablet by mouth every 12 hours for CVA (stroke)	F 655	CORRECTIVE ACTION TO THIS DEFICIENT PRACTICE: " RN63 reviewed Resident R336□s care plan and updated to include the use of Eliquis. Completed 09/21/2021 " The MDS Coordinator reviewed Resident R336□s Medication Orders and MAR and corrected the MDS. Completed on 09/21/2021 IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL OF BEING AFFECTED BY THIS DEFICIENT PRACTICE: " MDS Coordinator/Head Nurse to do an audit of all residents on anticoagulants in the past 6 months and correct any deficiency on care plan. Completed by: 10/29/21 MEASURES/SYSTEMIC CHANGES MADE TO ENSURE NO RECURRENCE OF THIS DEFICIENT PRACTICE:	

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F 655	Continued From page 38 was ordered on 09/03/21 at 8:00 PM. Review of the resident's admission MDS documented in Section N- Medications N.0410 was coded as zero (0), indicating the resident did not receive Eliquis within the past 7 days of the review. Review of the R336's care plan did not include the resident's use of an anticoagulant. During an interview and concurrent record review with the MDS Coordinator on 09/17/21 at 08:11 AM in the conference room, the MDS Coordinator confirmed R336's assessment was completed on 09/16/21, but had not yet been submitted. The MDS Coordinator reviewed the resident's medication orders and MAR and stated he/she had missed that the resident is administered Eliquis, and the medication should have been coded on the MDS but was not. The MDS Coordinator thanked this surveyor for finding the error and stated the resident's admission MDS would have been sent out with the error had this surveyor not informed him/her. The MDS Coordinator then proceeded to correct the R336's admission MDS to include the resident's use of an anticoagulant. On 09/17/21 at 09:12 AM, conducted an interview and concurrent record review with registered nurse (RN)63 regarding R336's use of an anticoagulant medication. RN63 confirmed R336 did have a Physician's Order for Apixaban (Eliquis) 2.5 mg every 12 hours and review of the MAR documented the resident was administered the medication as ordered, and review of the Care Plan documented the resident should have had a care plan for the use of the anticoagulant medication but did not. RN63 then proceeded to update R336's care plan to include the use of Eliquis.	F 655	" All Licensed Nurses re-educated regarding baseline care plans by RAI/Head Nurses. Completed by 10/29/2021. " In-services and re-education will be on-going for all nurses annually and as needed. " Process Improvement Plan (PIP) for Baseline Care Plans email group established by 10/15/2021. Licensed nurses and interdisciplinary team members will email group when he/she completes their care plans. 10/15/21 and On-going. " All NEW anticoagulant orders will have a care plan created within 24 hours of the order. 10/21/21 and on-going " MDS Coordinators/Head Nurse checks to ensure base line care plan developed provides effective and person-centered care. Implemented 10/12/2021 and on-going. MONITORING TO ENSURE EFFECTIVENESS OF CORRECTIVE ACTION: " MDS Coordinators/Unit Managers/Designee will monitor compliance through audit of new admissions□ baseline care plans by 40 hours□ post-admission. Anything found to be out of compliance to be completed by 48 hours post-admission by the discipline identified to be out of compliance. 10/21/21 and on going " The Nursing Supervisors and Head Nurses/or designee will continuously monitor every resident□s Baseline Care plan on each nursing unit. The	

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F 655	Continued From page 39	F 655	Pharmerica Monthly Facility Clinical Report on Anti -Coagulants, is reviewed monthly, to ensure that the anticoagulant is care planned and coded in the MDS accurately. This will be implemented by 10/29/2021 and will be on-going. " The results of this monthly monitoring will be reported to the quarterly Quality Assurance (QAPI) Committee Meeting, and actions/recommendations will be implemented as necessary. 10/29/21 and on-going IDR for this FTag has been sent as an attachment through ePOC.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		10/29/21

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F 656	Continued From page 40 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide services to four residents, R35, R50, R65 and R73, as outlined in their comprehensive care plan. This deficient practice does not provide care to these residents that are needed to maintain their highest practicable physical, mental, and psychosocial well-being. Findings include: 1) Several observations of R35 were done on 09/14/21 through 09/16/21. During these periods of observations, R35 remained in his bed curled up in the fetal position lying on his right side. After he was greeted by the surveyor, he would respond in a foreign language. Sensory stimulation like a television being on, iPad or	F 656	" R73, R35, R50 and R65□s current care plans were reviewed with RN20 by Unit Manager (for R73) and by the Young 3 Nursing and activity staff (including the unit Nurse Manager and Activity director) for R35, R50, R65 . 10/18/21. " For R73 the importance of reviewing the care plan pertaining to pain assessment during dressing change discussed with RN20 on 10/12/202. It was identified the need to update with the MD the pain medication order. Obtained updated order from MD on 10/12/2021 to assess pain level and administer pain medication prior to dressing changes. Pain medication to be administered one hour prior to R73□s daily dressing change. This was implemented on	

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F 656	Continued From page 41 music being played were not observed. On 09/16/21 at 12:26 PM, review of R35's EMR was done. R35 is a 65-year-old admitted to the facility on 04/17/21 for dementia (loss of cognitive functioning). His care plan (CP) with target completion date 07/28/21 revealed the following: "Problem: Need of activities to maintain quality of life." "Interventions: ...play Laotian music (You tube) ...turn television on daily" A search for activity flowsheets from January to August 2021 was done, but no activity flowsheets were found to have been completed by the nursing staff. A "Nurse Note" documented in the progress notes dated and timed for 09/06/21 at "14:36" (2:36 PM) stated: " ...He likes to watch TV in his room ..." On 09/17/21 at 08:41 AM, NM3 was interviewed at the unit's nursing station. She stated that R35 listens to Laotian music via the iPad. On 09/17/21 at 10:43 AM, the AC was interviewed at the unit's nursing station. She stated that there had been periods of time where activities personnel could not do activities with the resident because of restrictions placed due to the COVID-19 pandemic. She further stated that during those periods, nursing personnel were supposed to do activities with the residents and document it in the resident's EMR. She further informed the surveyor that doing activities with R35 was difficult because of the language barrier, but that he still enjoys music played via the iPad or television. On 09/17/21 at 3:00 PM, R35's activity flowsheets for the months of June to August 2021 were	F 656	10/12/2021 and will be ongoing until further review by MD and nursing staff, and/or pressure injury resolved and no longer requiring dressing changes. " Upon admission residents admitted with pressure injuries and current residents with pressure injuries requiring dressing changes, will have the Licensed nurses review with MD pain medication orders, and obtain or update orders from MD, for routine pain medication orders and prior to wound dressings. Effectivity of pain medication will be documented by licensed nurses. This was implemented on 10/12/2021 and will be ongoing for all residents with pressure ulcers requiring dressing changes. " Ongoing education provided by Head Nurses/Nursing Supervisors/Wound Care Nurse to all Licensed Nurses and newly hired licensed nurses, regarding importance of pain assessment and pain management for all residents. Policy #LNUR0014- Pain Assessment and Care Management will be reviewed and updated by DON, Nursing Supervisors, and Head Nurses, and will be completed by 10/20/2021. Head Nurses will be review the updated policy with all licensed nurses. For activity based care plans, the activity staff will add a summary of the residents care planned activities into the activity participation flow sheet chart to serve as cue, as to the resident□s interests, 10/26/2021. " The Activity Director met with the unit Activity Coordinator and Activity Aide assigned to Young 3 to review the care plans of R35, R50 and R 65□s and to	

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F 656	Continued From page 42 reviewed. A retrospective analysis of the activity flowsheets showed for the month of August: "Music/Radio" was marked as completed for seven of the 31 days. No days were marked done for "TV Favorites." The month of July revealed "Music/Radio" was not marked for the whole month. "TV Favorites" was marked completed for 13 of the 31 days. For June, there were 18 days of the 30-day total, marked as done for "TV Favorites" and no days were marked for "Music/Radio." (Refer to F679 Activities Meet Interest/Needs Each Resident) 2) Several observations of R50 were done on 09/14/21 through 09/16/21. All the following observations were of R50 in her room: On 09/14/21 at 09:22 AM and 09/15/21 at 07:48 AM, R50 was found lying on her back situated centrally on her bed which was placed on the floor, mattresses on either side of her bed. She had hand rolls in both of her hands, made eye contact with the surveyor when she was addressed, moved all her extremities, and made verbalizations to herself that were difficult to understand. On 09/14/21 at 11:56 AM, R50 was lying horizontally on the mattress, restless and moving her limbs. On 09/15/21 at 09:21 AM, R50 was up in a recliner and did not respond to the surveyor when she was greeted. On 09/16/21 at 2:00 PM, music via a radio player located in the corner of her room, was playing while she lied quietly, centered in her bed, and made eye contact with the surveyor when she was greeted. On 09/16/21 at 09:41 AM, R50's EMR was reviewed. R50 is a 54-year-old resident admitted to the facility on 11/18/20 for early onset Alzheimer's disease (loss of cognitive	F 656	discuss the importance of providing the identified activity preferences of residents on 10/13/2021. For R35, R50 and R 65□s: their room setups were evaluated and staff installed a wall mounted music players in each of their rooms on 10/12/2021, next to the head of their beds. Staff set up a loaned TV for use at the resident□s bedside of resident R35 on 10/12/2021. Play lists will be created on flash drives for music per each resident□s preferences (by 10/26/21), and is compatible to play on the wall mounted music players. The unit Activity Coordinator will conduct monthly audits of these residents and to discuss the results in the monthly staff meeting, to plan for any needed corrective action. These audits will be implemented by 10/26/21 and will be ongoing. " Activity and Nursing staff reviewed all of the resident□s activity based Care plans, to re-familiarize themselves to the resident□s current activity preferences. The Activity Director and Activity Coordinators will create a list of current resident□s that could have a potential of being impacted by this deficient practice (R35, R50 and R 65□s), noted as residents that are dependent of staff to engage in the pursuits of their listed preferences. New admissions will be identified and discussed in the admission IDT, which will further be noted on the resident□s participation flow sheet. Staff will utilize the list to highlight which residents are at risk in the future of this deficient practice. 10/26/21 and on-going. " The activity participation flow	

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F 656	Continued From page 43 functioning). Her CP with target completion date 08/12/21 revealed: "Problem: Need of activities to maintain quality of life" "Interventions: " ...Turn radio daily ..." "Problem: BEHAVIOR - Resident noted to yell at staff, constantly fidgets in bed, talking to self, grinding her teeth." "Interventions: "Sensory stimulation calming music" A search for activity flowsheets from January to August 2021 was done, but no activity flowsheets were found to have been completed by the nursing staff. R50's behavior monitors flowsheet for August 2021 was reviewed. There were 10 days (August 2, 3, 4, 10, 12, 13, 14, 16, 17 and 22) where music was documented as not being played to manage R50's behaviors as indicated by "6) turn on radio with calming music" not being entered. On 09/17/21 at 08:41 AM, NM3 was interviewed at the unit's nursing station. She stated that music helps to manage R50's behaviors and she stays calm when music is played. On 09/17/21 at 10:43 AM, the AC was interviewed at the unit's nursing station. She stated that there had been periods of time where activities personnel could not do activities with the resident because of restrictions placed due to the COVID-19 pandemic. She further stated that during those periods, nursing personnel were supposed to do activities with the residents and document it in the resident's EMR. On 09/17/21 at 3:15 PM, R50's activity flowsheet for the month of August 2021 was reviewed.	F 656	sheet/attendance will be kept on each unit for the nursing staff to be able to document leisure activities. The Nursing staff will be in-serviced for the process of the documentation by 10/26/21. " Licensed Nurse/Unit managers/MDS Coordinators and Wound Care Nurse /QAPI, will monitor compliance with the new admissions and newly identified Pressure Injury /Pressure Ulcer within 24 hours. Activity participation flow sheets will be audited monthly by each unit Activity Coordinator, to ensure identified resident□s activity preferences are being provided and to discuss the results in the monthly staff meeting for needed action/recommendation. The Activity Director will complete an independent quarterly audit of the activity participation flow sheets, to monitor that the documentation on the flow sheets, reflects the preferred resident care planned activities/preferences. Results of monthly QA audits will be reported to the facility□s Administration through the quarterly QAPI meetings, for further action and recommendations. 10/29/21 and on-going.	

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When it was compared to R50's August 2021 behavior monitors flowsheet, there was a total of seven days (August 2, 3, 4, 10, 13, 14, 17) where "Music" as a "Group Program" and "Music/Radio" as an independent activity were not documented as being done for R50. (Refer to F679 Activities Meet Interest/Needs Each Resident)

3) Several observations of R65 were done of the resident in his room on 09/14/21 through 09/16/21. R65 was observed receiving oxygen through tubing going to his tracheostomy (surgically formed hole in his trachea). An electronic pump delivering liquid nutrition was noted next to his bed. R65 did not respond to any verbal greeting given by the surveyor. Sensory stimulation like a television, iPad or music being played were not observed.

On 09/17/21 at 11:53 AM. R65's EMR was reviewed. R65 is a 57-year-old resident initially admitted to the facility on 10/12/16 and currently has the diagnosis of "persistent vegetative state" (severe brain damage). His CP with target completion date of 08/26/21 revealed:
"Problem: Need of activities to maintain quality of life"
"Interventions: keep radio (Hawaiian) on during day"
A search for activity flowsheets from January to August 2021 was done, but no activity flowsheets were found to have been completed by the nursing staff. A review of "Nurse Note(s)" in the progress notes was done from the 01/04/21 at "14:08" (2:08 PM) documentation to 09/16/21, "04:25" (04:25 AM) note, there was no indication about playing Hawaiian music on a device for R65.

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On 09/17/21 at 08:41 AM, NM3 was interviewed at the unit's nursing station. She stated that R65 likes to Hawaiian music and listens to sports. Surveyor informed NM3 that R65 did not have a music player in his room. She stated that R65 previously had a music player in his room. After the interview, NM3 was observed in the unit's hallway, holding a music player telling the CNA to place the player in R65's room.

On 09/17/21 at 10:43 AM, the AC was interviewed at the unit's nursing station. She stated that there had been periods of time where activities personnel could not do activities with the resident because of restrictions placed due to the COVID-19 pandemic. She further stated that during those periods, nursing personnel were supposed to do activities with the residents and document it in the resident's EMR. She stated that sensory stimulation is done with R65 and that he likes Hawaiian music.

On 09/17/21 at 3:30 PM, R65's activity flowsheets for the months of June to August 2021 were reviewed. A retrospective analysis revealed: nine of the 31 days of August were marked as done for "Music," 21 of the 31 days of July were marked completed for "Music," and 25 of the 30 days in June were marked as completed. (Refer to F679 Activities Meet Interest/Needs Each Resident)

4) R73 is a 92-year-old admitted on 06/01/20 with diagnoses of Alzheimer's disease and dementia (decreased memory and thinking skills), dysphagia (difficulty swallowing), vitamin D deficiency, hypothyroidism (underactive thyroid), on gastric tube (GT) feedings (liquid nutrition given through a surgically created tube to the stomach), contractures (shortening and

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hardening) of muscles of multiple sites and confined to bed. Per R73's weekly skin assessment dated 09/13/21, R73 has moisture-associated skin damage or MASD (inflammation and erosion of the skin caused by prolonged exposure to moisture and its contents) to the GT site, buttock and labia and a left great toe unstageable ulcer that requires a daily dressing change. Per R73's MDS assessment dated 06/22/21, R73 is non-verbal and rarely/never understood in her ability to express ideas, wants, and understanding verbal content and requires total assistance for activities of daily living.

On 09/16/21 at 11:11 AM in R73's room, R73 was observed contracted lying in bed on her back. Head of the bed was up at 45 degrees. A pillow was behind R73's head, a pillow behind each of R73's shoulders, and a pillow behind her back. Both of R73's arms were bent towards her chest, with a rolled bath towel in both elbow creases between each arm and trunk. Both of R73's fists were clenched around a paper towel. R73's knees were bent towards the chest with a pillow placed underneath the knees and between the legs. R73 also wore a brief. Both feet had foam heel protectors that were touching the bed. R73 eyes were closed and did not respond to surveyor's greeting. Surveyor observed registered nurse RN20 perform a daily dressing change to a pressure ulcer on her left great toe. R73 started moaning and had facial grimacing when her feet were removed from the heel protectors and when the pillow was removed from between her knees for the dressing change. R73 continued to moan and have facial grimacing during the dressing change. After the dressing change was completed, R73 moaned and grimaced when

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F 656	Continued From page 47 both feet were placed back into heel protectors and when knees were opened to place a pillow in between them. On 09/16/21 at 01:48 PM RN20 was interviewed at the unit's nursing station. Surveyor asked RN20 if any pain medication was given to R73 today, RN20 stated that no pain medication was given. No assessment was done as per R73's care plan dated 06/21/21, which stated for left great toe unstageable wound, intervention was to "Assess resident pain level thru facial grimacing. Administer medication prior to dressing change." Then, on 09/17/21 at 09:55 AM in R73's room, RN20 stated that R73 was recently given pain medication because R73 was moaning during nursing care that morning. Surveyor observed daily dressing change performed by RN20 again. R73 appeared to have decreased facial grimacing and moaning during dressing change compared to the day prior. RN20 stated that "I give medication if R73 is moaning but R73 always moans when position changes are done. R73 was on pain medication routinely but the doctor made it PRN [as needed] because it would mask symptoms of fever." A record review of R73's EMR was done on 09/17/21 at 12:29 PM. R73's MAR indicated Mapap Liquid (acetaminophen) 160 mg/5 mL (milliliters) Give 20 ml via GT every 4 hours as needed for pain or temperature of 100 or higher Max 4 gm/day. Acetaminophen was last given by RN20 on 09/16/21 at 2:06 PM and on 09/17/21 at 09:05 AM for a pain level of 2 with follow-up code listed as effective for both administrations.	F 656		
F 679 SS=E	Activities Meet Interest/Needs Each Resident	F 679		10/29/21

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F 679	Continued From page 48 CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide activities for four residents, R35, R50, R65 and R6. Resident activities are individually designed to meet their interests and supports the residents' physical, mental, and psychosocial well-being. This deficient practice has the potential to rob residents of having a meaningful life in the facility. Findings include: 1) Several observations of R35 were done on 09/14/21 through 09/16/21. During these periods of observations, R35 remained in his bed curled up in the fetal position lying on his right side. After he was greeted by the surveyor, he would respond in a foreign language. Sensory stimulation like a television being on, iPad or music being played were not observed. On 09/16/21 at 12:26 PM, review of R35's EMR was done. R35 is a 65-year-old admitted to the facility on 04/17/21 for dementia. His CP with target completion date 07/28/21 revealed the	F 679	" On 10/13/2021 Head Nurse discussed with R6 his current care plan for ambulation as part of his daily activities, as previously requested to ensure his current preference is being followed, except when he is not agreeable with this activity, staff to document refused. R6 has chosen his current preference for ambulation to occur twice a day. Care plan for R6 was updated 10/13/2021 to offer ambulation to R6 twice a day for mobilization and for activity, and to document if it occurred or if R6 declined activity. Re-educated CNAs the importance of acknowledging resident□s preference to improve mobility and provide pleasurable activities. The Activity Director met with the unit Activity Coordinator and Activity Aide assigned to Young 3 to review the care plans of R35, R50 and R 65□s and to discuss the importance of providing the identified activity preferences of these residents [10/13/2021]. The unit Activity Coordinator	

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following:
"Problem: Need of activities to maintain quality of life."
"Interventions: ...play Laotian music (You tube) ...turn television on daily"
A search for activity flowsheets from January to August 2021 was done, but no activity flowsheets were found to have been completed by the nursing staff.
A "Nurse Note" documented in the progress notes dated and timed for 09/06/21 at "14:36" (2:36 PM) stated: " ...He likes to watch TV in his room ..." (Refer F656 Develop/Implement Comprehensive Care Plan)

On 09/17/21 at 08:41 AM, NM3 was interviewed at the unit's nursing station. She stated that R35 listens to Laotian music via the iPad.

On 09/17/21 at 10:43 AM, the AC was interviewed at the unit's nursing station. She stated that there had been periods of time where activities personnel could not do activities with the resident because of restrictions placed due to the COVID-19 pandemic. She further stated that during those periods, nursing personnel were supposed to do activities with the residents and document it in the resident's EMR. She further informed the surveyor that doing activities with R35 was difficult because of the language barrier, but that he still enjoys music played via the iPad or television.

On 09/17/21 at 3:00 PM, R35's activity flowsheets for the months of June to August 2021 were reviewed. A retrospective analysis of the activity flowsheets showed for the month of August: "Music/Radio" was marked as completed for seven of the 31 days. No days were marked done

was instructed [10/19/2021] to conduct monthly audits of these residents and to discuss the results in the monthly staff meeting, to plan for any needed corrective action. Re-educated CNAs and activity staff of the importance of providing the residents with activities of their preference.
" Licensed Nurses and Head Nurses will assess to identify the resident□s ability and potential to ambulate, and to ensure ambulation is offered to R6 twice a day if appropriate. CNAs to report to Licensed Nurses and/or Head Nurses for any decline and changes for referrals to other services such as, rehab as needed, and care plan to be updated. Unit staff to refer to list of residents that are similar to these residents, impacted by this deficient practice (R35, R50 and R 65□s), noted as residents that are dependent on staff to engage in the pursuits of their listed preferences. List of residents will be completed by 10/26/21. Future admissions will be identified and discussed in the admission IDT, which will be noted on the resident□s participation flow sheet. Staff will utilize the list to focus on which residents are at risk of this deficient practice.
" Residents at risk for fall including R6 will continue to be assessed for assistance needed as necessary. CNS will continue to document report every shift about resident□s performance for re-evaluating resident□s level of function. For activity based care plans, the activity staff will add a summary of the residents care planned activities into the activity

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F 679	Continued From page 50 for "TV Favorites." The month of July revealed "Music/Radio" was not marked for the whole month. "TV Favorites" was marked completed for 13 of the 31 days. For June, there were 18 days of the 30-day total, marked as done for "TV Favorites" and no days were marked for "Music/Radio." 2) Several observations of R50 were done on 09/14/21 through 09/16/21. All the following observations were of R50 in her room: On 09/14/21 at 09:22 AM and 09/15/21 at 07:48 AM, R50 was found lying on her back situated centrally on her bed which was placed on the floor, mattresses on either side of her bed. She had hand rolls in both of her hands, made eye contact with the surveyor when she was addressed, moved all her extremities, and made verbalizations to herself that were difficult to understand. On 09/14/21 at 11:56 AM, R50 was lying horizontally on the mattress, restless and moving her limbs. On 09/15/21 at 09:21 AM, R50 was up in a recliner and did not respond to the surveyor when she was greeted. On 09/16/21 at 2:00 PM, music via a radio player located in the corner of her room, was playing while she lied quietly, centered in her bed, and made eye contact with the surveyor when she was greeted. On 09/16/21 at 09:41 AM, R50's EMR was reviewed. R50 is a 54-year-old resident admitted to the facility on 11/18/20 for early onset Alzheimer's disease. Her CP with target completion date 08/12/21 revealed: "Problem: Need of activities to maintain quality of life" "Interventions: " ...Turn radio daily ..." "Problem: BEHAVIOR - Resident noted to yell at	F 679	participation flow sheet chart, to serve as cue, as to the resident□s interests, 10/26/2021.The activity participation flow sheet/attendance will be kept on each unit for the nursing staff to be able to document leisure activities. The Nursing staff will be in-serviced for the process of the documentation by 10/26/2021. " Licensed Nurses/Nursing Supervisors and Rehab Department, for ambulation and the unit Activity Coordinators and Activity Director, for activity preferences, will audit compliance as evidence by monitoring resident□s level of function, on a monthly basis for ambulation, and for preferred activities being provided. Results of audits will be reported to DON and Quality Manager monthly for further action/recommendation as needed. 10/29/ 2021 and ongoing.	

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staff, constantly fidgets in bed, talking to self, grinding her teeth."
"Interventions: "Sensory stimulation calming music"
A search for activity flowsheets from January to August 2021 was done, but no activity flowsheets were found to have been completed by the nursing staff. R50's behavior monitors flowsheet for August 2021 was reviewed. There were 10 days (August 2, 3, 4, 10, 12, 13, 14, 16, 17 and 22) where music was documented as not being played to manage R50's behaviors as indicated by "6) turn on radio with calming music" not being entered.
(Refer F656 Develop/Implement Comprehensive Care Plan)

On 09/17/21 at 08:41 AM, UM3 was interviewed at the unit's nursing station. She stated that music helps to manage R50's behaviors and she stays calm when music is played.
On 09/17/21 at 10:43 AM, the AC was interviewed at the unit's nursing station. She stated that there had been periods of time where activities personnel could not do activities with the resident because of restrictions placed due to the COVID-19 pandemic. She further stated that during those periods, nursing personnel were supposed to do activities with the residents and document it in the resident's EMR.

On 09/17/21 at 3:15 PM, R50's activity flowsheet for the month of August 2021 was reviewed. When it was compared to R50's August 2021 behavior monitors flowsheet, there was a total of seven days (August 2, 3, 4, 10, 13, 14, 17) where "Music" as a "Group Program" and "Music/Radio" as an independent activity were not documented as being done for R50.

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3) Several observations of R65 were done of the resident in his room on 09/14/21 through 09/16/21. R65 was observed receiving oxygen through tubing going to his tracheostomy. An electronic pump delivering liquid nutrition was noted next to his bed. R65 did not respond to any verbal greeting given by the surveyor. Sensory stimulation like a television, iPad or music being played were not observed.

On 09/17/21 at 11:53 AM. R65's EMR was reviewed. R65 is a 57-year-old resident initially admitted to the facility on 10/12/16 and currently has the diagnosis of "persistent vegetative state". His CP with target completion date of 08/26/21 revealed:
"Problem: Need of activities to maintain quality of life"
"Interventions: keep radio (Hawaiian) on during day"
A search for activity flowsheets from January to August 2021 was done, but no activity flowsheets were found to have been completed by the nursing staff. A review of "Nurse Note(s)" in the progress notes was done from the 01/04/21 at "14:08" (2:08 PM) documentation to 09/16/21, "04:25" (04:25 AM) note, there was no indication about playing Hawaiian music on a device for R65. (Refer F656 Develop/Implement Comprehensive Care Plan)

On 09/17/21 at 08:41 AM, NM3 was interviewed at the unit's nursing station. She stated that R65 likes to Hawaiian music and listens to sports. Surveyor informed NM3 that R65 did not have a music player in his room. She stated that R65 previously had a music player in his room. After the interview, NM3 was observed in the unit's

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F 679	Continued From page 53	F 679		

hallway, holding a music player telling the CNA to place the player in R65's room.

On 09/17/21 at 10:43 AM, the AC was interviewed at the unit's nursing station. She stated that there had been periods of time where activities personnel could not do activities with the resident because of restrictions placed due to the COVID-19 pandemic. She further stated that during those periods, nursing personnel were supposed to do activities with the residents and document it in the resident's EMR. She stated that sensory stimulation is done with R65 and that he likes Hawaiian music.

On 09/17/21 at 3:30 PM, R65's activity flowsheets for the months of June to August 2021 were reviewed. A retrospective analysis revealed: nine of the 31 days of August were marked as done for "Music," 21 of the 31 days of July were marked completed for "Music," and 25 of the 30 days in June were marked as completed.

4) R6 is a 67 year old admitted on 06/13/19 with diagnoses of Parkinson's disease (chronic and progressive movement disorder that causes tremors in hands, stiffness, or slowing of movement), slurred speech, polyneuropathy (damage of peripheral nerves), colostomy (operation that creates an opening for the large intestine through the abdomen), urinary catheter (tube inserted into bladder to drain urine), acute embolism and thrombosis of unspecified deep veins of lower extremity (reduced blood flow to legs due to blood clots), congestive heart failure (heart unable to pump blood efficiently), difficulty walking, and gastroesophageal reflux disease without esophagitis (acid from stomach flows backward into the throat but no damage to the throat).

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F 679	Continued From page 54 In an observation on 09/14/21 at 11:30 AM in R6's room, R6 was alert and oriented to self, place, time and situation. R6 answered questions appropriately when asked. In an interview with R6 on 09/14/21 at 11:30 AM in R6's room, R6 stated that he walks with a certified nurse assistant (CNA) after lunch daily. R6 stated that he has asked staff to go walking in the hallway more than once a day, but his request was not addressed. R6 stated, "They said they don't have enough time. They are too busy charting." Record review on 9/17/21 at 11:37 AM, showed that R6's MDS, with ARD of 07/16/21, indicated a BIMS score of 15 meaning R6 is cognitively intact. MDS assessment with ARD 09/09/21 for Functional Abilities and Goals showed that once standing, R6 can walk at least 10-150 feet in a room, corridor or similar space with partial or moderate assistance. Resident's care plan on 06/21/21 for problem of decreased range of motion listed an intervention that resident requests to walk around unit at least one time a day.	F 679		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition	F 686		10/29/21

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F 686	Continued From page 55 demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to implement interventions to prevent a pressure ulcer and provide necessary treatment to prevent infection for R73 who was at risk for developing pressure ulcer/pressure injury (PU/PI) due to the presence of contractures. This deficient practice caused R73 to develop an unstageable PU/PI which was avoidable if the facility provided proper care. Findings include: R73 is a 92-year-old admitted on 06/01/20 with diagnoses of Alzheimer's disease and dementia, dysphagia, vitamin D deficiency, hypothyroidism, on GT feedings, contractures of muscles of multiple sites, and bed confinement status. R73 also presents with MASD to the GT site, buttock and labia and a left great toe unstageable ulcer that requires a daily dressing change. Per R73's MDS assessment dated 06/22/21, R73 is non-verbal and rarely/never understood in her ability to express ideas, wants, and understanding verbal content and requires total assistance for activities of daily living. On 09/14/21 at 8:30 AM in R73's room, R73 was observed contracted lying in bed on her back. Head of the bed was up at 45 degrees. A pillow was behind R73's head, a pillow behind each of	F 686	" Licensed Nurses and Head Nurse of the unit have commenced re-educating CNA□s regarding the importance of accurate and proper documentation for R73 and all other residents that require turning and repositioning every 2 hours, to prevent the development of pressure ulcers/injuries. Implemented as of 10/11/2021 and ongoing. Licensed nurses to ensure turning and repositioning are being done every shift and documented with the correct times when the activity is completed. Current re-education and in-service to be completed by 10/29/21 for CNA□s and follow-up will be ongoing. " Assessment of R73 and other identified residents with impaired mobility, as evidenced by contracture, incontinence, and at risk for developing pressure ulcers/injuries by Licensed Nurses and unit Head Nurse, and to ensure to re-educate nursing staff/CNA□s the importance of turning and repositioning to maintain an intact skin, and the importance of accurate and proper documentation for turning and repositioning every 2 hours when the activity is completed per protocol. 10/29/21 " As part of the admission in identifying skin issues, Licensed Nurse to ensure to	

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F 686	Continued From page 56 R73's shoulders, and a pillow behind her back. Both of R73's arms were bent towards the chest, with a rolled bath towel in both elbow creases between each arm and trunk. Both of R73's fists were clenched around a paper towel. R73's knees were bent towards the chest with a pillow placed underneath the knees and between the legs. R73 also wore a brief. Both feet had foam heel protectors that were touching the bed. R73 eyes were closed and did not respond to surveyor's greeting. Surveyor observed R73 in the same position on her back on 9/14/21 at 10:30 AM and at 11:39 AM. On 09/16/21 at 11:09 AM and 09/17/21 at 9:17AM in R73's room, surveyor observed RN20 perform a daily dressing change to her left toe wound. Surveyor observed R73's feet turned inward in a pigeon-toed fashion when heel protectors were opened. PU/PI to left great toe was located on right side of the toe and appeared to have dry black and white tissue with no drainage. Entire left great toe was colored deep pink compared to R73's other toes which were pale. R73's knees and legs closed together tightly after the pillow in between her legs was removed. On 09/16/2021 at 11:09 AM at the unit's medication cart, RN20 stated that R73's PU/PI "Started with a blister. R73 presses both feet together which is how she probably got the blister. She was on doxycycline antibiotics for infection." On 09/16/2021 at 1:51 PM at the unit's nursing station, in an interview with NM3, she stated that in R73's care plan, intervention of "Check positioning at least every two hours as needed" meant that patient needs to be physically turned	F 686	communicate to Head Nurse, Wound Care Nurse and Wound Consultant (as needed) for proper treatment, including pain level and any needed pain medication to be administered prior to wound dressings. Licensed Nurse to continue with Weekly Skin and Wound Assessments. Findings will be documented and Care planned as indicated. Training and education will be provided to all nursing staff and new hires. 10/12/2021 and ongoing. " Residents identified as at risk of pressure injuries including R73 will continue to be assessed for the need of any additional devices such as heel protectors, pillows, wedges, to aid in adequate repositioning that will prevent vulnerable areas of the body rubbing together that may create friction and lead to the development of a pressure injury. 10/13/2021 and ongoing. " Policy #ORNUR0003 will be reviewed and updated by DON and Education Director, by 10/20/2021. All licensed nursing staff and CNA□s are undergoing review of Policy #ORNUR0003-Skin Care and Pressure Injury Prevention. This will be completed by 10/29/21. " Licensed Nurses/Unit Managers/Nursing Supervisors/MDS Coordinators and Wound Care Nurse will audit compliance with the new admissions and newly identified Pressure Injury /Pressure Ulcer within 24 hours. Residents at risk of Pressure injury, current residents with pressure injuries, and residents requiring frequent turns and repositioning have been identified.	

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F 686	Continued From page 57 to a different position. When surveyor showed NM3 R73's turn and position flowchart with multiple entries for the same time, NM3 stated that "They (certified nursing assistants) might not chart in real time, so entries are put in late and only records the time that they inputted the entry not the actual time the patient was turned." A record review (RR) was done on 9/16/21 at 1:00 PM of R73's care plan dated 06/21/21. It stated that for the problem of left great toe unstageable, the intervention is to alleviate and minimize friction/shearing during repositioning. For care plan problem: the resident has an ADL [activities of daily living] self-care performance deficit r/t [related to] impaired mobility (Decrease Range of Motion to Bilateral Upper and lower extremities) impaired cognition Dx. [diagnosis] Alzheimer's dementia, the intervention is to check positioning at least every two hours as needed. R73's task flowchart for Turn and Reposition, revealed that turning and repositioning of R73 was completed on 09/14/21 at 06:34 AM, 07:44 AM, 9:08 AM, 12:50 PM, 2:01 PM, 8:01 PM, 8:01 PM, and 8:01 PM. Surveyor did not observe the repositioning and turning of R73 from 08:30 AM to 11:39 AM as evidenced by R73 being in the same position. From 09/03/21 thru 09/15/21 except for 09/11/21, R73's flowchart for turning and repositioning indicated that R73 was turned and repositioned at the same time 53 out of 164 total entries. According to RR on 09/17/21 at 11:30 AM, "Nursing note" for 08/05/21 at 10:30 AM stated,"...PCP [primary care physician] notified and new orders obtained for transfer to green zone and lt. [left] great toe tx. L/M [leave message] with podiatrist office for podiatry	F 686	Residents identified to be at risk on admission will be added to this list. These residents will be monitored daily by different shift nursing supervisors/designee, for timely turning and repositioning, as well as correct documentation (including correct times) by CNA□s on the appropriate flowsheets. An audit tool will be developed to document these audits. 10/20/21 and ongoing. Weekly Skin and Wound assessment will continue to be done and documented. Monthly audit results will be reported to the DON, and will be forwarded to the QAPI Coordinator, to be presented at the quarterly QAPI meeting for further action/recommendation, as necessary. This process will be implemented by 10/20/2021 and will be ongoing.	

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F 686	Continued From page 58 consult ...Resident transferred via her bed to Y4 [Young 4] at 1030. On 08/05/21, clinical physician order to apply bilateral heel protectors initiated. Weekly skin assessment note on 08/09/21 stated DTI [deep tissue injury] to right medial great toe AEB [as evidenced by] blister intact with discoloration. Measuring 1.2 cm (centimeter) x 1.8cm. Cleanse with normal saline, pat dry, and apply skin prep daily. Clinical physician orders on 08/26/21 of X-ray of left great toe. Diagnosis Left great toe redness and swelling. On 09/01/21, MAR stated, Doxycycline Hyclate (antibiotic) Tablet 100 mg. Give 1 tablet via GT two times a day for left great toe infection until 09/13/21. Weekly skin assessment note on 09/13/21 states Left first toe Unstageable. Area 1.0 cm x 1.4 cm with 50% dry dark scab and 50% dry white tissue. Toe swelling and redness decreased. Tx. [treatment] Cleanse left great toe unstageable wound with NS [normal saline], pat dry, apply sorbact dressing and cover with dry dressing daily. Improving. In a RR done on 09/17/21 at 12:00 PM, the facility's Policies and Procedures for Skin Care and Pressure Injury Prevention effective 11/08/17, stated that in Section D. Protection from Friction, Shear and Pressure, #11. For residents who are unable to turn or shift their weight, reposition every 2 to 3 hours.	F 686		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		10/29/21

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F 812	Continued From page 59 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to follow proper handwashing techniques as it relates to food safety requirements. The deficient practice has the potential to place residents at risk for foodborne illness. Antimicrobial gel (hand hygiene agent that does not require water) cannot be used in place of proper handwashing techniques in a food service setting. Finding includes: During an observation of the kitchen on 09/16/21 at 2:16 p.m. alcohol based hand sanitizer dispensers were observed at multiple locations throughout the kitchen. In an interview with the Kitchen Manager (KM) in the kitchen on 09/16, at 2:16 p.m., the KM stated, alcohol based hand sanitizer is used for hand hygiene (when face touched, change gloves, or whenever) by the kitchen staff in the kitchen area.	F 812	" All antimicrobial gel/hand sanitizer agent that does not require water has been taking out of the kitchen areas/ food service setting. (09/21/2021) " Inspection by the Administrator of the entire kitchen areas to ensure no antimicrobial gels or hand sanitizing agents are present or available for staff to use. (10/13/2021) " An in-service was conducted by the Education Director on proper hand hygiene with all the Dietary Staff, with the emphasis on NOT using antimicrobial gels or waterless sanitizing agents in the food service setting. The instructions were also focused on emphasizing to all Dietary staff that hand sanitizer must not replace hand washing by all means in the food service setting. (10/14/2021) Please find attached Hand Hygiene and gloving documentation of the review in-service conducted to all Dietary staff.	

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F 812	Continued From page 60	F 812	" The Administrator will be making rounds in the Dietary Department monthly to ensure that this action is continuously implemented and practiced, and that no Antimicrobial gels or hand sanitizers are kept/ used in the food service department. The results of the monitoring will be reported to the quarterly QAPI meeting for further actions or recommendations as necessary. (10/13/2021 and on-going). Please find attached Hand Hygiene and gloving documentation of the review in-service conducted to all Dietary staff.	
F 880 SS=D	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	F 880		10/29/21

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F 880	Continued From page 61 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 62 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to ensure infection control practices were implemented to help prevent the development and transmission of communicable diseases and infections for one (R37) of two residents sampled. Observed R37's catheter bag and tubing in direct contact with the floor. As a result of this deficiency, R37 is at an increased risk of infection. Findings include: On 09/14/21 at 09:39 AM, observed R37 laying in bed, the bed was in the lowest position and a catheter bag was hanging from the bed. Observed the catheter bag and tubing in direct contact with the ground. During an interview on 09/17/21 at 09:35 AM, RN63 confirmed R37's catheter bag and tubing should not touch the ground and places R37 at an increased risk for infection.	F 880	" R37□s urinary catheter bag has been covered and tubing is coiled to ensure none of the catheter bag nor the tubing touches the floor. 09/21/21 Staff involved (licensed and C.N.A.□s) in the care of R37 has been counseled and re-educated on the importance of ensuring the catheter bag and the tubing will not touch the floor to prevent the resident from having increased the risk of catheter associated infection. 10/12/21 The facility will conduct Root-cause analysis to find out the reasons why this incident happened in order to know what actions to take to avoid recurrence. 10/15/21 " All residents with urinary catheters will be checked to ensure they all have urinary bag covers and to ensure the placement of their tubings and catheter bags are not touching the floor. 09/21/21 " All staff (licensed and C.N.A.□s) are re-educated on the care of the urinary bags to ensure no catheter bags or tubings are found touching the floor. (CDC TRAIN-Module 10A □ Indwelling urinary Catheter Video) 10/29/21 The Unit Head nurse, the Infection Preventionist, and the Education Director will re-educate all Licensed staff and the C.N. A□s, on the care of catheter and catheter bags to ensure they understand the reasons of not letting the urinary bags	

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F 880	Continued From page 63	F 880	and the tubing touch the floor, to prevent the resident from having increased risk of catheter associated infection. 10/29/21 The C.N.A. in-charge of the care of any resident with catheter will ensure that he/she checks every time he/she repositions the resident to ensure the bag or the catheter tubing is not touching the floor. 09/21/21 and ongoing " The Unit Head Nurse/Designee will be checking the urinary catheters and the bags every shift to ensure this infection control guideline are being followed. The IP will be making rounds monthly, to ensure the infection prevention aspect of catheter care, including making sure the catheter tubings or bags are not touching the floor, catheter is secured, and catheter is free from kinks and loops, are implemented. The results of this monitoring will be documented and will be forwarded quarterly to the QAPI committee for further actions and recommendations, as necessary. 10/15/21 and on-going.	

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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
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: K-353 Sprinkler System-Inspection and Testing This standard is not met as evidenced by: Based on record review and staff interview with facility manager, the facility failed to produce documentation for a monthly and quarterly fire sprinkler system inspection and testing in accordance with NFPA 101, Life Safety Code, 2012 edition, section 9.7.5, and NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems 2011 edition, section 5.2. This deficiency could affect all residents, staff, and visitors during a fire due to the lack of monthly and quarterly inspections to ensure proper fire sprinkler operations during fire conditions within the facility.	K 353	All fire sprinklers within the facility have been inspected and tested on 11/02/2021 @ 11:35 AM by the Elite Fire Services. 11/02/2021 A log of fire sprinkler inspection and testing, monthly and quarterly, has been created, to ensure proper documentation is being maintained, every time a required monthly and quarterly inspection and testing are being conducted. 11/02/2021 To ensure this fire sprinkler inspection and testing requirements are being implemented and properly documented, the Hospital Administrator/Designee will be monitoring and conducting a monthly audit of the inspection and testing, and its	11/2/21

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

Electronically Signed | 11/04/2021

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/21/2021**

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K 353	Continued From page 1 Findings include: During record review on 10/21/21 at approximately 11:15 am revealed that the facility failed to provide documentation for the monthly and quarterly fire sprinkler inspection and testing. These findings were verified at the exit conference with the facility manager on 10/21/21 at 1:15 pm.	K 353	documentation. This is also to ensure safety for all residents and staff during any fire occurrence in the facility. 11/02/2021 and on-going. The results of this monitoring will be reported to the QAPI quarterly meeting for further actions and recommendations as necessary. 11/02/2021 and on-going	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: K-761 Maintenance, Inspection and testing-Doors This STANDARD is not met as evidenced by: Based on record review and staff interview with facility manager, the facility failed to produce documentation for an annual inspection for the fire doors in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 edition, sections 5.2, and 5.2.3. This deficiency could affect all residents, staff, and	K 761	All Fire Doors in the facility will be inspected by Fire Doors Hawaii, on 11/04/2021, and annually thereafter as required, in accordance with NFPA 80, Standard of Fire Doors and Other Opening Protectives, to ensure the safety of all residents and staff. 11/04/2021 and annually A log has been developed to ensure there will be proper documentation of	11/4/21

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	125010	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/21/2021**

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K 761	Continued From page 2 visitors during a fire due to the lack of an annual inspection to ensure proper protection from fire and smoke extension within the facility. Findings include: During record review on 10/21/21 at approximately 11:15 am revealed that the facility failed to provide documentation for the annual fire door inspection. These findings were verified at the exit conference with the facility manager on 10/21/21 at 1:15 pm.	K 761	annual inspection conducted on every fire door in the facility. 11/04/2021 The Maintenance Supervisor will submit the log to the Administrator each time the annual inspection and testing of all facility fire doors are conducted and completed, to ensure the inspection and testing conducted are properly documented. 11/04/2021 and on-going. The results of this audit will be submitted to the quarterly QAPI meeting for further discussion and recommendation as necessary. 11/04/2021 and on-going.	
K 918 SS=D	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	K 918		10/29/21

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	125010	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/21/2021**

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K 918	Continued From page 3 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 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: K-918 Electrical Systems-Essential Electric System Maintenance and Testing This STANDARD is not met as evidenced by: Based on record review and staff interview with facility manager, the facility failed to produce documentation for an annual testing of diesel fuel in accordance with NFPA 99 Healthcare Facilities Code, 2012 edition, section 6.5.4, and NFPA 110 Standard for Emergency and Standby Power Systems, 2010 edition, section 8.3.8. This deficiency could affect all residents, staff, and visitors during an interruption of grid power due to the lack of an annual diesel fuel test to ensure proper operation of the standby power system. Findings include: During record review on 10/21/21 at approximately 11:15 am revealed that the facility failed to provide documentation for the annual diesel fuel test. These findings were verified at the exit conference with the facility manager on 10/21/21 at 1:15 pm.	K 918	Annual diesel fuel test has been conducted by M. Nakai Repair Services, LTD., on 10/29/2021. The results are expected to be back in 2-3 weeks. Routine annual testing of diesel fuel will be conducted as required, in accordance with NFPA 99 Healthcare Facilities Code, and NFPA 110 Standard for Emergency and Standby Power Systems, to ensure proper operation of the standby power system. 10/29/2021 and annually. A log to document this annual diesel fuel testing has been created, to ensure proper documentation of every annual diesel fuel testing conducted. 11/03/2021 The Maintenance Supervisor will submit this log annually to the Administrator each time the diesel fuel testing is conducted. 11/03/2021 and annually The results of this monitoring will be submitted to the quarterly QAPI meeting for discussion and for further action as necessary. 11/03/2021 and on-going	

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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		

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