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4 000	Initial Comments A state relicensure survey was conducted by the Office of Health Care Assurance on 08/30/22 - 09/02/22. The facility was found not to meet the requirements at Hawaii Administrative Rules, Title 11, Chapter 94.1, Nursing Facilities. The census was 19 residents at the time of entrance.	4 000		
4 120	1-94.1-27(9) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (9) The right to names, addresses, and telephone numbers of pertinent resident advocacy groups; This Statute is not met as evidenced by: Based on interview with resident council representatives, the facility did not assure residents are aware of the contact information for the State Long Term Care Ombudsman and not aware of how to contact the State Survey Agency to file a complaint. Findings include: On 08/31/22 at 09:30 AM an interview was conducted with six resident council representatives. Residents were asked if they are aware of where the Ombudsman's information is posted. Resident (R)13 was aware	4 120		

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4 120	Continued From page 1 of the Ombudsman's name but not sure where to find the contact information. Resident (R)15 responded it is probably posted on the bulletin board. The representatives were asked if they were aware they can contact the State Survey Agency to file a complaint. The representatives could not confirm knowledge of contacting the State Survey Agency to file a complaint.	4 120		
4 127	11-94.1-28(a) Resident accounts (a) In the event the resident or family member requests the facility to manage the resident's personal funds, an itemized account shall be made available in writing to the resident or the legal guardian or surrogate, and shall be maintained and kept current for the resident, including: (1) Written receipts for all personal possessions and funds received by or deposited with the facility; and (2) Written receipts for all disbursements made to, or on behalf of, the resident. This Statute is not met as evidenced by: Based on interview with family member and staff member, the facility failed to assure quarterly bank statements were provided in writing to the resident's representative. Findings include: On 08/31/22 at 02:30 PM an interview was conducted with Resident (R)12's family member.	4 127		

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4 127	Continued From page 2 Family member stated R12 has a personal fund account with the facility. Family member reported they do not receive quarterly account statements. On 09/01/22 at 09:27 AM an interview was conducted with the Accountant. The Accountant confirmed R12 has two accounts with the facility, personal fund account and a bank account. The personal fund account is cash account held by the facility for accessibility and quarterly statements are sent to the residents and/or resident representatives upon request. The Accountant reported R12's family has not reached out to request quarterly petty cash statements. The Accountant provided a copy of R12's personal funds account, this statement was addressed to R12's family member. As requested by resident or resident representative, the facility will open a bank account for residents at a commercial bank. These accounts are opened on behalf of the resident and statements are sent to the facility. On 09/01/22 at 10:40 AM the Accountant provided a copy of R12's commercial bank statement for March through June 2022 for review. The bank statement was addressed to R12 and mailed to the facility. Inquired whether the bank statements are sent to resident's power of attorney (POA) or representative, Accountant responded statements do not go to the POA or representative. The Accountant further reported the statements are delivered to the residents as mail and the accounting department doesn't always receive a copy of the statement. Review of the policy and procedure titled, Resident Cash Funds (Policy No.: 600-105-5) with effective date of 10/15/20 notes the facility	4 127		

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4 127	Continued From page 3 has three types of account, interest-bearing account, personal account, and temporary holding account. In parentheses for interest-bearing account and personal account, it was documented "Quarterly reconciliation of account." However, the procedure does not include providing quarterly statements for any of the accounts to a resident or resident representative.	4 127		
4 153	11-94.1-40(a) Dietary services (a) The food and nutritional needs of the residents shall be met through a nourishing, well-balanced diet in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, and shall be adjusted for age, sex, activity, and disability. (1) At least three meals shall be served daily at regular times with not more than a fourteen hour span between a substantial evening meal and breakfast on the following day; (2) Between meals nourishment that is consistent with the resident's needs shall be offered routinely and shall include a regular schedule of hydration to meet each resident's needs; (3) Appropriate substitution of foods shall be promptly offered to all residents as necessary; (4) Food shall be served in a form consistent with the needs of the resident and the resident's ability to consume it; (5) Food shall be served with appropriate	4 153		

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4 153	Continued From page 4 utensils; (6) Residents needing special equipment, implements, or utensils to assist them when eating shall have the items provided by the facility; and (7) There shall be a sufficient number of competent personnel to fulfill the food and nutrition needs of residents. Paid feeding attendants shall be trained as per the facility's state-approved training protocol. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to provide care and services to prevent significant weight loss or to identify the need for closer monitoring and timely interventions for one Resident (R)4, as evidenced by a weight loss of 5.571% in one month. As a result of this deficient practice, the facility placed this resident at risk for avoidable declines and injuries. This deficient practice has the potential to affect all residents at the facility. Findings include: Resident (R)4 is a 94-year-old female admitted for long-term care on 03/29/22, then upgraded to a skilled nursing (SNF) level of care on 08/03/22. Her current diagnoses include dementia, diabetes, peripheral vascular disease, insomnia, and osteomyelitis (bone infection) of her right foot. Review of R4's electronic health record (EHR) noted that what began as a blister-like lesion on her right great toe in April 2022 has now progressed to osteomyelitis and gangrene (dead tissue due to a lack of blood flow or a serious bacterial infection) of her right big toe and hallux	4 153		

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metatarsal phalangeal (MTP) joint, or her big toe joint.

On 08/31/22 at 12:55 PM, further review of R4's EHR revealed that on 07/25/22, R4 was documented as weighing 104.1 pounds. One month later, on 08/29/22, R4 was documented as weighing 98.3 pound, reflecting a 5.571% weight loss.

On 08/31/22 at 02:06 PM, a phone interview was done with R4's family representative (FR). FR shared that R4 had initially gained weight when she was admitted to the facility and told her that she enjoyed the food. As time passed, with the development of the right foot wounds, FR stated that R4 has not seemed to be eating as much and has been sleepier than usual. FR expressed that she is concerned about R4 losing weight, stating that R4 is not even interested in her favorite foods that FR brings from home. When she asks the facility about R4 losing weight, FR stated that she is told that R4's weight "is stable."

On 09/01/22 at 03:20 PM, additional review of R4's EHR was done. The following was noted regarding her nutritional assessments and interventions:

Nutrition Evaluation done on 04/10/22 documented a regular diet, thin liquids, weight stable with an "Average Meal Consumption Per Day: 75-100%."

Nutrition Evaluation done on 07/07/22 documented a chopped diet with thin liquids, "overall beneficial weight gain," with an "Average Meal Consumption Per Day: 50-74%." No changes were made to R4's nutritional plan at that time. No nutrition/dietary referrals, notes, or

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assessments found between 07/07/22 and 08/12/22, despite a change in condition identified on 08/03/22.

Nutrition Note done on 08/12/22 documented the following: "Discussion of wounds with Interdisciplinary Team on 08/11/22 ... Nutritional concerns d/t [due to] resident with wounds. High protein needs d/t ulcer to promote wound healing. Resident with recent decline in oral intake ... Per RN [Registered Nurse] notes on 08/08 - [08/]09, poor oral intake AEB [as evidenced by] ate only 25% of her meals, ate only 3 bites and 100ml of her fluids for breakfast, stated, "I wanna die, I don't wanna eat" ..." The interventions implemented were to add eight (8) ounces of a nutritional shake three times a day with meals, and a recommendation "to continue encouragement and cueing at meal times [sic]."

Nutrition Consultation done on 08/16/22 documented the following: "Consult: Weight Difference ...Resident continue with poor oral intake AEB RN Notes (08/12 - 08/15) detailing meal intakes are 25% or less, refusal of supplement, poor appetite, requirement of much encouragement to eat and drink ...Resident on regular, bite sized, thin liquids ...Continue to encourage oral intake. Will continue to monitor." Further review found no indication on the frequency of the monitoring that would be done, no calculation of caloric, hydration, or protein needs, and no changes in interventions ordered. It was also noted that there was no dietary/nutrition referrals, notes, or assessments between 08/16/22 and 09/01/22, a period during which R4 lost 5.5 pounds, or 5.298% of her body weight.

On 09/02/22 at 09:13 AM, an interview was done

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4 153	Continued From page 7 in Conference Room C with the Chief Quality Officer (CQO). The CQO reported that R4 had been assessed by the Registered Dietician (RD) the previous day and moved to the Medical-Surgical Unit so that she could receive Total Parenteral Nutrition (TPN), a method of feeding done by IV, bypassing the gastrointestinal tract, and providing most of the nutrients the body needs. After concurrent record review of R4's EHR, the CQO agreed that the RD referral and review of R4's weight and dietary intake was delayed.	4 153		
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on observation, and interview, the facility failed to store, label, and serve food in accordance with professional standards for food service safety. Residents (R) risk serious complications from foodborne illness as a result of their compromised health status. Unsafe and/or unsanitary food handling practices represent a potential source of pathogen exposure for all residents at the facility.	4 159		

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4 159	Continued From page 8 Findings include: 1) On 08/30/22 at 09:50 AM an initial tour of the kitchen was done with Kitchen Staff (KS)1. Observations found the three-door refrigerator contained a plastic container of balsamic vinegar dressing and a plastic container of miso labeled with a used by date of 08/23/22. In the reach-in refrigerator there was a container of chickpeas that was not labeled to identify the food item and the use by date. The reach-in freezer found a plastic bag of frozen food that was not labeled. Inquired what was in the plastic bag, KS1 replied she did not know and threw out the food item. Upon entering the walk-in freezer, observed frozen red liquid on the floor close to the door jam with frozen red liquid trailing down an empty plastic container. Asked KS1 what is that? KS1 responded it is probably frozen blood and further states this is the area where raw hamburger is stored. Also observed a box on the floor of the walk-in freezer. KS1 confirmed this was a box of frozen chicken that was just delivered. 2) On 08/31/22 at 09:50 AM a confidential resident interview was conducted. The resident reported the dishware (plates, bowls, cups) are oftentimes chipped. The resident reported that this is not sanitary. On 09/01/22 at 08:15 AM observed breakfast meal, there were three plates (white in the center with grey trimming) with chips on the perimeter. At 08:20 AM, concurrent observation and interview was done with Certified Nurse Aide (CNA)5 as she was clearing the tables. Inquired whether she noticed if there were chips in the ceramic dishware. CNA5 stated she has not	4 159		

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4 159	Continued From page 9 noticed, however, confirmed there was a chip in the plate. On 09/01/22 at 12:55 PM concurrent observation of the dishware was done with the Kitchen Manager. Observation found five white plates with fluted edges with chips on the rim. The Kitchen Manager reported the chipped plates allow particles to permeate the plates and is not a good infection control practice. The Kitchen Manager stated she will go through the dishware and check for chips. 3) On 08/30/22 at 11:02 AM, observations were done in Resident (R)8's room as the Certified Nurse Aide (CNA)2 prepared to feed him his lunch. Observed CNA2 stir R8's pureed rice with a spoon, then stick her right index finger in it, wipe the finger on his napkin, and continued to stir. When asked about sticking her ungloved finger in his food, CNA2 explained that she was ensuring the food was cool enough to feed to the resident. As she explained what she was doing, CNA2 demonstrated the process by sticking her right index finger into R8's pureed main dish twice, in between stirring it with a spoon. When asked about hand hygiene, CNA2 explained that she washed her hands with soap and water before she left to pick up R8's lunch tray, then used an alcohol-based hand rub when she returned with the food, before she began feeding him.	4 159		
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,	4 175		

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4 175	Continued From page 10 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 recognize the need for closer monitoring and additional interventions to manage a significant change in physical condition for one resident (R) in the sample. Although R4 was identified with a serious, potentially life-threatening wound infection that required extended intravenous (IV) antibiotic therapy, placement of a central line (IV access into a large central vein near the heart), and an upgrade of her status to a skilled nursing level of care, the facility failed to assess the impact the infection had on her functional needs, or to refer her to the appropriate specialists for her condition. As a result of this deficient practice, the facility placed R4 at an increased risk for avoidable declines and injuries. This deficient practice has the potential to affect all residents in the facility with worsening wounds. Findings include: R4 is a 94-year-old female admitted for long-term care on 03/29/22, then upgraded to a skilled nursing (SNF) level of care on 08/03/22. Her current diagnoses include dementia, diabetes, peripheral vascular disease, insomnia, and osteomyelitis (bone infection) of her right foot. Review of R4's electronic health record (EHR) noted that what began as a blister-like lesion on her right great toe in April 2022 had progressed to osteomyelitis and gangrene (dead tissue due to a lack of blood flow or a serious bacterial infection) of her right big toe and hallux metatarsal phalangeal (MTP) joint, or her big toe joint.	4 175		

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4 175	Continued From page 11 On 08/31/22 at 12:55 PM, further review of R4's EHR noted that despite extensive documentation beginning in May 2022 about the worsening wound(s) on her right foot, prolonged wound infection(s), and peripheral vascular disease, no referrals were found to have been made to a wound specialist, an infection disease specialist, or a vascular disease specialist. On 09/01/22 at 10:26 AM, observations were done of Certified Nurse Aide (CNA)3 and CNA6 transferring R4 from her geriatric chair (Geri-Chair) to her bed. With the Geri-Chair in the fully upright position, it was observed that R4's feet dangled approximately four (4) inches above the ground. Both CNAs attempted to waken R4 as she slept sitting up, with no success. Observed CNA3 and CNA6 each use one arm to hook under one of R4's armpits and use their remaining free hand to grab the back of R4's elastic-waist pants. They then proceeded to lift R4 from the Geri-Chair to the bed with no assistance from her. After R4 was safely in the bed, an interview was done with both CNAs at the bedside. When asked why a mechanical lift was not used, both CNAs stated that R4 is a "2-man assist for transfer because she can bear weight on her good [left] foot and assist with the transfer when she is not sleepy." When it was pointed out that R4 was very sleepy and could not even lift a hand to assist with the transfer, nor could she bear weight on her good foot when her feet did not touch the floor, CNA3 explained that is why they transferred her the way they did. On 09/01/22 at 10:38 AM, an interview was done with Registered Nurse (RN)1 outside of R4's room. After describing the transfer that was just observed, RN1 agreed that when R4 is sleepy, as	4 175		

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4 175	Continued From page 12 she has been lately, the safer option for both resident and staff would be to transfer her utilizing a mechanical lift. RN1 stated that all staff should be using their own judgement to ensure transfers are safe and that an order is not needed for mechanical lifts. On 09/01/22 at 02:30 PM, the DON was interviewed at the NS. After a discussion regarding R4's increased transfer, mobility, dietary, and wound healing needs, the DON agreed that R4's functional needs had to be reassessed. On 09/02/22 at 09:13 AM, an interview was done in Conference Room C with the Chief Quality Officer (CQO). The CQO confirmed that although R4's condition had been followed by two different Podiatrists (a medical professional devoted to the treatment of disorders of the foot, ankle, and related structures of the leg), and reviewed by the facility's Chief Medical Officer, no referrals or orders had been made for a wound specialist, an infection disease specialist, or a vascular disease specialist.	4 175		