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GARDEN ISLE HEALTHCARE AND REHABILITATION CENTER	3-3420 KUHIO HIGHWAY, SUITE 300 LIHUE, HI 96766

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F 000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the Hawaii Department of Health, Office of Health Care Assurance. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 02/15/22 to 02/17/22 Survey Census: 70 Sample Size: 25 Supplemental Residents: 0	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the	F 578		3/25/22

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

Electronically Signed | 03/04/2022

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F 578	Continued From page 1 facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance 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 interviews, records review, and facility policies review, the facility failed to ensure the appropriate CPR (cardiopulmonary resuscitation) status was consistently recorded throughout the clinical records for three (Resident (R)12, R23, and R51) of five residents reviewed for advanced directives. The facility's deficient practice had potential for staff to provide or withhold CPR inconsistent with R12, R23 and R51's wishes and directives in an emergent situation. Findings include: 1. Review of R12's Electronic Medical Record (EMR) revealed an admission date to facility of 06/24/20. R12's undated "Face Sheet," under the heading, "Advance Directive," revealed the code status DNR [Do Not Resuscitate].	F 578	This Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. I. During survey, R12, R23, and R51□s orders and care plans were updated to reflect DNR code status in their medical records. II. Facility residents have the potential to be affected by this alleged practice.	

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F 578	Continued From page 2 A 10/20/20 physician's "Order," located in the "Orders" tab of the EMR documented, "Code Status: FULL[provide CPR]." The 07/22/17 "Care Plan," located in the "Care Plan" tab in the EMR documented under the heading, "Advance Directive," a Full Code status. In the EMR under the "CCD" tab, documented under the heading, "Advance Directive," a DNR status. In the EMR under the "Resident Documents" tab was a 07/22/17 Advance Directive, indicating R12 had chosen DNR status. An interview and concurrent record review were conducted on 02/17/22 at 1:32 PM with Resident Care Manager (RCM) 2, who confirmed and verified that staff would access a resident's EMR and view resident's "Face Sheet" to verify code status in the event of an emergency. RCM2 stated, "I am not positive if code status should be on the resident's 'Care Plans'." RCM 2 added, "Social Services enters that information." RCM2 stated the physician's "Orders" should contain each resident's correct code status. RCM2 confirmed and verified R12's code status on her "Face Sheet" was DNR and R12's physician "Orders" included an order for full code status. RCM2 confirmed the facility's staff did not update R12's EMR physician "Orders" for her correct code status (DNR). RCM2 confirmed and verified R12's code status on her medical record under the "Care Plan" was incorrectly documented as full code. RCM2 stated, "[R12's] code status was full code on admission, and somewhere along the way it was changed to DNR." RCM2 confirmed	F 578	III. Facility residents medical records were reviewed to ensure compliance with current code status and updated as needed. Education was provided to IDT team and licensed nursing staff regarding code status and the process of changing code status throughout the medical record by the Staff Development Coordinator (SDC) / designee. Inservicing will be ongoing as needed. IV. The Social Service Director (SSD) / designee will ensure compliance through medical record audits to be conducted weekly for a minimum of 12 weeks or until substantial compliance is achieved. The results of these audits will be brought to the Quality Assurance Performance Improvement Meeting for review and recommendations for a minimum of 3 months or until substantial compliance is achieved.	

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and verified the "Care Plan" was not updated to the correct status. RCM2 confirmed the facility should have corrected the code status to DNR in all placed in the EMR when the status change occurred. RCM2 confirmed and verified the facility failed to ensure the correct code status was included on R12's EMR to reflect her wishes of DNR status. RCM2 stated the inconsistent documentation had potential to affect the treatment R12 was provided by the staff in the event she was found unresponsive and not breathing.

An interview was conducted on 02/17/22 at 2:34 PM with the Social Services Director (SSD), who verified and confirmed R12's EMR "Face sheet" had DNR documented for her code status; however, the physician "Orders" included an incorrect code status order (full code). The SSD confirmed the facility should ensure R12's code status was consistent throughout her EMR. SSD confirmed the facility's deficient practice had potential to affect the treatment provided to R12, in the event of an emergent situation, that was possibly inconsistent with the resident's wishes.

An interview was conducted on 02/17/22 at 3:29 PM with the Director of Nursing (DON), who verified and confirmed R12's EMR on the "Face Sheet" contained the code status of DNR. DON verified and confirmed R12's physician "Orders" code status was full code. The DON confirmed the facility should have updated R12's physician "Orders" to reflect R12's wishes and desires for her code status (DNR status). The DON confirmed and verified the facility failed to include R12's DNR election on her "Care Plan."

2. Review of R23's EMR revealed the "Face

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Sheet" included an admission date of 03/09/21. R 23 had multiple diagnoses to include malignant neuroendocrine tumors. The "Advance Directive" heading contained the following information: "DNR" code status and hospice care.

The EMR "Orders" tab revealed no information regarding advance directives or code status.

The 12/30/20 "Care Plan," located under the "Care Plan" tab of the EMR, revealed both DNR and Full Code were documented.

An interview and record review were conducted on 02/17/22 at 1:48 PM with RCM2, who confirmed and verified R23's "Face Sheet" had code status listed as DNR. RCM 2 confirmed and verified the "Orders" tab included no physician "Order" for a code status. RCM2 confirmed and verified the facility should have ensured R23's physician "Orders" included a code status. RCM2 verified R23's "Care plan" had full code listed (and was incorrectly documented. RCM2 stated, "I do not know why R23's :Care Plan" was not updated with the correct code status (DNR).

An interview and record review were conducted on 02/17/22 at 2:40 PM with the SSD, who confirmed R23's contained two conflicting code status designations. The SSD stated, "It looks like his old 2020 "Care Plan" remained to be included with [R23's] EMR." The SSD stated, "the facility should only have only one code status; it should match the ribbon on the resident's Face Sheet." The SSD confirmed the EMR should not contain conflicting code status documentation and it was important for each resident's EMR to reflect their wishes for the staff to access in an emergency.

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An interview and record review were conducted on 02/17/22 at 3:39 PM with the DON, who confirmed R23's "Face Sheet" included DNR for code status, R23's physician "Orders" had no information for his code status, and R23's "Care Plan" included conflicting code statuses with both DNR and Full Code. The DON verified and confirmed R23's electronic medical should consistently reflect his wishes and desires for treatment for code status.

3. Review of R51's EMR, under the "Residents" tab, revealed the "Face Sheet" documented an admission date to the facility of 12/03/21 and a DNR status.

The EMR "Orders" tab revealed a physician's "Order" for Full Code\ status, dated 03/08/21.

The "Documents" tab revealed a 10/30/09 "Advance Directive" that documented, "I want my life prolonged as long as possible . . . " which was signed and notarized. In the same tab was a 12/05/11 "Code Status" document, signed by R51's family member, which included, "I refuse CPR . . . "

The EMR "Care Plan" tab revealed a 03/10/21 "Care Plan" that documented, "Code Status: Full Code" but the heading of the document read "DNR."

An interview and review of R51's EMR were conducted on 02/17/22 at 2:14 PM with RCM2, who verified R51's EMR, "Face Sheet" documented DNR but the physician "Orders" documented full code status. RCM2 stated, "when R51's POLST [Physician Orders for Life Sustaining Treatment] code status was changed,

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it appears the physician orders were not updated." RCM2 confirmed the facility failed to ensure R51's EMR under her orders were updated for his code status of DNR.

An interview and review of R51's EMR were conducted on 02/17/22 at 3:03 PM with the SSD, who confirmed R51's DNR code status on her "Face Sheet" ribbon and her physician "Orders" were inconsistent and incorrect as full code. SSD verified and confirmed R51's "Care Plan" was incorrect and included full code status.

An interview and review of R51's EMR were conducted on 02/17/22 at 3:47 PM with the DON, who verified the "Face Sheet" had code status of DNR, the "Care Plan" had full code listed and was incorrect, and R51's physician's "Order" was incorrect with full code instead of the correct DNR as per R51's wishes. The DON stated, "the deficient practice had potential to cause residents harm by providing wrong treatment or lack of providing treatment for a resident in an emergent situation."

Review of the facility-provided policy, titled "Code Status Form," dated 12/29/11, revealed "Ensure all residents have up-to date code [CPR] status information in medical records to provide appropriate care and services in accordance with their wishes."

Review of facility-provided policy titled "Care Plans," dated December 2016, revealed, "a comprehensive, person-centered care plan that includes measurable objectives to meet resident's physical, psychosocial, and functional needs is developed and implemented for each resident . . . Reflect the resident's expressed wishes regarding

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F 578	Continued From page 7 care and treatment . . . ." Review of a facility-provided policy titled, "Advanced Directives," dated 09/01/17, revealed "respect each resident/guest right to request . . . and to formulate an advance directive . . . noted in the resident/guest's medical record. . . . "	F 578		
F 609 SS=D	Reporting of Alleged Violations 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.	F 609		3/25/22

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F 609	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on facility policy, clinical record review, and staff interviews, the facility failed to ensure timely reporting of injuries of unknown origin for one (Resident (R) 59) of six residents who were reviewed for accidents. R59 suffered bruising of unknown origin and the injuries were not reported to administration to ensure timely investigation of the source. The findings include: The facility's "Accidents and Incidents-Investigating and Reporting Policy," provided directly to the survey team and dated July 2017, read, in pertinent part, "All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator." R59 was admitted to the facility on 12/01/20, according to the undated "Resident Face Sheet" found in the Electronic Medical Record (EMR) under the "Profile" tab, with diagnoses including type 2 diabetes and chronic kidney disease. According to the quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 01/28/22, R78 was cognitively intact, with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. R59's "Nursing Progress Note," dated 12/25/21 and found under the "Progress Notes" tab of the EMR, read, in pertinent part, "res (resident) noted to have a bruise to left upper arm - 8 x (by) 7 cm (centimeters), skin intact; nontender to touch; bruise to left hand - 3 x 2 cm skin intact;	F 609	I. An investigation of resident R59 bruise of unknown origin was completed and abuse and neglect were ruled out. Staff involved were in-serviced on facility abuse reporting policy and injuries of unknown origin by the SDC/designee. II. Facility residents have the potential to be affected by this alleged practice. III. Facility residents skin checks were completed and reviewed for any injuries of unknown origin or bruising. Facility staff were in-serviced on facility on reporting injuries of unknown origin and abuse policy by the SDC/designee. Inservices will be conducted regarding reporting injuries of unknown origin and abuse policy on hire, annually and ongoing as needed. IV. The Director of Nursing (DON) / Unit Managers/ SDC/ designees will ensure compliance through observations and medical record audits to be conducted weekly for a minimum of 12 weeks or until substantial compliance is achieved. The results of these audits will be brought to the Quality Assurance Performance Improvement Meeting for review and recommendations for a minimum of 3 months or until substantial compliance is achieved.	

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nontender to touch."

Comprehensive review of R59's record revealed nothing to indicate the resident's bruising was reported to administration and/or investigated as an injury of unknown origin, and no incident report related to the event could be found in the record.

During an interview with R59 on 02/15/22 at 1:53 PM, she indicated she did not know what the cause of the bruising to her left upper arm and hand was.

During an interview with Licensed Practical Nurse (LPN) 1 on 02/17/22 at 1:25 PM, she indicated she was the author of the 12/25/21 progress note referenced above, and stated she notified the resident and the resident's medical provider of the bruising but could not remember if she entered an incident report regarding the bruising or if she notified administration of the injury. LPN1 indicated she was aware injuries such as bruising were to be reported to the Director of Nursing (DON) immediately. She stated it was unknown what caused R59's bruising, but indicated the resident had an IV (intravenous) infusion a few days before the bruising was found and thought one of the bruises might have been caused by that.

During an interview with the DON on 02/17/22 at 1:02 PM, she stated, "There should have been an incident report for something like that (R59's bruising). After the incident report is written, we (administration) talk to staff and the resident to try and find out what happened. Then an investigation of injury of unknown origin is done if the source of the injury is not identified. I just heard about the bruise today. Staff is aware that

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F 609	Continued From page 10 they are supposed to report (injuries). If an incident report had been done, it would be in the (medical record) system."	F 609		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure one resident (Resident (R) 20) of two residents who were reviewed for positioning and mobility was provided with restorative services per his plan of care. R20 did not receive splinting services, recommended by the facility's therapy department, to treat severe contractures to his upper extremities. This failure had the potential to contribute to worsening contractures or pain for R20.	F 688	I. During survey, an order for resident R20 orthotic was obtained and submitted. II. Facility residents requiring specialized equipment have the potential to be affected by this alleged practice. III. An audit of current residents was conducted, and no other residents were awaiting specialized equipment. Residents requiring specialized equipment will be reviewed weekly by the unit	3/25/22

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F 688	Continued From page 11 Findings include: The facility's "Resident Mobility and Range of Motion Policy" dated July 2017 documented, in pertinent part, "Residents with limited range of motion (ROM) will receive treatment and services to increase and/or prevent a further decrease in ROM." Review of R20's undated "Resident Face Sheet," found in the Electronic Medical Record (EMR) under the "Profile" tab, revealed R20 was admitted to the facility on 10/16/18 with diagnoses including Alzheimer's Disease with early onset. Review of R20's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 12/10/21, indicated a Brief Interview for Mental Status (BIMS) could not be completed due to the resident's poor cognition, and the staff interview revealed R230 had both short- and long-term memory problems. The MDS indicated R20 had ROM impairment to his upper and lower extremities on both sides of his body, and that a splint or brace had not been applied to the resident on any of the seven days prior to the ARD. R20's "Interdisciplinary Care Plan," dated 11/15/21 and provided directly to the survey team, read, in pertinent part, "Patient will tolerate elbow ext (extension) orthotic with no redness or skin breakdown for 3 hours (per day)." This statement on the resident's care plan had a line marked through it on the copy provided to the survey team. Review of R20's "Physician's Orders, found in the EMR under the "Orders" tab, revealed no order	F 688	managers / DON/ designee in morning clinical meeting until equipment has been received. IV. The Director of Nursing (DON) / Unit Managers/ SDC/ designees will ensure compliance through observations and medical record audits to be conducted weekly for a minimum of 12 weeks or until substantial compliance is achieved. The results of these audits will be brought to the Quality Assurance Performance Improvement Meeting for review and recommendations for a minimum of 3 months or until substantial compliance is achieved.	

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F 688	Continued From page 12	F 688		

for the extension orthotic.

R20's "Occupational Therapy (OT) Therapist Progress and Discharge Summary," dated 10/07/21 through 12/10/21 and provided directly to the survey team, indicated elbow orthotics had been ordered and read "Patient will tolerate elbow ext. orthosis for 3 hours daily with no skin integrity issues;" and "12/09/21 (addendum) Patient is awaiting elbow orthosis arrival;" and "12/10/21 (addendum) "Goal not met-on 12/10/21**Elbow orthotic still has not arrived. Will re-assess when orthotics arrive." No further OT notes could be found in the resident's record.

R20 was observed laying in his bed sleeping on 02/15/22 at 2:07 PM, 02/16/22 at 9:45 AM, 02/16/22 at 2:52 PM, 02/17/22 at 08:53 AM, and 02/17/22 at 2:55 PM. The resident was observed to have severe contractures to both of his upper extremities at the elbows. R20 was not wearing splints or orthotics of any kind to his bilateral upper extremities during these observations.

During an interview with the Director of Nursing (DON) on 02/17/22 at 9:48 AM, she indicated she was not aware of the orthotics ordered for R20 had not been provided.

During a follow-up interview with the DON on 02/17/22 at 1:11 PM, she stated the facility's rehabilitation department had requested the orthotics for R20 on 10/21/21, but the email with the request had been missed, and the orthotics had never been ordered. The DON stated her expectation was that there should have been follow up by staff when the resident's orthotics did not arrive. She indicated four months (10/21/21 through 02/17/22) was a "definite delay" in

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F 688	Continued From page 13 services for the resident's elbow contractures.	F 688		
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, electronic medical record (EMR) review, interview with facility staff, and review of facility policies and procedures, the facility failed to ensure that assistance devices to prevent accidents were available on the third floor and the "Care Plan" was followed for one (Resident (R) 67) of 25 sampled residents. Findings include: R67's diagnoses, listed on the undated Profile tab in the EMR, included hemiplegia-hemiparesis following a stroke affecting the left dominant side, unspecified dementia, age related osteoporosis, and weakness. R67's quarterly "Minimum Data Set (MDS)" assessment, with an Assessment Reference Date (ARD) of 01/22/22, revealed R67 required extensive assistance of one person for bed mobility and transfers and limited assistance of one person with walking in her room. Locomotion off the unit did not occur. R67 used a wheelchair to mobilize herself. R67 had moderately impaired	F 689	I. During survey, involved staff were in-serviced on implementing and following care plan interventions. Reassessment of resident R67 revealed due to change of condition resident is no longer an elopement risk. II. Facility residents requiring specialized equipment have the potential to be affected by this alleged practice. III. An audit of current residents who are at risk for elopement was conducted to ensure that appropriate interventions were in place and care plans were updated as needed. DON/ Unit Managers/ SDC/ designee in-serviced facility staff on assessing and reassessing residents at risk for elopement and care planned interventions. IV. The Director of Nursing (DON) / Unit Managers/ SDC/ designees will ensure compliance through observations and	3/25/22

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F 689	Continued From page 14 cognition according to the staff assessment of mental status. A "Progress Note," taken from the Progress Notes tab of the EMR, dated 05/20/21 at 10:28 AM, documented the Administrator informed the nurse that R67 was found in the first-floor lobby outside the Mauka elevators in the hospital area of the building. When R67 was asked why she went downstairs, she replied, "I wanted to go down. I want to come here. I press, press the button on the elevator. No can help." An "Incident Report," dated 05/20/21 at 9:50 AM and provided by administration, indicated R67 pushed the wrong button and ended up on the first-floor lobby of the hospital from the Mauka elevators. A note on the "Incident Report" indicated that R67 would be "handed off to direct care staff upon returning from visits/activities." Review of R67's "Care Plan" initiated on 05/25/21, located in the MDS tab of the EMR revealed a new intervention for activities staff to transport R67 "first to activity room on 2nd floor or nursing to hand off to activities and then activities staff to hand off when returning back to the floor or unit." Another "Progress Note" revealed on 09/09/21 at 3:52 PM, R67 was wheeled to activities on the second floor by her certified nurse aide (CNA) and had her lunch there. When activity staff were going to bring her back to her room from the second floor, she was found by staff on the first floor and was brought back to the third floor to go to her room. The note documented, "Resident wheeled self to elevator and went down to first floor on her own. She stated on her return that	F 689	medical record audits to be conducted weekly for a minimum of 12 weeks or until substantial compliance is achieved. The results of these audits will be brought to the Quality Assurance Performance Improvement Meeting for review and recommendations for a minimum of 3 months or until substantial compliance is achieved.	

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F 689	Continued From page 15	F 689		

she was independent and wanted to see others on different floors."

The "Incident Report," dated 09/09/21 at 12:50 PM, revealed that the resident was "found on the first floor by herself." The first floor was part of the community hospital. R67 was not injured. The "Incident Report" indicated, "care plan was not followed . . . resident found on the first floor. Resident care planned for direct hand off. Resident in common area on second floor outside of the cafeteria room. Resident wandered from the Mauka second floor (M2) activities area to the elevator to the first floor . . . Will update care plan to add wander guard to resident chair to alarm all staff if resident attempts to leave M2 after activities or lunch."

Review of the "Care Plan," revised on 09/09/21, indicated a wander guard alarm was added as an intervention.

On 02/17/22 at 11:20 AM, the surveyor observed as the Administrator took R67's empty wheelchair to the Mauka elevators on the nursing unit. The wheelchair had the wander guard device strapped to the left leg; however, no alarm went off after passing through the third-floor elevators from her bedroom. No wander guard signals were observed on the third floor. After going down the elevator to the second floor, the second-floor wander guard alarm went off after passing through the elevator doors. In addition, there were no wander guard devices on the first-floor lobby are at the Mauka elevators.

The Administrator verified the events above on 02/17/22 at 11:20 AM. Further interview with the Administrator on 02/17/22 at 11:30 AM revealed

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F 689	Continued From page 16 the wander guard detection device was not present on the third floor and stated, "she's not a problem from this floor and didn't [sic] expect her to elope." Interview with the Director of Nursing (DON) on 02/17/22 at 2:25 PM indicated she had in-serviced all staff after the resident's second elopement and added the wander guard to her plan of care. The DON added, "We discussed as a team. She functions better on the third floor. Does not always get along with others on the second floor." The DON also verified that there was no wander guard system on the third floor. Therefore, the resident could access the elevator without an alarm from the floor of her bedroom and go to the first floor without detection. The DON added the wander guard system was only on the second floor. Review of the undated facility policy provided by administration titled "Signal Device (Wander guard) and Door Alarm Monitoring" revealed that for residents who wandered, "a monitoring device will be placed on a resident according to the manufacturer's recommendations."	F 689		
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 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.	F 812		3/25/22

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F 812	Continued From page 17 (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, staff interview, and review of facility policy, the facility failed to ensure foods stored in the kitchen were labeled, dated when opened, and sealed closed. They also failed to allow dishes to air dry before being stored. These failures had the potential to contribute to foodborne illness among the 70 residents in the facility who ate food from the kitchen. Findings include: On 02/15/22 from 8:25 AM to 8:45 AM, the following observations in the kitchen were made with, and verified by, the Dietary Manager (DM): 1. The walk-in refrigerator contained one box of carrot cake and one bag of hard-boiled eggs; both were not covered and open to air. 2. The walk-in freezer contained one box of hot dogs, one bag of chicken patties, and one bag of chicken tenders; all were not covered and open to air. There was also no labeling and dating of these items. 3. Observation was made of cups, lids, plates, bowls, and pans that were stacked before air dried with water in between each dish. Interview on 02/15/22 at 8:45 AM with the DM	F 812	I. On 2/15/22 the carrot cake, hard-boiled eggs, hot dogs, chicken patties, and chicken tenders identified by the surveyor were discarded. Dishes that were not air dried properly were rewashed and allowed to air dry completely prior to storing. Food Services Manager audited the food storage areas during survey to ensure compliance with proper storage, labeling, and dating of food items. II. Facility residents have the potential to be affected by the alleged practice. III. Food Services Manager or designee inserviced dietary staff on proper storage, labeling, dating of food items and on proper drying of service wares. Inservicing will be ongoing as needed. IV. Food Service Manager/ designee will ensure compliance through observation and kitchen audits to be conducted weekly for a minimum of 12 weeks or until substantial compliance is achieved. The results of these audits will be brought to the Quality Assurance Performance	

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F 812	Continued From page 18 revealed that the dishes should not be wet when stacked. She stated, "moisture is not good and harbors bacteria." She explained that the kitchen was so small, that they did not have room to air dry dishes. On 02/17/22 at 2:10 PM, interview with the Administrator revealed that his expectations were that all food should be labeled, dated, and monitored. He was made aware of the wet dishes and understands the importance of air drying. The facility's policy titled, "Labeling Guidelines," not dated, documented "If food is held for more than 24 hours, it shall be clearly marked to indicate the date by which the food shall be consumed . . . the day the original container is opened is counted as Day 1 . . . The day or date marked by the food service establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use by date based on food safety . . . When in doubt, consult a manager or supervisor."	F 812	Improvement Meeting for review and recommendations for a minimum of 3 months or until substantial compliance is achieved.	
F 909 SS=D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to ensure physical	F 909	I. On 2/17/22, resident R69□s mattress was repositioned and secured in	3/25/22

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F 909	Continued From page 19 bed safety for one (Resident (R) 69) of six sampled residents who were reviewed for accident hazards. R69's bed and side rails were not routinely checked to ensure the physical safety of the bed/rail system. This failure had the potential to cause injury from entrapment due to ill-fitting side rails. Findings include: The facility's policy related to the physical safety of side rails on resident beds was requested on 02/17/22. During an interview with the Director of Nursing (DON) on 02/17/22 at approximately 4:20 PM, she provided a policy for the proper use of side rails, but stated she was unable to locate a facility policy related to physical bed/side rail safety checks. R69 was admitted to the facility on 02/03/17 with diagnoses, according to the undated "Resident Face Sheet," in the electronic medical record (EMR), including dementia with behavioral disturbance. According to R69's most recent "Minimum Data Set (MDS)," a quarterly assessment with an Assessment Reference Date (ARD) of 01/25/22, the resident's "Brief Interview for Mental Status (BIMS)" score was three out of 15, revealing she was severely cognitively impaired. The assessment indicated the resident required limited assistance from one staff member for bed mobility and for transfers in and out of bed. R69 was observed sleeping in her bed on 02/15/22 at 2:59 PM, on 02/16/22 at 1:55 PM , and on 02/17/22 at 8:34 AM. There was a ¼ side rail on the side of the resident's bed not against	F 909	place to reduce the space between the mattress and side rail by maintenance. II. Facility residents using side rails have the potential to be affected by this practice. III. Administrator / designee inserviced maintenance and nursing staff on appropriate measurements between mattresses and side rails. Audits of spacing between mattresses and side rails were completed on facility resident□s beds utilizing side rails to ensure compliance and modifications made as needed. IV. Administrator / maintenance director / designee will ensure compliance through room rounds to be conducted weekly for a minimum of 12 weeks or until substantial compliance is achieved. The results of these audits will be brought to the Quality Assurance Performance Improvement Meeting for review and recommendations for a minimum of 3 months or until substantial compliance is achieved	

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F 909	Continued From page 20 the wall, in the raised position. A large gap was observed between the resident's mattress and the rail. The surveyor observed R69 on 02/17/22 at 9:57 AM, along with the DON and the Administrator, in her bed sleeping with the ¼ side rail raised on the outside of her bed. A large gap was observed between the rail and the mattress. The DON and the Administrator stated the gap between the resident's bed rail and mattress was too large. During an interview with the Environmental Services (EVS) Manager on 02/17/22 at 10:37 AM, he stated the facility was not doing any type of routine check on bed rails for physical safety. On 02/17/22 at 10:45 AM R69's bed was measured by the EVS Manager with the surveyor in attendance. The gap between the resident's mattress and bed rail measured 4.25 inches. According to the Federal Drug Administration (FDA)'s "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" dated 03/10/06, the gap in Zone 3 (the space between a resident's mattress and the side rail) should be no more than 4.75 inches to avoid entrapment.	F 909		
F 924 SS=E	Corridors have Firmly Secured Handrails CFR(s): 483.90(i)(3) §483.90(i)(3) Equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observations and interview with facility staff, the facility failed to equip each side of the corridor firmly secured handrails on two of two	F 924	I. Maintenance will install handrails securely in the identified corridors and checked handrails in other corridors for	3/25/22

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F 924	Continued From page 21 floors. This failure had the potential to affect the balance and mobility of all facility residents who used the rails for mobility. Findings include: Observations on 02/15/22 at 1:30 PM on the second floor revealed handrails lacking on each side in the corridor near the activity room and corridor leading to the stairway exit and elevators commonly used by residents. The missing sections included one 21-foot section, one 15-foot section, and one 5-foot section on one side of the corridor and one 19-foot section and one 14-foot section on the other side of the corridor. The corridor wall space without handrails on the second floor totaled 74 feet. Observations on 02/15/22 at 1:40 PM on the third floor revealed handrails lacking on each side in the corridor near the activity room and corridor leading to the stairway exit and elevators commonly used by residents. The missing sections included one 21-foot section, one 15-foot section and one 5-foot section on one side of the corridor and one 19-foot section and one 14-foot section on the other side of the corridor. The total wall corridor wall space without handrails on the third floor totaled 74 feet. Interview with the Administrator at 1:45 PM on 02/15/22 indicated he had never considered handrails were needed in these areas on the second and third floors. Interview with the Environmental Services Manager on 02/17/22 at 2:45 PM verified the handrails were not present in the areas noted above on both the second and third floors.	F 924	compliance . II. Facility residents have the potential to be affected by this practice. III. Administrator inserviced maintenance director on having firmly secured handrails in corridors. Inservicing will be ongoing as needed IV. Administrator / maintenance director / designee will ensure compliance through facility rounds to be conducted weekly for a minimum of 12 weeks or until substantial compliance is achieved. The results of these audits will be brought to the Quality Assurance Performance Improvement Meeting for review and recommendations for a minimum of 3 months or until substantial compliance is achieved.	

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F 924	Continued From page 22 Interview with the Director of Nursing on 02/17/22 at 3:15 PM indicated that not many residents used the handrails throughout the building, but handrails should be provided on each side of any corridor wall.	F 924		

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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
E 000	Initial Comments A Recertification Emergency Preparedness survey was conducted by Healthcare Management Solutions, LLC on behalf of the Hawaii Department of Health, Office of Health Care Assurance on 02/17/22. The facility was found to be in compliance with 42 CFR 483.73.	E 000		

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

Electronically Signed | 03/04/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125004	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/15/2022**

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K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K 363		4/28/22

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	125004	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/15/2022**

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K 363	Continued From page 1 This REQUIREMENT is not met as evidenced by: K-363 Corridors-Doors This STANDARD is not met as evidenced by: Based on observation and staff interview with Administrator and facility manager, the facility failed to produce documentation for the removal and relocation of the fire doors in the Kona Wing, in accordance with NFPA 101, Life Safety Code, 2012 edition, section 19.3.6.3. This deficiency could affect all residents, staff, and visitors during a fire due to the lack of protection of the fire wall to ensure proper protection from fire and smoke extension within the facility. Findings include: During record review on 3/15/22 at approximately 1:45 pm revealed that the facility failed to provide documentation for the removal and relocation of the fire doors located in the Kona Wing. These findings were verified at the exit conference with the facility manager and Administrator on 3/15/22 at 2:30 pm.	K 363	1. Documentation will be provided to show that the removal and relocation of the fire doors located in the Kona Wing was done in an approved manner, which did not compromise any fire walls. 2. Maintenance staff did a facility wide audit to ensure that all identified fire walls are intact. 3. Education will be provided to maintenance staff on ensuring fire walls are kept intact and not compromised. 4. Maintenance director or designee will conduct audits to ensure that fire walls are intact. Audits will be done weekly x4 and monthly x2 thereafter. The results of these audits will be brought to the Quality Assurance Performance Improvement Meeting for review and follow up as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125004	A. BUILDING _____ B. WING _____	03/15/2022

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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		

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