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	125041	A. BUILDING _____ B. WING _____	02/10/2022

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LILIHA HEALTHCARE CENTER	1814 LILIHA STREET HONOLULU, HI 96817

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA). The facility was not in compliance with 42 CFR 483 Subpart B. Survey Dates: 02/07/22 to 02/10/22 Survey Census: 78 Sample Size: 28	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.	F 578		3/22/22

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

Electronically Signed | 03/11/2022

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F 578	Continued From page 1 (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interview, review of policy on Resident Rights regarding Treatment and Advance Health Care Directives (AHCD), the facility failed to provide information concerning the right to formulate an AHCD for three Residents (R) 24, 47, 65 out of twenty eight residents reviewed. Findings include: 1) Review of the Electronic Health Record (EHR) showed R24 was admitted on 11/10/21 with a diagnosis of Urosepsis, Diabetes, Hypertension, Cerebral Vascular Accident, Atrial Fibrillation. There was also a physician order to provide Cardiopulmonary Resuscitation (CPR) if needed in emergency situations. During an interview with R24, on 02/08/22 at 10:00 AM, R24 stated that the facility did not offer anything about formulating an AHCD. On 02/08/22 at 10:30 AM, Social Worker (SW) was queried about providing R24 information to	F 578	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility□s credible allegation of compliance. F578 1. Immediate action(s) taken for the resident(s) found to have been affected include: The Advanced Directives status of RI# 24, 47, 65 was verified and entered into all relevant locations within the electronic medical record. Social Services Director or Designee to communicate with resident or family as applicable for changes or initiation of Advanced Healthcare Directives(AHCD).	

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F 578	Continued From page 2 formulate an AHCD. SW stated that he/she was temporarily in the current staff position and that the previous staff member in charge of the AHCD information has since left. SW acknowledged that there was no documentation that R24 was provided any information concerning the right to formulate an AHCD. 2) On 02/10/22 at 09:55 AM, conducted a record review of R47's EHR. There was no documentation that R47 had an ACHD. A review of the resident's progress notes did not document that R47 (or resident representative) had an AHCD on file, was offered assistance with an AHCD, or refused assistance with formulating an AHCD. On 02/10/2022 at 11:30 AM, inquired with the SW regarding R47's AHCD. SW confirmed there was no documentation that R47 had an AHCD, was offered assistance with formulating an AHCD, or refused assistance with formulating an AHCD. 3) On 02/09/22 at 02:26 PM, R65's EHR was reviewed. R65 was admitted to the facility on 07/29/20. R65's "Face Sheet" under "Advanced Directives" stated that R65 was "Full Code" requiring "Full treatment" and that a copy of the AHCD was on file. A copy of R65's AHCD was not found in R65's EHR. A review of facility policy on Resident ' s Rights regarding Treatment and Advance Directives stated the following: Policy, it is the policy of the facility to support and facilitate a resident ' s right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive. Policy explanation and Compliance guidelines; 1. On admission, the facility will	F 578	Documentation of that communication/education will be provided in the medical record. 2. Identification of other residents having the potential to be affected was accomplished by: Determining the code status or presence/absence of AHCD is required for all residents. Therefore, all residents have the potential to be affected. 3. The Director of Nursing Services educated social services staff and licensed nurses regarding the documentation procedures for Advance Directives/code status. A chart audit of all residents was completed on March 14, 2022. Discrepant findings were addressed immediately, and all needed actions were completed on March 18, 2022. Upon admission Social Services Director or Designee will educate and document in the medical record discussions with family or resident regarding completing Advanced Directives. Quarterly, residents and families who have not yet executed advanced directives, will be offered by Social Services Director or Designee. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: For a period of three months, the Director of Social Services or designee will perform weekly medical record audits of new admissions and those residents on the MDS assessment schedule for consistent documentation of the	

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F 578	Continued From page 3 determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. 2. The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive. 3. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff. 4. The facility will periodically assess the resident for decision-making abilities and approach the health care proxy or legal representative if the resident is determined not to have decision making capacities. 5. The facility will identify or arrange for an appropriate representative for the resident to serve as primary decision maker if the resident is assessed as unable to make relevant health care decisions. 6. The facility will define and clarify medical issues and present them to the resident or legal representative as appropriate ... 8. Decisions regarding advance directives and treatment will be periodically reviewed as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions. 9. Any decision making regarding the resident ' s choices will be documented in the resident ' s medical record and communicated to the interdisciplinary team and staff responsible for the resident ' s care ...14. The facility will use the process as provided by State law for handling situations in which the facility and/or physician do not believe that they can provide care in accordance with the resident ' s advance directives or other wishes.	F 578	resident□s Advance Directive/code status throughout the electronic medical record. After three months, the Director of Social Services will complete a random medical record audit of at least 10 records for consistent documentation. Results of the audits will be discussed monthly with the QAA committee until such time it is determined that substantial compliance is maintained. Corrective action completion date: By: March 22, 2022	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months	F 638		3/22/22

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F 638	Continued From page 4 CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and review of the facility's policy, the facility failed to conduct a quarterly review assessment at least every 3 months for Resident (R) 1. As a result of this deficient practice, R1's was put at risk for inadequate monitoring of her health status. On 02/08/22 at 04:59 PM, R1's Electronic Health Record (EHR) was reviewed. Admission Minimum Data Set (MDS) review with an Admission Reference Date (ARD) of 09/30/21 was documented in R1's EHR. Under "Assessments Due" tab, Quarterly MDS Review with ARD of 12/31/21 was documented as overdue. On 02/09/22 at 09:56 AM, Minimum Data Set Coordinator (MDSC) 1 was interviewed. MDSC1 reviewed R1's EHR and stated that R1's Quarterly MDS with ARD 12/31/21 was "Not on file and not done. It is overdue. I will do it right away." On 02/10/22 at 09:07 AM, MDSC1 reviewed the facility policy "MDS 3.0 Completion" dated 03/01/21. MDSC1 confirmed that the policy stated, "2e. Quarterly Assessment-completed using an ARD no >92 days from the most recent prior quarterly or comprehensive assessment (counting ARD to ARD)." MDSC1 stated, "We	F 638	F638 1. Immediate action(s) taken for the resident(s) found to have been affected include: MDS Coordinator completed MDS Assessment for Resident # 1 on February 10, 2022. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service education was conducted by MDS Consultant or designee for MDS Coordinator to address the importance of tracking and completing MDS within the required time limit of not less frequently than 3 months. Completed on March 17, 2022. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: MDS Coordinator or designee will develop and maintain a monthly Calendar, reflecting the date by which these assessments are due to ensure there are	

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F 638	Continued From page 5 finished R1's quarterly assessment yesterday. R1's quarterly assessment was done late and was done past the 92 days deadline."	F 638	no late assessments. MDS Coordinator will report weekly for 4 weeks, Monthly for 3 months and Quarterly thereafter regarding on time completion of MDS. Results of the audits will be discussed monthly with the QAA committee until such time it is determined that substantial compliance is maintained. Corrective action completion date: By: March 22, 2022	
F 641 SS=D	Accuracy of Assessments 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 observations, review of Electronic Health Record (EHR), review of Minimum Data Set (MDS) and staff interview, the facility documented, in error, the use of a restraint for Resident (R) 41. As a result of this error, R41 ' s assessment was not accurately documented on the RAI. Findings include: On 02/08/22 at 02:00 PM, R41 was noted to be lying in bed, there was no restraint use noted. Review of R41 ' s EHR on 02/08/22 at 02:10 PM showed that there was no doctor ' s order for restraints and no care plan for restraints. Review of R41 ' s MDS Quarterly Review, Assessment date 12/12/21, Section P0100	F 641	F641 1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident # R41 was reassessed on February 11, 2022 to correct erroneous capture of a restraint (not present with resident). 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service education program was conducted by the Nurse Consultant	3/22/22

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F 641	Continued From page 6 Physical Restraints showed that Other Restraint was used less than daily. On 02/08/22 at 02:45 PM, Minimum Data Set Coordinator (MDSC) 1 was queried. MDSC1 acknowledged that there was no restraint use for R41 and that the MDS Quarterly Review, Assessment date 12/12/21 was miscoded in error. MDSC1 stated that they would look into the situation further.	F 641	and the Director of Nursing Services with all licensed staff including MDS Coordinator(s) addressing the importance of identifying the use of antipsychotic medications and the effect on the resident. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services, Regional Reimbursement Consultant, or designee, will conduct a random audit of five (5) resident MDS for four (4) consecutive weeks, monthly for 3 months to insure for MDS accuracy. The results of this audit will be reviewed by the QAPI Committee for further direction and follow up.	
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	F 656		3/25/22

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F 656	Continued From page 7 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure comprehensive care plans were developed and/or implemented for 4 of 18 Residents (R) 35, R76, R79, and R78. Findings include: 1) R35 was admitted to the facility on 10/16/20 with diagnosis that include cerebrovascular accident (stroke), anemia, epilepsy, dysphagia, quadriplegia, major depression disorder, and contracture to the right and left ankle. Review of R35's annual Minimum Data Set (MDS) with an	F 656	F656 1. Immediate action(s) taken for the resident(s) found to have been affected include: Care plan(s) of the resident identifier(s) RI# 35, 76, 79, 78 were reviewed and updated as indicated. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that residents with 1) altered texture diets, 2) residents who require a hoyer lifts for transfers, 3) residents who	

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F 656	Continued From page 8 Assessment Reference Date (ARD) of 03/02/2021 documented in Section O, 0500 Restorative Nursing Programs, documented with in the last 7 days R35 had splint or brace assistance all 7 days. Conducted multiple observation (02/07/22 at 09:32 AM, 10:38 AM, 11:12 AM, 12:30 PM, and 1:30 PM; 02/08/22 at 8:40 AM, 10:32, 11:37, 12:28, and 1:30 PM; 02/10/22 at 08:15 AM, 09:15 AM, and 10:00 AM) of R35 in bed with no handrolls, splint, boot, brace, or appliance applied to prevent the worsening of contractures to both feet and hands. On 02/09/22 at 09:15 AM, conducted a record review of R35's electronic medical records (EMR). Review of the resident's care plan (started on 09/21/21) documented a history of stroke (which resulted in the resident not being able to move himself/herself willingly) with interventions to utilize foot boot to bilateral feet for contracture prevention and to utilize split to right hand for prevention of contractures. On 02/10/22 at 09:01 AM, conducted a concurrent observation and interview with Restorative Nurse Aide (RNA)1 regarding the application of foot boots to both feet and the right-handed splint. RNA1 confirmed that R35 did not have the boots or splint applied and should have. RNA1 stated the boots and splints should be put on for four (4) hours from 8:00 AM to 12:00 PM by the certified nurse aides and the restorative nurse aides are responsible to remove the boots and splint. At 09:05 AM, conducted an interview with Certified Nurse Aide (CNA)6 who stated that it is the responsibility of the restorative nurse aides to apply the splints and boots.	F 656	have splinting devices, and 4) all residents who receive Hemodialysis (HD) have the potential to be affected. Each resident impacted above will have their care plan reviewed by March 25, 2022. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All interdisciplinary care plan team members responsible for writing care plans will be re-educated on the facility□'s policy and procedure for developing Comprehensive Care Plans. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing (DON), or designee, will complete random weekly audits of 3 resident care plans for six (6) consecutive weeks. Random audits will be completed to ensure that comprehensive care plans are developed for residents based on residents present needs. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident/Family Group Council for comment and suggestions. Corrective action completion date: March 25, 2022.	

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On 02/10/22 at 09:31 AM, conducted a concurrent interview while the Director of Nursing (DON) reviewed R35's EMR. This surveyor shared observations of no boots or splint applied to prevent the worsening of contractures for R35. After reviewing the resident's care plan the DON confirmed the boots and right-hand splint should have been applied to prevent the worsening of contractures for R35.

Review of the facility's policy and procedure on 02/10/22 at 12:05 PM, Restorative Nursing Program, document identified residents will receive services from restorative nursing services that includes splint or brace assistance.

2) R76 was admitted to the facility on 01/22/22 after being discharged from an acute hospital for altered mental status, metabolic encephalopathy, and weakness. R76 has a history of high blood pressure, Diabetes Mellitus, and end stage renal disease with dialysis dependence. Review of R76's admission MDS with an ARD of 01/29/22, Section C. Cognitive Patterns, documented a Brief Interview for Mental Status (BIMS) was a 15, indicating R76 is cognitively intact. Section O.-Special Treatments and Programs document the resident has dialysis treatment.

During an interview with R76 on 02/08/22 at 09:46 AM, the resident reported staff do not weigh the resident and the access site is not assessed by staff when returning from dialysis treatment on Mondays, Wednesdays, Thursdays, and Fridays.

On 02/08/22 at 09:52 AM, query Nursing Staff (NS)1 regarding how staff documents their

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assessment of R76's access site and the resident's weight prior to and after the hemodialysis appointment. NS1 confirmed R76 is not weighed upon returning to the facility and assessment of the access site was not documented in the resident's progress notes for the 3:30 PM- 11:30 PM, and 11:30 PM - 07:30 AM shifts on 02/07/22 and 02/09/22.

On 02/08/22 at 3:45 PM, conducted a review of R76's EMR. Review of the resident's care plan documented on 02/07/22 and 02/09/22 review of the progress notes documented R76's access site was not assessed upon returning to the facility after dialysis treatment. Review of the resident's care plan documented R76 requires dialysis secondary to End Stage Renal Disease. Approaches include for staff to monitor the dialysis port and monitor R76's weight, both as prescribed. Review of the physician orders documented an order for post dialysis weight once a day on Monday, Tuesday, Wednesday, and Thursday 3:30 PM to 11:30 PM. (started on 02/01/22) and to assess the vascular access LAVF, document thrill and bruit, monitor for pain, bleeding three (3) times a day 07:30 AM- 3:30 PM; 3:30 PM- 11:30 PM, and 11:30 PM- 07:30 AM (started on 02/01/22).

Review of the facility's policy and procedure on Hemodialysis, compliance guidelines, documented "7. The nurse will monitor and document the status of the resident's access site(s) upon returning from the dialysis treatment to observe for bleeding or other complications."

3) R79 was admitted to the facility on 01/28/22 with diagnosis that include traumatic subdural hemorrhage, prostate cancer, muscle weakness,

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F 656	Continued From page 11	F 656		

and dysphagia (difficulty swallowing). Review of R79's admission MDS with an ARD of 01/31/22, Section K. Swallowing/Nutritional Status K0510.2. documented the resident is on a mechanically altered diet that requires change in texture of food or liquids (e.g., pureed food or thickened liquids).

On 02/07/22 at 12:45 PM, while conducting dining observations during lunch, observed R79's meal card documented Nectar thick liquids. On R79's lunch tray was a bowl of soup with regular (no thickener added) consistency and a cup of water which contained thickener but was not nectar thick consistency. Immediately alerted NS16, who confirmed the soup base should have been Nectar thick and although the water did have thickener in it, it was not the correct consistency. NS16 notified the Dietary Manager (DM) who also confirmed the soup and water was not Nectar thick consistency. Posted on the wall behind the R79's bed was a bright pink sign documenting with bullet points:

Resident's name
Must have thickened liquids
His swallowing is not normal
Watery liquids will go down his windpipe
Water, juice, milk, clear soup must all be thickened
Thickened liquids should be like nectar or watery syrup

On 02/08/22 at approximately 10:30 AM, conducted an interview with the Registered Dietician (RD). RD confirmed R79 has swallowing difficulties and requires Nectar thick liquids for aspiration precaution.

On 02/09/22 at 08:15 AM, conducted a record

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review of R79's EMR. Review of the resident's diet order documented Nectar thick liquids (started on 01/28/22). On 02/08/22, Speech Therapy (SP)1 evaluated R79 and recommended Nectar thick liquids. Review of the resident's care plan documented the resident is at risk for fluid and nutrition deficit related to dysphagia (underweight; poor intake, and stage IV prostate cancer). An approach to R79's fluid and nutrition risk included to provide the resident's diet as ordered: Regular diet, chopped solids, nectar thick liquids (started 01/31/22).

4) On 02/08/22 at 12:56 PM, Certified Nurse Assistant (CNA) 4 and CNA5 was observed using a Hoyer lift to transfer R78 from her wheelchair to her bed. R78 appeared to be alert and well nourished.

On 02/08/22 at 01:03 PM, CNA4 and CNA5 were interviewed. CNA4 and CNA5 both stated that R78 requires two people and a Hoyer lift to transfer R78 from her wheelchair to her bed.

On 02/08/22 at 02:04 PM, R78's record was reviewed. R78 was admitted to the facility on 07/01/21 for congestive heart failure. On 02/08/22, R78's weight was documented at 217.5 lbs. with a Body Mass Index (BMI) of 38.52 meaning that R78 is obese. R78's quarterly Minimum Data Set (MDS) review with an Assessment Reference Date (ARD) of 01/31/22, stated that R78 requires "Two Persons physical assist." when transferring to or from the bed, chair, wheelchair, or to a standing position. In "Progress Note" dated 10/28/21, Registered

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F 656	Continued From page 13 Nurse (RN) 2 documented, "Explained by PT (physical therapist) to resident that due to pain issues, would recommend use of Hoyer lift for safe transfers for now ...Resident agreed to try using Hoyer lift." Review of R78's care plan did not show documentation that R78 required using two people and a Hoyer lift for transfers. On 02/09/22 at 09:32 AM, Unit Manager (UM) 2 reviewed R78's care plan. UM2 confirmed that there was no documentation in R78's care plan showing that R78 required two people and a Hoyer lift for transfers. UM2 stated, "It should be included in R78's care plan that R78 needs two people for transfers and a Hoyer lift." On 02/09/22 at 11:05 AM, RN2 was interviewed. RN2 confirmed that R78 required two people and a Hoyer lift to transfer R78 to and from her bed to her wheelchair and that this requirement should have been included in R78's care plan.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and review of policy, the facility failed to identify a potential accident hazard as evidenced by a cabinet, that contained various chemical	F 689	F689 1. Immediate action(s) taken for the	3/22/22

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F 689	Continued From page 14 solutions, in the bathroom for rooms 202-204 not being secured with a padlock. As a result of this deficient practice, the facility put the safety and well-being of the residents at risk for chemical accident hazards. Findings include: During an observation of the shared bathroom for rooms 202-204 on 02/07/22 at 09:35 AM, a cabinet door was not secured with the attached padlock. The padlock was open and not locked and the cabinet could easily be accessed. The cabinet contained various chemical solutions including Tuberculocidal Spray Disinfectant, Micro-Kill Bleach Germicidal Wipes, and Selenium Sulfide Shampoo with urea and zinc pyrithione. Resident (R) 77 was seen walking with a walker near the unsecured cabinet and there was no staff in the immediate vicinity to prevent access to the chemical solutions that were in the unsecured cabinet. On 02/08/22 at 02:45 PM, the Administrator (Admin) was queried and stated that the cabinet door should have been locked, with the padlock, at all times. Review of policy on Environmental Services Safety Procedures stated the following: Policy, it is the policy of this facility to ensure general safety procedures are followed in the course of performing housekeeping and/or laundry duties. Policy Explanation and Compliance Guidelines ... Staff will ensure equipment (e.g. Cords, ladders, or chemicals) is properly stored and not left unattended in areas that are accessible to residents. When not in use, equipment will be stored in a locking closet, cabinet or storage area	F 689	resident(s) found to have been affected include: The Administrator and the Maintenance Supervisor met with the maintenance staff on February 9, 2022. All cabinets throughout the entire facility in were reviewed for any possible hazard to include: working secured combination lock on each cabinet. Any area of concern was corrected at that time. 2. Identification of other residents having the potential to be affected was accomplished by: All residents have the potential to be affected. The Maintenance staff reviewed all cabinets within the facility on February 9, 2022. Any area of concern was corrected. All cabinets are currently secure and are now inaccessible to residents. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The Administrator and/or Maintenance supervisor will instruct all employees to report any issue with cabinets to the maintenance supervisor per the maintenance reporting system. All staff will be in-serviced on the policy and procedure on the facility policy for Accidents and Supervision. All resident falls/accidents will be reviewed daily by the nursing management team to ensure appropriate implementation of safety interventions including updating the plan of care. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur: The maintenance team will	

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F 689	Continued From page 15 for safety.	F 689	conduct routine cabinet checks weekly to ensure that all cabinets are in proper working order. Findings of routine bathroom cabinet checks will be documented and kept for further review. These audits will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident/Family Group Council for comment and suggestions. Corrective action completion date: By March 22, 2022	
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the food was palatable and attractive for 7 Residents (R) 10, R49, R80, R38, R79, R67, and R76. As a result of this deficiency, residents are at risk for nutritional deficiency due to food palatability. Findings include:	F 804	F804 1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident Food Preference was completed for resident #□s (10, 49, 38, 67 not found on resident list) and R#□s 80, 79, 76. Food preferences were updated	3/22/22

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F 804	Continued From page 16 On 02/07/22 at 12:25 PM, conducted mealtime observations for the 1st floor unit. Lunch consisted of vegetable soup, roast beef sandwich with lettuce and tomato, and apple pie with the resident's choice of beverage (milk, juice, coffee, tea). Conducted interviews with R10, R49, R80, R38, R79 R67, and R76 regarding the palatability, attractiveness, and the temperature of the food and drink when they received their meal. All the residents stated the food did not look attractive. R49, R10, R80, and R38 stated that the bread was hard, and the sandwich did not look like it tasted bland, and the meat was dry. R80, R67, and R49 all stated that the soup had no flavor, and the overall presentation of the meal was not the most inviting. R49 stated that the residents receive eggs almost every day and the eggs have no taste and doesn't look like its edible. She stated that she has been in the facility for a while and food, especially the taste of the food makes the resident feel depressed. On 02/08/22 at 09:59 AM, during an interview with R76, the resident stated that although she is on a renal diet and must watch her salt intake, the food is often bland. She stated that there is little to no flavor because the food is not seasoned with different types of herbs for taste. R76 also complained that eggs are served almost every breakfast and herbs aren't used to change up the flavor and its overall presentation of the eggs is not appetizing. On 02/10/22 at 10:05 AM, conducted an interview with the Dietary Manager (DM)1. During the interview, DM1 confirmed that the plating of the meals could use some work and the kitchen will be focusing more on making the meal plates	F 804	within the medical record. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: March 18, 2022 the Dietary Manager in-serviced the dietary staff on the facility food preparation guideline for presentation. Dietary Manager and/or Dietician will evaluate alternatives to eggs to reduce the frequency of these items on the menu. Dietician will identify suitable alternative to the egg products. Resident Council will have the opportunity to review the menu for feedback and updating. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Dietary Manager or designee will conduct 2 x weekly food preparation and service audits x 4 weeks to ensure compliance. Further food preparation and service audits will be completed monthly for 3 months. Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. By March 22, 2022	

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F 804	Continued From page 17 more appetizing. DM1 was unaware that residents were not satisfied by the taste of the food. On 02/09/22 at 10:05 AM, conducted a record review of the resident's diet orders. R49, R80, R38, and 79 all have regular diets; R10 has a regular diet with low potassium; R67 has a consistent carbohydrate diet; and R76 has a renal diet (low sodium). At 12:00 PM on 02/10/22, reviewed a copy of the facility's meals for five weeks (Sunday-Saturday; breakfast, lunch, and dinner). The breakfast menu was reviewed for all five weeks, 30 of 35 five breakfast meals contained either scramble eggs (either alone or with green onions) or a hard-boiled egg; 4 days of hard-boiled and 26 days with scrambled eggs.	F 804		
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	F 880		3/22/22

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F 880	Continued From page 18	F 880		

and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(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.

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F 880	Continued From page 19 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of facility policy, the facility failed to perform hand hygiene in between serving three residents their lunch meal. As a result of this deficient practice, the residents were put at risk for contracting communicable diseases or infections. On 02/07/22 at 11:58 AM, surveyor observed residents being served their lunch meal in the 2nd floor dining room. Certified Nursing Assistant (CNA) 3 was observed placing a tray on the table in front of a resident, taking the lids off the entrée and soup bowl, and placing the lids on a side table. CNA3 walked to the dining tray rack and then removed another lunch tray. CNA3 walked to another resident's table and placed the tray down in front of the resident. CNA3 took the lid off the entrée and pushed the resident's chair in. CNA3 then placed the entrée lid with the other entrée lids on a side table. CNA3 then took another tray from the dining tray rack and placed it on an empty table. CNA3 then walked across the room to a resident seated on a bench. CNA3 held the resident's arm as they both walked to the empty table. CNA3 helped resident sit in a chair and CNA removed lid from entrée. CNA3 placed entrée lid with other entrée lids on side table. CNA3 then performed hand hygiene with hand	F 880	1. Immediate action(s) taken for the resident(s) found to have been affected include: The certified nursing assistant (CNA # 3) was immediately in-serviced on proper hand hygiene procedures. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All personnel will be in-serviced on the facility□s policy for hand hygiene. In-service training includes random observation of personnel performing hand hygiene procedures according to facility policy. Findings are reviewed with all personnel. Corrective action is provided as needed. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services (DNS), or designee, will complete random Validation Checklists of personnel and the	

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F 880	Continued From page 20 sanitizer. On 02/07/22 at 11:58 AM, CNA3 was interviewed. CNA3 stated, "I am supposed to sanitize my hands before and after setting up each meal tray." On 02/10/22 at 09:28 AM, Director of Nursing (DON) was interviewed. DON stated, "Hands should have been washed before and after setting up meal trays for each resident. That is our procedure." On 02/11/22 at 09:30 AM, a review of facility policy "Hand Hygiene" dated 02/10/22, stated that hand hygiene should be performed by employees between resident contacts.	F 880	timing and technique of hand hygiene procedure. To ensure personnel are performing the procedure in accordance with our facility□s Practice Guideline, random monitoring will occur each week for 4 weeks. Findings of this audit will be discussed with Resident Council. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Corrective action completion date: By March 22, 2022.	

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E 000	Initial Comments The facility was in compliance with the Health Section of §483.73, Requirements for Long Term Care Facility, Appendix Z, Emergency Preparedness.	E 000		

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

Electronically Signed | 03/11/2022

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

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K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: K-293 Exit Signage 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 30 second test for the battery backed up exit signs in the facility in accordance with NFPA 101, 2012 edition, and section 7.9.9.1.1 (1). This deficiency could affect all residents, staff, and visitors during an emergency requiring evacuation during a power outage. Findings include: During record review on 2/10/22 at approximately 11:30 am revealed that the facility failed to provide documentation for the monthly exit sign test. These findings were verified at the exit conference with the facility manager and Administrator on 2/10/22 at 12:45 pm.	K 293	1. Immediate action(s) taken for the resident(s) found to have been affected include: A specific resident was not identified in the survey. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: A 30 second test for all battery backed up exit signs will be completed by the Maintenance Director or designee by March 22, 2022. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Maintenance Director will document completion of monthly tests and maintain for review by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been	3/22/22

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILIHA HEALTHCARE CENTER	**1814 LILIHA STREET** **HONOLULU, HI 96817**

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K 293	Continued From page 1	K 293	achieved as determined by the committee. Corrective action completion date: March 22, 2022.	
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,	K 353	1. Immediate action(s) taken for the resident(s) found to have been affected include: A specific resident was not identified in the survey. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has	3/22/22

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K 353	Continued From page 2 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. Findings include: During record review on 2/10/22 at approximately 12:15 pm revealed that the facility failed to provide documentation for a complete monthly and quarterly fire sprinkler inspection and testing. Maintenance staff conducting monthly and quarterly inspections are not testing tamper and flow switches in coordination with the fire alarm system. These findings were verified at the exit conference with the facility manager and Administrator on 2/10/22 at 12:45 pm.	K 353	determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Facility will contract with licensed inspector to ensure that 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 will be maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Maintenance Director will maintain required automatic sprinkler and standpipe system inspection documentation for review by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: March 22, 2022.	

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K 531 SS=D	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: K-531 Elevators 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 monthly tests for the facility's elevators in accordance with NFPA 101, Life Safety Code, 2012 edition, section 9.4.6.2. This deficiency could affect all residents, staff, and visitors during a fire due to the lack of monthly tests to ensure proper fire fighter operations. Findings include: During record review on 2/10/22 at approximately 11:45 am revealed that the facility failed to provide documentation for the monthly fire fighter emergency operations elevator inspection and	K 531	1. Immediate action(s) taken for the resident(s) found to have been affected include: A specific resident was not identified in the survey. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include:	3/22/22

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K 531	Continued From page 4 testing. These findings were verified at the exit conference with the facility manager and Administrator on 2/10/22 at 12:45 pm.	K 531	Facility is contracted with licensed inspector to complete monthly tests for the facility's elevators in accordance with NFPA 101, Life Safety Code, 2012 edition, section 9.4.6.2. Documentation of these monthly tests will be readily available. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Maintenance Director will maintain required elevator fire testing documentation for review by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. By March 22, 2022	
K 761 SS=D	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	K 761		3/22/22

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K 761	Continued From page 5 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 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 2/10/22 at approximately 11:30 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 and Administrator on 2/10/22 at 12:45 pm.	K 761	1. Immediate action(s) taken for the resident(s) found to have been affected include: A specific resident was not identified in the survey. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. Fire doors assemblies are inspected and tested annually in accordance with NFPA 80 Standard for Fire Doors and Other Opening Protectives. Fire doors that are not located in required fire barriers, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspection and testing have an understanding of the operating components of the doors. Written records of inspection and testing are maintained and are available for review. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: A staff member will be trained using the online training module for NFPA 80: Standard for Fire Doors and Other Opening Protectives to locate, interpret, and correctly identify and apply the requirements for the inspection, testing, and maintenance of fire door assemblies. This one-hour self-paced module is based on the 2016 edition of NFPA 80 will be	

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K 761	Continued From page 6	K 761	completed by March 18, 2022 and annually thereafter. Trained staff member will perform door inspection for all doors by March 25, 2022. Records of this maintenance inspection will be maintained in a secure location and readily available. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Maintenance Director will maintain documentation for review by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: March 22, 2022.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of	K 923		3/22/22

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K 923	Continued From page 7 noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: K-923 Gas Equipment-Other This STANDARD is not met as evidenced by: Based on observation and staff interview with facility manager, the facility failed to provide adequate separation and proper signage for full and empty "E" oxygen cylinders in accordance with NFPA 99, Healthcare Facilities Code, 2012 edition, sections 11.6.5.2, and 11.6.5.3. This deficiency could affect all residents requiring oxygen therapy by the possibility of administering an empty oxygen cylinder in lieu of a full cylinder during an emergency. Findings include: During facility survey on 2/10/22 at approximately	K 923	1. Immediate action(s) taken for the resident(s) found to have been affected include: A specific resident was not identified in the survey. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: the facility's oxygen storage	

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K 923	Continued From page 8 12:00 pm, observation of the facility's oxygen storage compartment did not provide adequate separation of empty and full cylinders, proper signage for separation, and did not have signage posted on the entrance door. These findings were verified at the exit conference with the facility manager and Administrator on 2/10/22 at 12:45 pm.	K 923	compartment now provides adequate separation of empty and full cylinders, proper signage for separation, and signage posted on the entrance door. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Maintenance Director or designee will audit the oxygen room daily x 1 week, weekly x 4 weeks and monthly thereafter. The Director will maintain documentation of these audits for review by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: March 22, 2022.	

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E 000	Initial Comments THIS FACILITY MET THE LIFE SAFETY REQUIREMENTS OF APPENDIX "Z"; IN ACCORDANCE WITH CFR 483.73, REQUIREMENT FOR LONG-TERM CARE (LTC) FACILITIES	E 000		

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

Electronically Signed | 03/11/2022

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