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4 000	Initial Comments A licensure survey was conducted by the Office of Health Care Assurance on 06/30/22. The facility was found not to be in substantial compliance with Hawaii Administrative Rules, Title 11, Chapter 94.1, Nursing Facilities. Seven Facility Reported Incidents (FRIs) from the Aspen Complaints/Incidents Tracking System (ACTS) were investigated, ACTS #9559, #9575, #8715, #8481, #8167, #8114, and #8478. ACTS #9575 was substantiated. Survey Dates: 06/27/22 to 06/30/22 Survey Census: 85 residents Sample Size: 18 residents	4 000		
4 130	11-94.1-29(a) Resident abuse, neglect, and misappropriation (a) The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to protect one resident's right to be free from abuse from other residents. As a result of this deficient practice, Resident (R)22 was observed by staff hitting R23 in the left temple, without provocation. This deficient practice has the potential to affect all residents in the facility.	4 130		

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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4 130	Continued From page 1 Findings include: On 06/29/22 at 09:50 AM, conducted a record review (RR) of a facility-reported incident (ACTS #9575) documenting a resident-to-resident abuse allegation occurring on 06/09/22. Per the completed facility report received by the State Agency (SA) on 06/13/22, "At 0845 this morning, Resident [R23] ... was in his wheelchair ... [Resident 22] exited his bed, headed toward the bathroom ... suddenly turning toward [Resident 23] ... and striking him on his (L) [left] temple." During a review of the facility's Resident to Resident Abuse Allegation Checklist, completed by Charge Nurse (CN)1 on 06/09/22, the following was noted: "Pt [patient] B [R22] got frustrated & hit Pt A [R23] because Pt A makes noise occasionally." A review of the facility's Abuse: Patient/Resident Policy, last revised on 05/01/17, noted the following regarding physical abuse: "includes hitting, slapping, pinching, kicking ..." On 06/30/22 at 07:26 AM, an interview was done with CN1 in the fourth-floor hallway. CN1 stated he was not the staff member who witnessed the incident, but he did initiate the investigation and completed the checklist referenced above. When asked about documenting that R22 hit R23 out of frustration, CN1 stated that is what the staff witness, Certified Nurse Aide (CNA)2 reported to him. CN1 continued on to explain that when he interviewed R22 following the incident, he nodded that he hit R23 but CN1 could not tell if R22 was just nodding his head to everything being said or actually confirming that he remembered doing that. When asked, R22 could not express to CN1 why he hit R23, "because of his aphasia [loss of	4 130		

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4 130	Continued From page 2 ability to communicate in words]." On 06/30/22 at 07:52 AM, an interview was done with CNA2 in the fourth-floor hallway. While recalling the incident, CNA2 stated he had just gotten R23 up to a wheelchair and placed it in the center of the room so he could adjust the footrests, R22 came around his privacy curtain with his walker, and began walking towards the bathroom. As he passed the wheelchair, R22 punched R23 straight on, hitting R23 on the left temple with the front of his closed fist. CNA2 stated that R22 did not appear startled when he came around his privacy curtain, and the punch did not look accidental. CNA2 described R22's movements as "purposeful" and deliberate. CNA2 stated that he thinks R22 might have been frustrated with R23 because of his history of yelling out, but CNA2 was not aware of any behaviors from either resident that morning or the previous night. CNA2 could not recall any verbalizations or expressions of frustration from R22, but "just think[s]" that could be the reason for the incident. When asked about R23's behaviors, CNA2 stated that "sometimes" R23 would call or yell out in the middle of the night for no reason. On 06/30/22 at 10:30 AM, during a review of R22's progress notes, the following was noted in Medical Doctor (MD)1's MD Note from 06/09/22 at 03:00 PM: " ...he [R22] struck his roommate ...has difficulty giving information due to aphasia but tells me he was frustrated. Nursing reports the roommate frequently yells out, bothering others in the room. [R22] ... has been moved to another floor ... [and] tells me he is happy about that."	4 130		

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4 136	Continued From page 3	4 136		
4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: Based on observations, record review and interview with staff members, the facility did not provide necessary services for a resident who is unable to carry out activities of daily living to maintain good grooming. The facility also failed to provide adequate supervision while a resident wandered on the unit. Resident (R)12 was observed wandering on the unit and entered another residents' room. This has the potential to be unsafe as it may lead to an altercation. Findings include: 1) On 06/27/22 observed Resident (R)12 in bed with Certified Nurse Aide (CNA)4 at bedside. CNA was planning to assist R12 with lunch and was raising the head of the resident's bed. Suddenly R12, tossed off her blanket and said "shit" and stated that she wanted to go home.	4 136		

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4 136	Continued From page 4 R12 swore a couple more times and repeated that she wanted to go home. R12 sat up on the side of her bed and looked down at her feet and stated something is wrong with her feet. Observed, R12's toe nails were white, thick, and long. CNA4 attempted to assist R12 to put on her house slippers, she refused, and again said something is wrong with her feet. R12's feet looked swollen. Record review on 06/29/22 at 11:16 AM found a physician order for triamcinolone cream for left foot rash/intertrigo (inflammatory rash of the superficial skin that occurs within a person's body folds) for fourteen days. The order was dated 05/04/22. The order was continued on 05/17/22. A review of the comprehensive/annual Minimum Data Set with assessment reference date of 03/25/22 notes R12 requires extensive assistance with one-person physical assist for personal hygiene (how resident maintains personal hygiene, including combing hair brushing teeth shaving, applying makeup, washing/drying face and hands). On 06/29/22 at 12:45 PM, R12 was observed wheeling herself on the unit. At 01:11 PM she approached the nurses' station and was removing her house slippers and sock. Observed R12's left foot to be reddened and there was an indention on her ankle from her socks. Also observed an indention of her across the top of her foot below the ankle. The resident's toe nails were white, thick, and long. R12 stated something is wrong with her feet. The Director of Nursing (DON) and Charge Nurse (CN)1 was asked to look at R12's feet. CN1 stated R12's physician will be called to look at her feet. Inquired when was the last time R12's toe nails were cut. CN1 reported the podiatrist cuts R12's toe nails. The staff member	4 136		

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4 136	Continued From page 5	4 136		

seated at the nurses' station reported the podiatrist comes every three months. Staff members were asked when was the last time R12's nails were cut. Requested to review the podiatrist report. CN1 reviewed R12's medical chart and found the last podiatry consult was 11/19/21, the podiatrist debrided R12's nails.

2) R12 was admitted to the facility on 03/25/20 from an acute hospital. Diagnoses includes but not limited to right intertrochanteric hip fracture, dementia, osteoporosis, hypertension, and depression.

On the afternoon of 06/27/22, R12 was observed seated in her wheelchair and wheeling herself on the unit. Initially the Minimum Data Set Coordinator (MDSC)2 walked alongside R12 and engaged her in conversation. MDSC2 left R12 and she was observed wheeling alone on the unit. R12 was observed to wheel into room 417 where R33 and R47 resides. The male resident in the bed closest to the door was not in the room. The curtains were drawn closed around the bed furthest from the door. A male resident was observed seated in a chair behind the curtain. There was a banner that was hanging from one side of the door. R12 continued to wheel herself about the unit.

Record review was done on 06/29/22 at 11:16 AM. Review of the "Elopement Risk Assessment" completed on 06/23/22 notes R12 yielded a score of 15 indicating high risk for elopement. Previous assessments done on 02/19/22, 12/22/21, 09/21, 06/30/21, and 03/16/21 found R12 yielded a score of 15 (high risk) for elopement. The "Fall Risk Assessment" completed on 02/24/21 indicates R12 is at risk for falls.

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4 136	Continued From page 6 On 06/29/22 at 12:45 PM, R12 was observed wheeling herself on the unit. R12 would wheel out to the lanai where male resident, R67 was seated outside eating his lunch. R12 did not enter room 417. A wheelchair was parked to the left of the door and observed, the male resident closest to the door was seated in his lounger. R12 continued to wheel herself on the unit. Last observation of resident wandering on the unit was 01:11 PM (26 minutes later). Review of the annual MDS with an assessment reference date of 03/25/22 assesses R12 cognitive abilities at 0 (zero) indicative of severe impairment. R12 was coded for wandering behavior (behavior of this type occurred daily). R12 also coded for not being at significant risk of getting to a potentially dangerous place or significantly intrude on the privacy or activities of others. Review of R12's care plan for being at risk form elopement noted the following interventions: redirect me as needed if I'm verbally or physically inappropriate towards staff of other residents, I understand that I may be given medications to calm me down if necessary; Involve interdisciplinary team, my family, physician in regard to my safety and/or others; check exit doors on my unit that the alarms are on; I like to self-propel my wheelchair around the unit, check on me every 1-2 hours prn and/or every turns regarding my whereabouts; use theatre rope by elevator as needed so that I don't get lost going in the elevator myself; stop sign at the theatre rope area (elevator) to help me remember I should not be by elevator area for safety; I have wanderguard system attached to my wheelchair, check that the system is functioning properly; and join my journey when I'm verbally saying that I	4 136		

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4 136	Continued From page 7 want to go home, let me know that I am in the hospital because my doctor is caring for me and I hurt my hip, let me know that my family is/are aware that I am safe, this sometimes gives me peace of mind.	4 136		
4 174	11-94.1-43(b) Interdisciplinary care process (b) An individualized, interdisciplinary overall plan of care shall be developed to address prioritized resident needs including nursing care, social work services, medical services, rehabilitative services, restorative care, preventative care, dietary or nutritional requirements, and resident/family education. This Statute is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure a comprehensive person-centered care plan that includes measurable objectives and timeframe to meet the resident's medical, nursing, and psychosocial needs identified on the comprehensive assessment was developed for one of 18 residents sampled, Resident (R)62. Findings include: On 06/27/22 at 11:11 AM, observed R62 in the 3rd floor dining room, seated in a wheelchair with a bedside table in front of the resident, and a catheter bag attached to the bottom of the wheelchair seat. The catheter tubing was observed to be coming out the bottom of R62's left pant leg on the ground. Approximately 9-12 inches of tubing was in direct contact with the ground before the tubing was threaded through metal center bars (located under the wheelchair	4 174		

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4 174	Continued From page 8	4 174		

seat) elevated the catheter tubing off the ground. The catheter tubing that was on the floor also ran under a base leg of the bedside table (between two wheels).

On 06/27/22 at 12:30 PM, an interview was conducted with the 3rd floor Nurse Manager (NM)3 regarding observation of R62's catheter tubing in direct contact with the ground. NM3 confirmed the tubing should not be in contact with the ground.

A record review on 06/28/22 at 11:18 AM of R62's medical chart documented the resident was admitted on 05/13/22 with diagnosis that included chronic urinary retention and an indwelling Foley catheter. A review of R62's comprehensive care plan documented the facility did not develop a care plan for the resident's goals related to the indwelling catheter with measurable objectives, timeframe, and interventions to meet the resident's medical, nursing, and psychosocial needs. R62's admission Minimum Data Set (MDS) with an assessment reference date of 05/20/22 documented an indwelling catheter in Section H- Bowel and Bladder and Section V- Care Area Assessment, urinary incontinence and indwelling catheter care area was triggered and addressed in the care plan.

During an interview and concurrent record review of R62's medical chart on 06/29/22 at 01:30 PM, NM3 confirmed that R62 was admitted to the facility with an indwelling catheter and a comprehensive care plan had not been developed for the use of the indwelling catheter. NM3 could not provide documentation of the involvement of the resident/ resident representative in the discussion of the risk and benefits of the use of the catheter, a plan for the

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4 174	Continued From page 9 removal of the catheter when criteria or indication for use is no longer present, assessments related to the indication for the use of an indwelling catheter, as well as criteria for the discontinuance of the catheter when the indication for use is no longer present, ongoing care and catheter removal protocols, or ongoing monitoring for changes in condition related to Catheter Acquired Urinary Tract Infections (CAUTI). On 06/30/22 at 11:17 AM, Registered Nurse (RN)3 reported that R62's catheter was removed, and a plan had been implemented for bladder training.	4 174		
4 203	11-94.1-53(a) Infection control (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staff conducting point-of-care (POC) COVID-19 outbreak testing on themselves conducted the testing in a manner consistent with current standards of practice for conducting COVID-19 tests. As a result of this deficient practice, the facility placed the residents and staff at an increased risk of COVID transmission. This deficient practice has the potential to affect all residents in the facility, as well as all healthcare personnel, and visitors at the facility.	4 203		

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4 203	Continued From page 10 The facility also failed to ensure infection control practices were implemented for a resident Resident (R)62 with an indwelling catheter. Findings include: 1) On 06/27/22 at 10:07 AM, observed four staff members outside the main entrance taking turns at two testing stations, swabbing themselves for COVID-19. There were no gloves or personal protective equipment (PPE) worn by any of the four staff members while testing and/or handling the test kits. There was no cleansing or wiping down of the testing stations observed between uses, nor were there any cleaning supplies available at the testing stations. On 06/30/22 at 09:07 AM, an interview was done with the Infection Preventionist (IP) at the second-floor Nurses' Station. The IP confirmed that the facility was conducting outbreak testing twice a week of all staff due to COVID-positive staff members. The IP stated that all staff were sent the information/education on self-testing for COVID-19 by Staff Development. To his knowledge, there were no competency checklists, no audits, and no formal training done. As the IP, he does not expect to see staff wearing any PPE to conduct the tests or swab themselves, but he would like to see the testing stations wiped down between uses. On 06/30/22 at 09:50 AM, an interview was done with Staff Development (SD)1. SD1 confirmed that the COVID-19 self-testing education had been sent out by e-mail to all staff on 07/28/21 and that there had been no formal education, competency checks, or audits done.	4 203		

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4 203	Continued From page 11 On 06/30/22 at 10:41 AM, during a review of the educational handout sent out by Staff Development, How to Collect an Anterior Nasal Swab Specimen for COVID-19 Testing, dated 04/13/21, the following was noted: "1. Disinfect the surface where you will open the collection kit." 2) On 06/27/22 at 11:11 AM, observed Resident (R)62 in the 3rd floor dining room, seated in a wheelchair with a bedside table in front of the resident, and a catheter bag attached to the bottom of the wheelchair seat. The catheter tubing was observed to be coming out the bottom of R62's left pant leg on the ground. Approximately 9-12 inches of tubing was on the ground before the tubing was threaded through metal center bars (located under the wheelchair seat) and off the ground, then connected to the catheter bag (located at the back bottom of the wheelchair seat). The portion of the catheter tubing that was on the floor, went under one of the base legs of the bedside table (that was in front of the resident). The way the leg of the bedside table was positioned, it appeared that staff had ran over the catheter tubing with the wheels of the bedside table. On 06/27/22 at 12:30 PM, an interview was conducted with the 3rd floor Nurse Manager (NM)3 regarding observation of R62's catheter tubing in direct contact with the ground. NM3 confirmed the tubing should not be in contact with the ground. On 06/30/22 at 12:20 PM, conducted an interview with the IP. The IP was informed of the observation of R62's catheter tubing being on the ground. IP confirmed the catheter tubing should	4 203		

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4 203	Continued From page 12 not have been on the ground and should be kept off of the ground to prevent the potential for an infection.	4 203		