STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125014	A. BUILDING: _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA RETIREMENT RESIDENCE	1434 PUNAHOU STREET HONOLULU, HI 96822

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4 000	Initial Comments A relicensure 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. One Facility Reported Incidents (FRI) from the Aspen Complaints/Incidents Tracking System (ACTS) #9270 was found unsubstantiated. Survey Dates: February 15, 2022 to February 18, 2021. Survey Census: 61 Sample Size: 17	4 000		
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty- first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of	4 149		3/11/22

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4 149	Continued From page 1 direct care staff to ensure quality resident care is provided. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide that appropriate treatment and services for 1 out of 2 sampled residents R(55) to increase ROM and/or to prevent further decrease in range of motion and maintain and/or improve physical functioning. Findings include: During an interview on 02/15/22 at 12:25 PM , the R55 stated that she had blisters on her buttocks and the nurse stated that it is from the sheets caused by friction. R55 further stated that she does not get out of bed and that she had physical therapy at home. She does not know if she will get physical therapy in the facility. Record review (RR) done on 02/15/22 shows an 84-year-old female admitted from home to facility for 24-hour nursing care with activities of daily living assistance and mobility. R55 was diagnosed with a history of stroke and left sided weakness and admitted to the facility on 04/21/21. Care plan report dated 04/27/21 interventions states contracture of muscle-left upper arm OT 2x period in 60 days-resident would like to maintain current ROM and decrease risk of increased contractures. Refer to OT POC and rehab notes. Due to insurance coverage and resident not willing to private pay services, only OT eval done. No further treatment needed at this time. Will continue to monitor contracture to left shoulder. Care plan report dated 05/27/2021 interventions states to provide extensive assistance with 1-2-man support with bed mobility, transfers, total assist with locomotion	4 149	On 2/28/22, Director of CNA Services discussed with R55 current routine for ADLs and an out of bed routine to maintain R55'□s range of motion. R55 agreed to participate to get out of bed on Tuesdays and Thursdays to start and increase as tolerated, Care Plan updated as of 3/10/22. R55 was also seen by OT and Wellness manager to provide Passive Range of Motion training and established a routine for R55.(See attached ROM training logs) The facility identified other residents having the potential to be affected by the same deficient practice by reviewing all residents at risk for decline of range of motion. Audit was completed by 3/11/22 to ensure care plan incorporated therapy, Wellness range of motion program and/or out of bed routine. Measures and systemic changes that will be implemented to ensure this deficient practice does not recur by identifying residents during utilization review meeting to determine that if a personalized plan is not able to be established with therapy, then an alternative or general range of motion program can be established and care planned. The Facility will monitor its corrective action to ensure that the deficient practice	

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4 149	Continued From page 2 with wheelchair to reach destination in her room with 1 person support. Record review (RR) done on 02/15/22 of care plan entry date of 08/15/21 states R55 had difficulty transferring requiring 3-4-man support from bed to shower chair. Record review (RR) done on 02/15/22 of care plan entry dated 08/18/21 shows Physical therapy (PT) evaluation completed. PT eval only. PT recommended to use only Hoyer lift for transfer due to staff/resident concerns safety. Observation and concurrent interview made on 02/15/22 at 02:30 PM with R55 shows resident in bed. R55 stated that she did not get out of bed today. Observation and concurrent interview made on 02/16/22 at 10:00 AM with R55 shows resident in bed. R55 stated she did not get out of bed today. Observation and concurrent interview made on 02/17/22 at 09:00 AM with R55 shows resident in bed. R55 stated she did not get out of bed today. She does not know if she will get physical therapy. Interview on 02/18/22 at 12:49 PM 02/18/22 12:49 PM with the administrator was done. Surveyor queried why resident was only receiving PT and OT evaluations and not treatment. Queried also why resident was not getting out of bed with Hoyer lift. Administrator stated that R55 would need to get therapy outside and if she wanted it here, her insurance doesn't cover part B for inpatient services. We did do some evaluation and plan of care, but her insurance plan doesn't cover it. Before the outbreak, we	4 149	is being corrected and will not recur by tracking residents discussed in utilization review that have an alternative or general range of motion program and/or decreased mobility or range of motion and present findings in QAPI and QA Programs.	

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4 149	Continued From page 3 were getting a supplemental plan but that takes guidance for therapy. We also looked at her changing her insurance plan, but she must wait for the enrollment plan if changing her insurance as well. Although the facility had done an OT and PT evaluations, R55 was not able to receive treatment due to lack of insurance. During R55's stay, she has not been getting out of bed and has blisters on her buttocks. R55 further stated she requires a Hoyer lift. Documentation states that at times, R55 requires 4-5 staff to get her out of the bed. R55 states that she sometimes gets range of motion in the morning. R55 was admitted with limited range of motion and is not receiving the appropriate treatment and services to increase or prevent further decrease in range of motion.	4 149		
4 185	11-94.1-46(b) Pharmaceutical services (b) A facility shall have a current pharmacy policy manual consistent with current pharmaceutical practices developed and approved by the pharmacist, medical director/medical advisor, and director of nursing that: (1) Includes policies and procedures, and defines the functions and responsibilities relating to pharmacy services, including the safe administration and handling of all drugs and self-administration of drugs. Policies and procedures shall include pharmacy functions and responsibilities, formulary, storage, administration, documentation, verbal and telephone orders, authorized personnel, recordkeeping, and disposal of drugs;	4 185		3/11/22

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4 185	Continued From page 4 (2) Is reviewed at least every two years and revised as necessary to keep abreast of current developments in overall drug usage; and (3) Has a drug recall procedure that can be readily implemented. This Statute is not met as evidenced by: Based on interview and record reviews, the facility did not ensure that the residents are free from unnecessary medications for 1 of 17 sampled residents (R10). The facility failed to identify and consistently monitor behaviors and side effects for the residents. These failures had the potential to prevent Residents from attaining their highest practicable level of mental, physical and psychosocial well-being. Findings include: R10 was admitted to the facility on 09/28/18 with several diagnoses including history of transient ischemic attack (TIA), and cerebral infarction without resident deficits, Alzheimer's dementia with episodes of increased confusion and has balance problems with weakness. R10 was recently diagnosed with depression and started on an antidepressant. Review of the psychotropic meeting progress notes dated 10/20/21 revealed that the resident was started on Escitalopram 50 mg every day on 07/15/21 for depression with target behaviors of sadness and poor food intake. Review of the medication administration record (MAR) revealed that the resident had been receiving the antidepressant drug as ordered.	4 185	R10's current behavior documentation, consultation of pharmacist and tracking of behavior, indicated the continued use of escitalopram 5 mg. The Facility followed up with R10's PCP on 3/11/22 to discontinue tracking of target behavior - sadness and to continue to monitoring for agitation and restlessness. The Facility will continue to monitor R10'□s Behavior Flow Record and perform a GDR if/when indicated. The Facility identified other residents having the potential to be affected by the same deficient practice by performing a 100% audit by 3/11/22.□ Residents on psychotropic medications were audited to ensure documentation of medication, orders and target behaviors were indicated and appropriate. Measures and systemic changes that will be implemented to ensure this deficient practice does not recur by In-servicing licensed staff on appropriate documentation of behaviors using Behavior Flow sheet, monitoring and updating when indicated by 3/11/22. Findings will be reviewed by the	

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4 185	Continued From page 5 Review of the behavior monitor/intervention flow record for the month of July failed to identify and document the behavior of sadness for the use of an antidepressant medication from the start and ongoing through August the need for use of an antidepressant medication. In an interview on 02/18/22 at 02:16 PM with the Director of Nursing and Administrator, the lack of documentation regarding the antidepressant was discussed and acknowledged. Without adequate behavior monitoring as well as monitoring for adverse effects, the antidepressant is deemed an unnecessary drug.	4 185	Psychotropic/Behavior Committee with collaboration of Medical Director and Consultant Pharmacist who will continue to review the records monthly to make recommendation(s) for GDR, if indicated. Starting 3/11/22, audits on new or changed psychotropic medication will be conducted by Licensed Social Worker, Director of Nursing or designee to review the medication, target behavior and documentation (behavior flow record is executed). The Facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not recur by presenting any findings from the Psychotropic/Behavior Committee with collaboration of Medical Director and Consultant Pharmacist. Any fluctuations in residents□ behaviors will be tracked and trended through the Psychotropic/Behavior Committee and will be reported through the Facility'□s QA program.	
4 210	11-94.1-54(a) Sanitation (a) The facility shall be in compliance with all applicable laws of the State and rules of the department relating to sanitation. This Statute is not met as evidenced by: Based on observations and interviews, the facility failed to store soiled laundry in closed plastic bags and off the floor of the laundry room. As a result of this deficient practice, the facility was put	4 210	The identified bags of soiled cleaning towels were addressed on 2/17/22 and 2/18/22 by the housekeeping supervisor.	3/11/22

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4 210	Continued From page 6 at potential risk for spread of infection. Findings Include: On 02/17/22 at 06:30 AM in the first-floor laundry room, surveyor observed two opened black plastic trash bags on the ground next to the sink. The two plastic bags were full of dirty cleaning towels. A commercial laundry washer next to sink was labeled with a sign that stated, "Out of order. Do not use." A smaller washing machine was turned on and running. On 2/17/22 at 02:13 PM in the first-floor laundry room, surveyor observed ten black plastic trash bags on the ground next to the sink and washing machine. The ten bags were opened and were full of dirty cleaning towels. There was a small luggage cart with no side walls. Three closed plastic bags were stacked in the cart and took up half of the space in the cart. On 02/17/22 at 2:13 PM, Housekeeping Supervisor (HS) was interviewed in the 1st floor laundry room. HS stated, "The plastic bags should be closed and not opened. We only have this cart for bringing down the laundry. The cart cannot hold a lot of bags. Our main washer broke last week so we had to bring down a smaller laundry machine to wash all of this laundry until it can get fixed." On 2/18/22 at 06:27 AM at the first-floor laundry room, surveyor observed two opened plastic bags on the ground next to the sink. The two plastic bags were full of dirty cleaning towels. On 02/18/22 at 06:45 AM, HS was interviewed on the second floor. HS stated, "I just saw the two opened bags of dirty laundry downstairs and tied	4 210	All residents in the health care center had the potential to be affected by the deficient practice. Measures and systemic changes that will be implemented to ensure this deficient practice does not recur by adjusting storage process of soiled linen to utilize covered bins for storage. (see attached bins) In-service was conducted by 3/11/22 for housekeeping staff on the new process for storage and handling of soiled cleaning towels. (See attached in-service records) The Facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not recur by conducting random weekly audits by housekeeping supervisor or designee to visually check bins and laundry areas and report any significant findings through QAPI/QA.	

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4 210	Continued From page 7 them closed. I told staff the bags need to be closed." On 02/18/22 at 08:54 AM, Infection Preventionist (IP) was interviewed in the second floor IP office. IP stated, "Bags with dirty laundry should be tied closed and stored off of the ground."	4 210		