STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(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) COMPLETE DATE
4 000	Initial Comments A relicensing survey was conducted by the Office of Healthcare Assurance (OHCA). The facility was found not to be in substantial compliance with Hawaii Administrative Rules, Title 11, Chapter 94.1 Nursing facilities. Survey dates: June 6 to June 9, 2022 Survey Census: 53 Sample size: 18	4 000		
4 103	11-94.1-22(e) Medical record system (e) When a resident is transferred to another facility or discharged, there shall be: (1) Written documentation of the reason for the transfer or discharge and efforts made by the facility to mitigate any stress that may arise due to the transfer; (2) Documentation to indicate that the resident understood the reason for transfer, or that the duly authorized healthcare decision maker and family were notified; (3) A complete summary including current status and care, final diagnosis, and prognosis; and (4) Documentation of efforts made for effective discharge planning. This Statute is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that a transfer summary detailing R50's medical history was completed by	4 103		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(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) COMPLETE DATE
4 103	Continued From page 1	4 103		

his physician and sent to the local area hospital he was transferred to. This deficient practice failed to communicate important information about R50's acute illness that may have hindered continuity of his care. This has the potential to affect all residents who transferto a hospital for treatment.

Findings include:

On 06/07/22 at 2:32 PM, R50's EHR was reviewed. R50 is a 62-year-old resident that was initially admitted to the facility on 06/20/20 for complicated diabetes and chronic obstructed pulmonary disease (an inflammatory lung disease that causes obstructed airflow from the lungs). A physician encounter with date of service 05/17/22 was read. It stated that R50 was transferred to a local area hospital on 05/10/22 for difficulty breathing and decreasing oxygen levels in his blood. "Given his rapid decline and his expressed desire to be fully treated, it was felt that he would benefit from a higher level of care ..." Further review of progress notes revealed that R50 was transferred back to the same local area hospital on 05/29/22 for low blood oxygen levels in his blood again. No transfer summary for this hospitalization was found in R50's chart.

On 06/08/22 at 08:30 AM, a request for R50's transfer summary to the local area hospital on 05/29/22 was made with the facility.

On 06/08/22 at 1 p.m., a progress note from the physician was given to the State Agency (SA) by the director of nursing (DON). The DON stated that there was no transfer summary made at the time of R50's transfer to the hospital on 05/29/22 and the progress note provided to SA was the transfer summary. As indicated on the progress

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(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) COMPLETE DATE
4 103	Continued From page 2	4 103		

note, the physician created the document on 06/08/22 at 12:23 PM.

On 06/09/22 at 08:55 AM, medical doctor (MD)1 was interviewed at the nursing station. MD1 stated that a transfer summary was not made because he was unsure if R50 was going to be admitted to the hospital. MD1 stated that facility's process needed to be improved.

On 06/09/22 at 12:00 PM, the facility's "Transfers and Discharges" policy, reviewed 05/11/21, was read. A document must be made by the physician and provided if the " ...transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility ..." This document should include " ...appropriate information is communicated to the receiving health care institution or provider ...to ensure a safe and effective transition of care ..."

Based on record reviews and interviews, the facility failed to ensure that a transfer summary detailing R50's medical history was completed by his physician and sent to the local area hospital he was transferred to. This deficient practice failed to communicate important information about R50's acute illness that may have hindered continuity of his care. This has the potential to affect all residents who transfer to a hospital for treatment.

Findings include:

On 06/07/22 at 2:32 PM, R50's EHR was reviewed. R50 is a 62-year-old resident that was initially admitted to the facility on 06/20/20 for complicated diabetes and chronic obstructed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(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) COMPLETE DATE
4 103	Continued From page 3	4 103		

pulmonary disease (an inflammatory lung disease that causes obstructed airflow from the lungs). A physician encounter with date of service 05/17/22 was read. It stated that R50 was transferred to a local area hospital on 05/10/22 for difficulty breathing and decreasing oxygen levels in his blood. "Given his rapid decline and his expressed desire to be fully treated, it was felt that he would benefit from a higher level of care ..." Further review of progress notes revealed that R50 was transferred back to the same local area hospital on 05/29/22 for low blood oxygen levels in his blood again. No transfer summary for this hospitalization was found in R50's chart.

On 06/08/22 at 08:30 AM, a request for R50's transfer summary to the local area hospital on 05/29/22 was made with the facility.

On 06/08/22 at 1 p.m., a progress note from the physician was given to the State Agency (SA) by the director of nursing (DON). The DON stated that there was no transfer summary made at the time of R50's transfer to the hospital on 05/29/22 and the progress note provided to SA was the transfer summary. As indicated on the progress note, the physician created the document on 06/08/22 at 12:23 PM.

On 06/09/22 at 08:55 AM, medical doctor (MD)1 was interviewed at the nursing station. MD1 stated that a transfer summary was not made because he was unsure if R50 was going to be admitted to the hospital. MD1 stated that facility's process needed to be improved.

On 06/09/22 at 12:00 PM, the facility's "Transfers and Discharges" policy, reviewed 05/11/21, was read. A document must be made by the physician and provided if the " ...transfer or discharge is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(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) COMPLETE DATE
4 103	Continued From page 4 necessary for the resident's welfare and the resident's needs cannot be met in the facility ..." This document should include " ...appropriate information is communicated to the receiving health care institution or provider ...to ensure a safe and effective transition of care ..."	4 103		
4 142	11-94.1-37(a) Social work services a) The facility shall provide medically related social work services to help residents attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being. This Statute is not met as evidenced by: Based on observations, interview, and record reviews, the facility failed to ensure that medically related social services were provided to one resident (R)32, out of a sample of two residents. This deficient practice failed to provide emotional support to R32 and ensure the highest practicable mental and psychosocial well-being is maintained. The deficient practice has the potential to affect all residents in the facility who suffer from depression. Finding includes: On 06/07/22 at 08:30 AM, an initial observation and query was done with R32. R32's bed was by the window, and he was watching television. R32 had a depressed affect. R32 stated that there was no social worker (SW) in the facility, that the staff are too busy to talk to him, and that State Agency (SA) had been the only one to come into his room to converse. On 06/07/22 at 12:24 PM, R32's electronic health	4 142		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(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) COMPLETE DATE
4 142	Continued From page 5	4 142		

record (EHR) was reviewed. R32's PHQ-9 (Patient Health Questionnaire; a nine-question survey to assess for the presence and severity of depression) dated 01/17/22 was scored at zero or minimal depression. PHQ-9 assessment done on 04/19/22 was scored at 12 indicating moderate depression.

On 06/08/22 at 08:21 AM, R32 stated with a depressed affect, that he wanted to die. R32 laid in bed with the television on.

On 06/08/22 at 08:30 AM, a query was made with licensed practical nurse (LPN)3 about R32's statement of wanting to die and LPN3 stated that R32 sometimes makes comments like that, but that he is okay.

On 06/08/22 at 1:51 PM, R32's EHR was reviewed. Progress notes from 02/16/21 to 06/07/22 were reviewed. The last "Psychosocial Note" found was dated 01/24/22. It stated that he had a Brief Interview for Mental Status Interview (BIMS) score of 15, which meant that he was cognitively intact, and he was able to communicate his needs and wants to the staff. The resident and staff reported "no negative changes in demeanor nor onset of new bx at this time." "Mood/PHQ-9" progress note dated 04/19/22 for 2:51 PM stated that "...he feels down every day. That he feels like he let his daughter down. And that he has difficulty concentrating (sic) on things. That he has thought that he would be better off dead, but he has no plan of hurting himself..." No follow up progress notes addressing his depressive symptoms or any attempts to provide emotional support were found after the entry on 04/19/22 at 2:51 PM. R32's care plan with last review date of 05/06/22 was reviewed. Focus "BEHAVIOR: [R32] exhibits s/sx

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(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) COMPLETE DATE
4 142	Continued From page 6 [signs and symptoms] r/t [related to] depressed mood ..." Interventions included " ...Offer [R32] non-pharmacological options during times of emotional distress: utilize active listening, 1-1 [one to one] validation of his concerns - offering realistic solutions to his concerns ..." On 06/09/22 at 11:46 AM, registered nurse (RN)1 was interviewed at the nursing station. RN1 stated that R32 had been very depressed in the past but he improves after the SW speaks with him. RN1 stated that the facility's SW left in March. RN1 stated that R32 had been depressed again and that the SW duties had been divided among three of the facility's staff but doesn't know who provides the emotional support for the residents. On 06/09/22 at 3:00 PM, the facility's "Behavioral Health Management" policy and procedure, revised on 05/09/22 was reviewed. Stated under "Policy": " ...The facility will provide medically related social services for highest practicable well- being as necessary for each resident. The facility will identify the need for medically- related social services and ensure that these services are provided. It is not required that a qualified social worker necessarily provide all of the services ..."	4 142		
4 160	11-94.1-41(b) Storage and handling of food (b) Effective procedures to promptly and consistently clean all equipment and work areas shall be enforced. This Statute is not met as evidenced by: Based on observations, interviews with staff and	4 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(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) COMPLETE DATE
4 160	Continued From page 7	4 160		

review of the facility's dish machine log, the facility failed to ensure appropriate concentration of the sanitizing solution was maintained for the dish washing machine. This deficient practice has the potential to affect all resident in the facility.

Findings include:

On 06/07/22 at 2:55 PM interviewed Dietary Aide (DA)1 regarding the dishwashing machine. DA1 reported dishes are sanitized with a chlorine solution. Requested DA1 test the solution. DA1 was observed to dip the test strip into the pool of water/solution mixture under the dish rack of the dishwasher. DA1 matched the color of the strip to the manufacturer's color chart. DA1 reported the solution was 50 ppm (parts per million). A request was made for the Food Service Director/Registered Dietitian (FSD/RD) to perform the testing. FSD/RD dipped the strip into the water/solution mixture and compared the strip to the color chart and stated it was at 50 ppm. Further observation found the test strips expired, 12/20/21.

A review of the "Low Temperature Dish Machine Log" for June 2022 noted the chlorine solution at 100 ppm for breakfast, lunch, and dinner service. The entry for 06/07/22 at breakfast was 100 ppm. Further review of the log, notes "during the COVID-19 outbreak, along with [contractor name], we are requesting PPM's to be at 100 PPM..." FSD/RD agreed to contact their contractor.

On 06/07/22 at 1:10 PM, observed the contractor test the solution. The test strips were not expired. The contractor dipped the strip into the solution in the dishwasher. The contractor tested the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(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) COMPLETE DATE
4 160	Continued From page 8 solution and read it as 75 ppm. Observed the color chart did not include a color match for 75 ppm and the color of the strip did not match the manufacturer's color chart. This was brought to the contractor's attention, he replied the color is between 50 and 100 ppm so it is 75 ppm. The contractor asked the surveyor if he should change the solution, he will do whatever the surveyor wanted. Redirected the contractor to ask the FSD/RD what should be done. FSD/RD informed the contractor that their corporation requires 100 ppm. Contractor was agreeable to make the adjustment.	4 160		
4 175	11-94.1-43(c) Interdisciplinary care process (c) The overall plan of care shall be reviewed periodically by the interdisciplinary team to determine if goals have been met, if any changes are required to the overall plan of care, and as necessitated by changes in the resident's condition. This Statute is not met as evidenced by: Based on observation, record review, and interview, the facility failed to review and revise the Comprehensive Care Plan (CP) for five residents (R) (R11, R46, R19, R48, and R13) in a sample of 18 residents, to effectively address their status, condition, and needs. As a result of this deficient practice, staff did not have the information necessary to adequately care for these residents so that they could meet their highest potential of physical and psychosocial well-being. This deficient practice has the potential to affect all the residents at the facility. Findings include:	4 175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(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) COMPLETE DATE
4 175	Continued From page 9 1) R11 was with moisture-associated skin damage (MASD) for approximately one month and eventual development of a Stage 2 pressure ulcer. R11 was admitted to the facility on 04/14/21. Diagnoses includes but not limited to personal history of transient ischemic attach and cerebral infarction without residual deficits, fistula of vagina to large intestine, dementia with behavioral disturbance, and history of urinary tract infections. A review of the weekly skin assessments from 04/07/22 through 06/03/22 revealed that R11's skin was intact on 04/07/22, On 04/15/22 documentation stated that R11's skin was assessed with blanchable redness and open area/wound caused by moisture-associated skin damage (MASD) to the groin and coccyx. The director of nursing (DON) and minimum data set coordinator (MDSC) were notified. The documentation from weekly assessments from 04/22/22 to 05/28/22 noted continued MASD to groin and coccyx, noting it "comes and goes." On 06/08/22 at 2:39 PM a concurrent interview and record review was done with the MDSC. R11's care plan included the following interventions to prevent skin breakdown: Perform Braden Scale assessments, weekly skin checks, notifying of skin breakdown, pressure reducing mattress, diet as ordered, and treatment as ordered (use skin barrier, A&D ointment). MDSC confirmed that R11 had MASD documented in his record on 04/22/22 through 05/28/22. Asked the MDSC whether the facility changed R11's treatment/interventions. MDSC reviewed the electronic health record (EHR) and responded	4 175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(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) COMPLETE DATE
4 175	Continued From page 10	4 175		

that she didn't see any change from A&D ointment and further stated a change in ointment is not always helpful. MDSC reported A&D is an ointment which creates a moisture barrier. Further queried if there are other ointments that are used for MASD, for example calmoseptine (ointment to treat and prevent skin irritation). MDSC responded calmoseptine contains zinc which aides in treatment of skin.

On 06/09/22 at 09:07 AM an interview was conducted with the DON and Infection Preventionist (IP). The DON reported R11 has a long fistula so that stool comes out of her vagina, with continual seepage which makes it difficult to keep R11 "clean and dry" to prevent MASD. DON also reported resident has behavior of repetitively wiping herself, resulting in irritation of her skin. Inquired if the facility changed R11's ointment/treatment in response to development of MASD. DON stated she does not believe anything beyond A&D ointment was used. DON reported there are three ointments used to create moisture barrier and treat skin, A&D ointment, calmoseptine and triad. Requested documentation different ointments/treatments were tried. DON reported the facility would change the treatment if it were not working and then go from there. The IP confirmed there is no documentation other treatments were tried.

2) R46 fell on 02/26/22 at 06:30 AM. The facility conducted a root cause analysis. The five why(s) of contributory factors included: she was reaching for her Reacher that was by her calf; because she has limited mobility and uses a Reacher to extend her personal space area; she uses the Reacher to give herself independence; she keeps items on her bed along both sides of her legs and uses two bedside tables; and she is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(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) COMPLETE DATE
4 175	Continued From page 11	4 175		

on an air mattress and prefers to stay in bed. The root cause identified, R46 is unable to recover her balance after reaching forward for her Reacher and the air mattress may have further aided her losing her balance. Inquired whether it would be helpful to revise the resident's care plan to include keeping her Reacher within reach so that she can independently have access to her belongings. The Administrator responded she is not sure whether this intervention has been included in R46's care plan.

3) The facility failed to ensure R19 was free from accident hazards by thoroughly assessing and developing a plan to keep her safe once an elopement risk had been identified.

R19 is an 82-year-old female admitted on 07/31/21 for long-term care. R19's admitting diagnoses include, but are not limited to, dementia, osteoporosis, rheumatoid arthritis, and a history of falls and stroke with residual weakness.

On 06/07/22 at 12:17 PM, during a review of R19's electronic health record (EHR), it was noted that R19 had been placed on "alert charting" on 06/02/22 for behaviors, restlessness, and confusion. Progress notes beginning on 06/03/22 document R19 exhibiting exit-seeking behavior and verbalizations, " ... Res [R19] very difficult to deal with ... perseverating ideations ... insisting she needs to get "on the elevator to go to Disneyland!" R19's family was notified of the exit-seeking behavior and verbalizations on 06/04/22. On 06/06/22 at 06:23 PM, a Nursing Behavior Note documented, "Resident exit seeking. Attempting to open both entrance door and Rehab door." The last Elopement Risk Assessment, done on 03/23/22, determined R19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(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) COMPLETE DATE
4 175	Continued From page 12	4 175		

was at no risk for elopement. A review of R19's comprehensive care plan noted no interventions or care plan initiated for exit-seeking behavior and/or risk for elopement.

On 06/08/22 beginning at 3:15 pm, observations were made of R19 sitting in her wheelchair facing the visitor entrance doors, staring intently at the doors. Several staff members walked past with no attempts to re-direct her. The facility receptionist posted near the visitor entrance stated, "she's been having some sundowning," but made no attempts to speak to R19 or inform unit staff that she was near the entrance. At 3:23 PM, another resident observed R19 at the door and stated, "you gotta watch her, she's going to try to get out, she did yesterday." At 3:24 PM, R19 was observed trying to open the visitor door, which set off the alarm. At this point, the receptionist approached R19 and unsuccessfully tried to redirect her. This behavior continued for several minutes with R19 repeatedly trying to open the visitor door and setting off the alarm. At 3:28 PM, the receptionist alerted a staff member on the unit by phone of the behavior, stating, "if someone can come talk to ... [R19] over here, she keeps setting off the alarm."

On 06/09/22 at 08:49 AM, an interview was done with the Minimum Data Set Coordinator (MDSC) in her office. The MDSC stated R19's last quarterly assessment was completed on 03/31/22, and she had not been exhibiting exit-seeking behavior at that time. The MDSC reported that the exit-seeking behavior and verbalizations were "pretty new," but had been identified, discussed in Interdisciplinary Team (IDT) meetings, and reviewed with R19's family, both in person and over the phone. During a concurrent review of R19's EHR, the MDSC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(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) COMPLETE DATE
4 175	Continued From page 13	4 175		

stated the earliest documentation she could find regarding exit-seeking behavior was on 05/26/22, which she confirmed was when the issue was first discussed with the IDT. After reviewing R19's comprehensive care plan, the MDSC also confirmed that the care plan had not been revised to include any interventions for the identified problem, but it should have been.

4) R48 is a 69-year-old male admitted to the facility on 11/30/18 for long-term care. R48's admitting diagnoses include, but are not limited to, high blood pressure, difficulty in walking, right-sided weakness following a stroke, and aphasia (loss of ability to express speech).

On 06/06/22 at 10:55 AM, observed R48 yelling gibberish out of his room. When surveyor entered, R48 was sitting up in bed with his bed set at a very high position. The bed had no bed rails, and his call light was noted to be hanging off the bed out of his reach and sight. It took several minutes of him yelling before a staff member entered to attend to his needs.

On 06/08/22 at 10:00 AM, an interview was done with Certified Nurse Aide (CNA)3 outside of R48's room. CNA3 stated R48 is very particular and likes things a certain way, he will object loudly if he is not happy. Regarding the height of his bed, CNA3 stated R48's bed is left at the highest level per his preference and request.

On 06/09/22 at 08:49 AM, an interview was done with the Minimum Data Set Coordinator (MDSC) in her office. During a concurrent review of R48's comprehensive care plan (CP), the MDSC confirmed that his CP includes to "Provide a safe environment: Call light in reach, Adequate low glare light, Bed in lowest position and wheels

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(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) COMPLETE DATE
4 175	Continued From page 14 locked ..." The MDSC stated she is aware that R48's bed is left in the highest position per his preference and agreed that his CP should have been revised to include that preference. 5) R13 is a 73-year-old female admitted to the facility on 04/26/21 for skilled services but has since been changed to long-term care. Since 05/21/22, R13 has been on isolation related to COVID-19 exposure, then on 05/31/22 tested positive for COVID-19 herself. On 06/09/22 at 07:34 AM, during a review of R13's CP, it was noted that there was no revision to her CP to address the social isolation and changes in needs resulting from her quarantine since 05/21/22. On 06/09/22 at 08:49 AM, an interview was done with the MDSC in her office. During a concurrent review of R13's CP, the MDSC confirmed it had not been revised since 04/10/22 and agreed that her needs would have changed when she went into quarantine. When asked why R13 did not have a COVID-19 isolation care plan, the MDSC stated "I have no good answer as to why not."	4 175		
4 190	11-94.1-46(g) Pharmaceutical services (g) Each drug shall be rechecked and identified immediately prior to administration. This Statute is not met as evidenced by: Based on observation, and record review, the facility failed to ensure a medication error rate of less than 5%, as evidenced by two medication errors observed out of twenty-eight opportunities for errors, for an error rate of 7.14%. Safe	4 190		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(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) COMPLETE DATE
4 190	Continued From page 15 medication administration practices are essential for the health and well-being of the residents. As a result of this deficient practice, two residents received the wrong medication. This deficient practice has the potential to affect all residents in the facility. Findings include: On 06/08/22 at 08:23 AM, during medication administration, observed Registered Nurse (RN)1 prepare and administer to Resident (R)48 one tablet of Senna Plus 50/8.6mg [milligrams]. Senna Plus is senna and docusate sodium, a laxative with stool softener compound. At 09:56 AM while reviewing R48's electronic health record (EHR), it was noted that the medication order was for senna 8.6mg (the laxative) alone. On 06/08/22 at 08:31 AM, during medication administration, observed RN1 prepare and administer to R41 one tablet of Calcium 600mg. At 10:00 AM while reviewing R41's EHR, it was noted that the medication order was for a Calcium Carbonate - Vitamin D Tablet 600-400 MG-UNIT.	4 190		
4 197	11-94.1-46(n) Pharmaceutical services (n) Discontinued and outdated prescriptions and containers with worn, illegible, or missing labels shall be disposed of according to facility policy. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to ensure all medications used in the facility were securely stored in locked compartments,	4 197		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(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) COMPLETE DATE
4 197	Continued From page 16 and that floor stock medications were not used past the manufacturer expiration dates. Proper storage and labeling of medications is necessary to promote safe administration practices, and to decrease the risk of medication errors and diversion of resident medications. This deficient practice has the potential to affect all residents in the facility. Findings include: On 06/07/22 at 09:10 AM, while walking through the unit, observed an unlocked and unmonitored medication cart outside a resident room, blocking the doorway. There was no staff in sight. The resident's room had no resident in Bed A, closest to the door, and Bed B, near the window, had its privacy curtain pulled closed. State Agency (SA) sat in hallway across from the resident's room and the unsecured medication cart to continue observations. Observed two residents and one staff member walk past the cart. At 09:14 AM, observed Licensed Practical Nurse (LPN)4 come from behind the privacy curtain at 303, Bed B, return to the medication cart, place something on it, then turn and walk away from it without locking it. At 09:15 AM, LPN4 returned to the medication cart from the resident's privacy curtain once again. When asked if she usually locks the medication cart when she walks away from it, initially LPN4 answered "yes, I do." When asked why the medication cart was left unlocked this time, LPN4 responded by stating she doesn't lock the medication cart "if I can keep my eyes on it." On 06/08/22 at 08:18 AM, while walking through the unit, observed Registered Nurse (RN)1 walk	4 197		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(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) COMPLETE DATE
4 197	Continued From page 17 away from a medication cart, leaving it unlocked as she entered a resident's room and walked to the bed closest to the window, which had its privacy curtain pulled closed. Neither the resident nor RN1 were visible from the medication cart. At 08:21 AM RN1 returned to the medication cart. When asked if she usually locks the medication cart when she walks away from it, RN1 responded "yes." When the surveyor pointed out that the medication was not locked, RN1 stated, "I didn't that one time for that short time, and it was within my view." On 06/09/22 at 08:28 AM, during an inspection of the medication cart on a nursing unit, observed two floor stock bottles of medication that had exceeded the manufacturer's expiration date. One bottle of Aspirin (a non-steriodal anti-inflammatory drug) 325 mg (miligram) had a manufacturer's expiration date of "02/2022." The Aspirin bottle also had a facility label on it that indicated it had been opened and used since 02/28/22. One bottle of Vitamin B-12 1000mcg [micrograms] had a manufacturer's expiration date of "05/22." The Vitamin B-12 bottle also had a facility label on it that indicated it had been opened and used since 09/18/21. Both bottles were given to RN1 who agreed that they should have been pulled and discarded.	4 197		
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.	4 203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(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) COMPLETE DATE
4 203	Continued From page 18	4 203		

This Statute is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure appropriate protective and preventive measures for COVID-19 and other communicable diseases and infections and 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. These deficient practices has the potential to affect all residents in the facility, as well as all healthcare personnel, and visitors at the facility.

Findings include:

1) On 06/06/22 at 10:00 AM, upon entering the facility, the State Agency (SA) was informed that the facility was experiencing a COVID-19 outbreak. The facility stated that there were two residents on quarantine for COVID-19, one in room 404 and another in room 405. Both residents were "sheltering in place" with their roommates (who were previously positive).

On 06/06/22 at 11:36 AM, while making observations outside the two COVID-19 rooms, the following was noted on the bright orange signs posted outside each room:

" ...KEEP DOOR CLOSED ..."

It was observed at this time, and throughout the length of the survey, that neither door was closed. The doors to both rooms remained open with thin plastic barriers unevenly secured around the inner door frames. The barriers went from the top of the door frames to approximately two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(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) COMPLETE DATE
4 203	Continued From page 19 inches above floor level. The center of each plastic barrier had a red zipper that extended the length of the barrier, to allow entry and exit into the room. At this time, and at several other points in the survey, the zippers on one or both of the plastic barriers were observed partially or fully open, with no staff in sight. The plastic barrier in the doorway of room 405 had an approximately 12-inch horizontal tear in it that had been repaired with clear 2-inch tape. On 06/06/22 at 11:51 AM, observed a bright yellow sign in the dining room and at the nurses' stations with the following information: "INFECTION PREVENTION ...LEVEL 2 ACTIVATION EFFECTIVE 5/21/22 ...EMPLOYEES (ALL) EYE PROTECTION REQUIRE IN RESIDENT AREAS ..." On 06/06/22 at 12:00 PM, while making observations outside room 404, observed Certified Nurse Aide (CNA)2 deliver lunch to both residents in the room. Resident (R)13's lunch was packed in disposable containers, while R5's lunch was on a plastic tray with reusable tableware. Both lunches were passed through the plastic barrier by Staff Member (SM)2 to CNA2. After CNA2 delivered the lunch to R5, she passed the plastic cover for the main dish back out to SM2, who placed it back on the meal cart. It was observed at this time that CNA2 was wearing her N95 respirator with both bands together at the back top of her head. On 06/06/22 at 1:42 PM, an observation was done of Licensed Practical Nurse (LPN)3 exiting a resident's room with her eye protection sitting on the top of her head.	4 203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(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) COMPLETE DATE
4 203	Continued From page 20 On 06/07/22 at 09:20 AM, during a review of the day-shift nurse staffing schedule for the week, it was noted that on 06/07/22 through 06/09/22, there was one CNA assigned to Rooms 306A-404A, and a second CNA assigned to Rooms 404B-412. On 06/07/22 at 10:15 AM, while standing outside of Room 404, observed CNA1 exiting the plastic barrier with trash collected in the room in a double-bagged clear trash bag. CNA1 carried the trash from Room 404 through the hall to the dirty utility room where she placed it in a covered gray bin. Asked LPN2 if that was the proper handling of trash from a room with active COVID-19. LPN2 stated she would double-check. On 06/07/22 at 10:20 AM, an interview was done with CNA3 outside room 404. Regarding meals, CNA3 stated all residents in rooms on isolation for COVID-19 should have disposable containers and utensils. Regarding staff assignments, CNA3 confirmed that staff who entered the COVID-19 isolation rooms were not dedicated to those rooms but assisted other residents in the unit as well. On 06/07/22 at 10:27 AM, LPN2 stated she had confirmed that the protocol for trash taken from the isolated COVID-19 rooms was that they should be placed in yellow trash liners which are stocked in the bottom drawer of the PPE carts outside the rooms, then placed in the yellow bins in the dirty utility room. The yellow color of the trash liners and bins indicating that special handling was required. On 06/08/22 at 09:38 AM, observed R36 sitting in his wheelchair outside of Room 405. R36 un-zipped the plastic barrier to his room and	4 203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(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) COMPLETE DATE
4 203	Continued From page 21	4 203		

attempted to enter but his wheelchair got stuck on the plastic barrier. At 09:40 AM, Registered Nurse (RN)1 walked by and assisted R36 into the room. When asked about R36 being out of the isolation room when his roommate still had active COVID-19, RN1 stated "he is recovered from COVID, so he is allowed to be out ...[the Infection Preventionist] said he can be out even though his roommate has COVID as long as he wears a mask while he is out."

On 06/08/22 at 12:17 PM, an interview was done with the Infection Preventionist (IP) in an office next to the Reception area. The IP confirmed that the residents in isolation for COVID-19 were not in a dedicated space and did not have dedicated staff. The IP also confirmed that rather than cohorting the confirmed positive residents together, with their exposed roommates quarantined in a separate space, the decision had been made to leave them with their COVID-positive roommates. The IP stated that the facility had been advised by the State Disease Outbreak and Control Division (DOCD) that the residents could be "shelter[ed] in place," amongst other recommendations. The IP agreed that several of the infection control practices being followed in the facility, particularly in regard to the management of a COVID-19 outbreak, did not align with CDC recommendations, but stated that the decision had been made to follow DOCD recommendations instead. Documentation of recommendations made by DOCD and/or the evidence-based rationale for them was requested, but never produced by the facility.

During a review of the CDC's Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, updated 02/02/22, the following

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(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) COMPLETE DATE
4 203	Continued From page 22	4 203		

recommendations were noted:

"Identify Space in the Facility that Could be Dedicated to Monitor and Care for Residents with Confirmed SARS-CoV-2 Infection ... location of the COVID-19 care unit should ideally be physically separated from other rooms or units housing residents without confirmed SARS-CoV-2 infection ..."

"Identify HCP [healthcare personnel] who will be assigned to work only on the COVID-19 care unit when it is in use."

" ... it is recommended that the door to the room remain closed to reduce transmission of SARS-CoV-2. This is especially important for residents with suspected or confirmed SARS-CoV-2 infection being cared for outside of the COVID-19 care unit."

"Residents should only be placed in a COVID-19 care unit if they have confirmed SARS-CoV-2 infection."

2) On 06/09/22 at 07:10 AM observed a contractor enter the facility alongside a facility staff member. The contractor stopped at the nurse's station, reviewed a binder, and was observed walking down the hall and into a resident's room. The contractor was wearing a lab coat, procedural mask and eye protection. Observed the contractor did not take her temperature and complete the facility's screening questions for COVID-19. Reviewed the visitor log and found the contractor did not sign in.

On 06/09/22 at 07:15 AM, interviewed the Infection Preventionist (IP). Queried whether contractors entering the facility are required to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(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) COMPLETE DATE
4 203	Continued From page 23	4 203		

wear an N95 and sign-in. IP replied contractor's are required to wear an N95 and sign-in. After reviewing the facility's sign-in log, the IP confirmed the contractor did not sign-in. IP agreed to find the contractor and have her follow the facility's procedure for screening and wearing the appropriate personal protective equipment.

3) On 06/08/22 at 12:21 PM, an interview was done with the Infection Preventionist (IP) in the conference room. The IP stated that the facility was currently in outbreak testing since 05/21/22. Residents were being tested for COVID-19 twice a week until 05/30/22, then decreased to once a week. Staff remained on twice a week testing.

On 06/09/22 at 06:55 AM, arrived at the facility and observed Occupational Therapist (OT)2 and Staff Member (SM)1 standing outside the staff entrance after just swabbing themselves for COVID-19. Neither OT2 nor SM1 were wearing gloves or a gown at the time. SM1 was observed changing out her procedure mask for an N-95 respirator as she waited for the COVID-19 point-of-care (POC) test to result. Interviewed OT2 about the process and was told that staff had been trained to swab themselves, then verify each other's results for the screening log.

On 06/09/22 at 07:27 AM, during an interview with the Infection Preventionist (IP) in the conference room, The IP stated that staff had been trained to test themselves in January of 2022, prior to her employment at the facility. The IP continued on to say that she expected staff to at least be wearing gloves when swabbing themselves but did not expect full personal protective equipment (PPE) to be worn because staff were conducting the tests outside the facility. The IP was asked to locate the education and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(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) COMPLETE DATE
4 203	Continued From page 24 competency logs from the January 2022 training. Education logs were received, but competency logs were not. During a review of the Centers for Medicare & Medicaid Services (CMS) Memorandum QSO-20-38-NH, Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements, last revised on 03/10/22, the following was noted regarding COVID-19 testing: "During specimen collection, facilities must maintain proper infection control and use recommended personal protective equipment (PPE), which includes a NIOSH-approved N95 or equivalent or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown, when collecting specimens." During a review of the Centers for Disease Control and Prevention's (CDC) Interim Guidelines for Collecting and Handling of Clinical Specimens for COVID-19 Testing, updated May 18, 2022, the following was noted: "For healthcare providers collecting specimens or working within 6 feet of patients suspected to be infected with SARS-CoV-2, maintain proper infection control and use recommended personal protective equipment (PPE), which includes an N95 or higher-level respirator (or face mask if a respirator is not available), eye protection, gloves, and a gown."	4 203		