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	125009	A. BUILDING _____ B. WING _____	07/22/2022

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MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 07/22/22. The facility was not in substantial compliance with 42 CFR §483 subpart B. Survey dates: 07/19/22 to 07/22/22. Survey Census: 79 Sample Size: 19	F 000		
F 635 SS=D	Admission Physician Orders for Immediate Care CFR(s): 483.20(a) §483.20(a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff members the facility failed to follow the physician's order upon admission regarding psychotropic medications for one Resident (R)31 in the sample of five residents investigated. As a result of this deficient practice,all residents who are taking psychotropic medications in the facility are at risk of maintaining and improving their functional abilities. Findings Include: Resident (R)31 was admitted to the facility on 05/11/22 with a diagnoses that included unspecified single episode major depressive disorder. Review of R31's Electronic Health Record (EHR)	F 635	DIRECTOR OF NURSING (DON), HEAD NURSE (HN), SOCIAL WORKER (SW) AND INTERDISCIPLINARY TEAM (IDT)WILL IMPLEMENT CORRECTIVE ACTIONS FOR RESIDENT 31 AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: "HN and DON reviewed resident #31□s Admission MD order in facility□s electronic medical record (EMR). Resident was admitted with Citalopram and EMR order entered that all psychotropic medications will be discontinued 14 days from admission, unless reassess and reordered was not done. Completed 07/21/22 "IDT to review/assess and discuss resident #31□s condition and if	9/4/22

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

Electronically Signed | 08/15/2022

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F 635	Continued From page 1 documents R31 had admission physician orders of Citalopram Hydrobromide (an antidepressant) tablet 10 milligrams (mg), give 1 tablet by mouth one time a day and "all psychotropic medications will be discontinued 14 days from admission, unless reassessed and reordered by provider/attending MD [physician] or psychiatry consult," ordered on 05/11/22. Review of R31's Medication Administration Record (MAR) and EHR documents R31 administered Citalopram daily starting 05/12/22 in May, June, and July with no documentation found that indicated the order was discontinued after 14 days of admission, or the physician reassessed and reordered the medication. Review of the facility's policy and procedure on psychotropic drug use, policy number "ORNUR009", with an effective date of 09/01/18, documents major categories of psychotropic medication including antidepressants and documents "All antipsychotic medications will be discontinued 14 days from admission, unless reassessed and reordered by provider/attending MD or psychiatry consult." On 07/21/22 at 01:50 PM interview with Unit Manager (UM) 2 confirmed the facility did not follow the physician's order to discontinue all psychotropic medications including Citalopram for R31, 14 days of admission, and the physician did not reassess the medication.	F 635	antidepressant medication is needed. If needed and appropriate, HN/LN will collaborate with resident□s physician to obtain order to continue medication. If not needed, will obtain order to discontinue medication or suggest gradual dose reduction. Completed 08/11/22 "HN and SW will arrange for Geri-psychiatrist consult. Appointment scheduled for 08/18/22 DIRECTOR OF NURSING (DON), NURSING SUPERVISOR (SRN), HEAD NURSE (HN), LICENSED NURSES (LN) WILL ASSESS OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS PRACTICE, INCLUDING: "DON, SRN, HN reviewed the Psychotropic P&P and Admission Physician Order. EMR order template was changed to reflect updated P&P and Admission Physician Order (effective date 09/01/2018) stating all antipsychotic medications and PRN psychotropic medications will be discontinued 14 days from admission, unless reassessed and reordered by provider/attending or psychiatry consult. Completed 07/22/22 "HNs discontinued all residents with psychotropic admission orders and updated order template in PCC Completed 07/22/22 "DON, SRN, HN will identify residents who have been admitted/readmitted in 2022 with antipsychotic and PRN psychotropic medications and if orders were followed. Completed 08/13/22	

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F 635	Continued From page 2	F 635	HEAD NURSE (HN), LICENSED NURSE (LN), EDUCATION NURSE (ED), SOCIAL WORKERS (SW), MINIMUM DATA SET NURSE (MDS), INTERDISCIPLINARY TEAM (IDT) WILL IMPLEMENT MEASURES TO ENSURE THAT THIS PRACTICE DOES NOT RECUR, INCLUDING: "HN and ED will educate the LN regarding the importance of reviewing admission medication list, placing stop orders, monitor log in PCC and initiating care plan to address use of psychotropic medications Start 08/16/22□Completed 09/04/22 "LN to review list of medications ordered on admission/readmission, place stop order and re-assesses need after 14 days for all antipsychotic medications and PRN psychotropic medications. Start 08/16/22-Ongoing "HN, LN and SW will discuss each admission with psychotropic medication to determine if Geri-psychiatrist consult is necessary. If deemed necessary, HN and LN will obtain order from provider or attending doctor for Geri-psych consult to assess appropriateness of medication and to establish a baseline with Geri-psych doctor for follow up as indicated. Start 08/16/22-Ongoing "HN will ensure that at the IDT Admission Conference meeting, MDS/IDT will review list of medications resident is admitted/readmitted with. Documentation and behavior monitoring log will be reviewed to determine residents□ current status and appropriateness of antipsychotic and PRN psychotropic	

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F 635	Continued From page 3	F 635	medication. Care plan will be reviewed and updated. Start 08/16/22-Ongoing DIRECTOR OF NURSING (DON), NURSING SUPERVISOR (SRN), HEAD NURSE (HN), SOCIAL WORKERS (SW), MINIMUM DATA SET NURSE (MDS), INTERDISCIPLINARY TEAM (IDT), QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) WILL MONITOR CORRECTIVE ACTIONS TO ENSURE THE EFFECTIVENESS OF THESE ACTIONS, INCLUDING: "HN will log residents admitted/readmitted with antipsychotics or PRN psychotropic medications, review behavior monitoring in PCC 14 days from admission/readmission, check if antipsychotic and PRN psychotropic medications are addressed at 14 days, and discuss with SW and IDT. (POC Tracking Log for Admissions/Readmissions with Antipsychotic or PRN Psychotropic Meds. Start 08/18/22-Ongoing "SRNs will perform monthly audit to ensure all admissions/readmissions with antipsychotic and PRN psychotropic medications are discontinued 14 days from admission/readmission, unless reassessed and reordered by provider/attending MD or psychiatry consult. Start 08/31/22-Ongoing "HN and SRN will submit audits on a monthly basis to the DON. Start 08/31/22-Ongoing "DON will be report to the QAPI Committee on a quarterly basis. Start 11/22/22□Ongoing Plan to be discussed	

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F 635	Continued From page 4	F 635	at next 08/16/22 meeting.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		9/4/22

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F 656	Continued From page 5 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop effective and individualized care plans (CP) for two of 19 residents sampled (Resident (R) 80 and R24). Interventions were not developed to address problems identified for R80. Non-pharmacological interventions to address behaviors related to the use of psychotropic medication was not developed for R24. As a result of this deficiency, all residents are at risk of potential negative quality of life outcomes and not reaching their highest practicable physical and psychosocial well-being. Findings include: 1) On 07/20/22 at 11:49 AM, a record review (RR) of R80's electronic health record (EHR) was done. R80 was a 77 year old resident admitted to the facility on 04/18/22 for advanced dementia (a condition with the impaired ability to remember, think, or make decisions that interferes with daily activities), and family were unable to care for R80 at home due to increased care needs. R80's CP was reviewed. Problem identified, "I refused care at times, yells or screams during care," initiated on 05/13/22, had no goal or interventions outlined for this behavior. Problems for having come from a home environment, admitted to the facility with dementia, and needing isolation for COVID-19 precautions were also not identified on R80's CP.	F 656	HEAD NURSE (HN), NURSING SUPERVISORS (SRN), DIRECTOR OF NURSING (DON), SOCIAL WORKER (SW), LICENSED NURSES (LN), AND MINIMUM DATA SET NURSE (MDS) WILL IMPLEMENT CORRECTIVE ACTIONS FOR RESIDENT #80 AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: "DON, SW, MDS reviewed Resident #80□s care plan where problem identified, I refused care at times, yells or screams during care was initiated on 05/03/2022 and incomplete. Goal and interventions were NOT documented in the care plan. In addition, we concur that problems were not identified such as resident with dementia, new/unfamiliar environment and needing isolation. IDT reviewed this incomplete care plan and citation, and concurred that care should have been completed to address resident□s problems/needs/behavior. UM3 reviewed 7/21, DON, SW, MDS coordinator/IDT reviewed on 08/10/22 HEAD NURSE (HN), NURSING SUPERVISORS (SRN), DIRECTOR OF NURSING (DON), SOCIAL WORKER (SW), LICENSED NURSES (LN), AND MINIMUM DATA SET NURSE (MDS)	

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F 656	Continued From page 6 On 07/21/22 at 2:45 PM, a concurrent interview and RR were done with Unit Manager (UM)3 in her office. UM3 confirmed that no goal and interventions were identified for the problem, "I refused care at times, yells or screams during care." UM3 identified that behavior interventions are present on the "MONITORS" flowsheet that only the registered nurses have access to, but no other disciplines have access to this and therefore would not know how to effectively and individually care for R80's behaviors. UM3 stated that R80's problem with coming from a home environment and transitioning into a facility with dementia and being isolated for COVID-19 precautions should have been identified on the care plan and interventions developed to provide the optimal care for R80. On 07/22/22 at 08:00 AM, the facility's "Comprehensive Care Plan Guideline" was reviewed. It stated under "Procedure:...2. This comprehensive care plan will address resident goals, actual and potential problems, needs, strengths and individual preferences of the resident." 2) R24 was admitted to the facility on 10/06/21 with diagnoses of inadequate sleep hygiene and unspecified dementia without behavior disturbance. Record review of a psychiatry consult dated 05/12/22 documents reason for visit, "behavioral problems", and vascular dementia with behavioral problems as the psychiatric diagnosis evaluated. The consult further documents R24's history "...nursing notes that patient [R24] has been reasonably calm although period where he will	F 656	WILL ASSESS OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: "Residents admitted/readmitted and currently placed in isolation have been identified. Completed 08/08/22 "MDS and IDT will review care plans to ensure it is complete with resident□s problems/needs, goals, and interventions. Start 08/15/22-Ongoing HEAD NURSE (HN), NURSING SUPERVISORS (SRN), DIRECTOR OF NURSING (DON), SOCIAL WORKER (SW), LICENSED NURSES (LN), AND MINIMUM DATA SET NURSE (MDS) WILL IMPLEMENT MEASURES TO ENSURE THAT THIS PRACTICE DOES NOT RECUR, INCLUDING: "MDS and IDT will create a Care plan for all New Admissions/Readmissions, where resident will be placed on quarantine or isolation. This care plan will address Potential for isolation / Psychosocial issues that include observations for feelings of isolation, sadness or feeling alone or lonely, difficulty of adjustment to new environment, lifestyle or homelike environment and to address any behaviors that are observed or the resident exhibits. This care plan will be separate from the covid-19 infection care plan. Started 08/11/22-Ongoing "Based on the CAAS that are triggered, MDS coordinator will ensure that an appropriate care plan will be in place for new admissions/readmissions and for all comprehensive assessments. Care plans	

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F 656	Continued From page 7 complain of pain or that he is not being changed but then denies problems when approached...some concerns about mood, repeating what staff has said. On interview patient is paranoid about nursing, believes they are intentionally trying to harm him. Reports main problem is problems with being cleaned after defecation - nursing reports that he complains of defecation but no stool." The consult recommended a trial with antipsychotic such as Risperdal 0.5 milligrams (mg) at bedtime (hs) to help with paranoia and agitation. On 07/21/22 at 09:48 AM, review of R24's record indicated the physician ordered Risperidone tablet 0.5 mg for paranoia and agitation on 05/13/22. Review of R24's care plan did not document non-pharmacological interventions for paranoia and agitation. On 07/21/22 at 01:50 PM concurrent record review and interview with UM2 was done. UM2 reported that R24 was prescribed Risperidone due to paranoia and agitation, R24 thinks someone is trying to harm him and yells, shouts and is combative when provided care. UM2 reported examples of non-pharmacological interventions provided are reorienting him with reality, praising R24, and divert his attention such as watching television. Inquired if non-pharmacological interventions were documented in R24's CP, UM2 stated "It is not care planned for agitation or paranoia." On 07/22/22 at 10:07 AM concurrent record review and interview with Director of Nursing (DON) was done. Inquired with DON if R24's care plan includes non-pharmacological interventions to target the behaviors listed for the use of	F 656	will be reviewed during quarterly IDT meetings to ensure that the Care plans are still appropriate. Start 08/15/22-Ongoing "The MDS will conduct monthly QA Audits on Care plans to ensure that all triggers that need to be addressed are Care Planned. Start 08/31/22-Ongoing "HN and LN will follow the care plan and document observations in the behavior monitoring log related to new admissions/readmissions feeling isolated, sad, lonely, and having difficulty in adjusting to the new environment/quarantine/isolation. Start 08/15/22-Ongoing HEAD NURSE (HN), NURSING SUPERVISORS (SRN), DIRECTOR OF NURSING (DON), SOCIAL WORKER (SW), LICENSED NURSES (LN), AND MINIMUM DATA SET NURSE (MDS) WILL MONITOR CORRECTIVE ACTIONS TO ENSURE THE EFFECTIVENESS OF THESE ACTIONS, INCLUDING: "MDS will perform a monthly Care plan audit that includes the Behavior care plan / Isolation Care Plan / psychosocial care Plan. In addition, for Comprehensive Assessments, care plans triggered by CAAS will also be reviewed to ensure their appropriate goals and interventions are in place. Start 08/31/22-Ongoing "Findings of this audit will be reviewed with HNs/SRNs/DON at the monthly Nurse Manager□s Meeting. Start 09/02/22-Ongoing "MDS will submit audit reports to the	

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F 656	Continued From page 8 Risperidone, DON confirmed non-pharmacological interventions were not documented in the care plan and further explained "...it should be included in the care plan..." along with the psychotropic medication targeting specific behaviors. Review of the facility's policy and procedure on psychotropic drug use, policy number "ORNUR0009", with an effective date of 09/01/18 documents: "E. Interdisciplinary Care Plans... 1. The care plan must have specific problems stated what symptoms or behaviors are being addressed. 2. The care plan must be specific, individualized and have measurable goals with a time frame for evaluation. 3. Specific interventions include. a. Behavior modifications and management techniques to be used for situations (non-pharmacological interventions). b. Monitoring of behavior and side effects on BIMFR [Behavior/Intervention Monthly Flow Record] c. Which staff is to care out the intervention(s) 4. Care plans will be individualized to reflect resident preference and family input as appropriate and feasible. "	F 656	DON to report at the quarterly QAPI meeting. Start 11/22/22 Ongoing. (Audit plan will be discussed at the next QAPI meeting on Start 08/16/22-Ongoing HEAD NURSE (HN), NURSING SUPERVISORS (SRN), DIRECTOR OF NURSING (DON), SOCIAL WORKER (SW), LICENSED NURSES (LN), AND MINIMUM DATA SET NURSE (MDS) WILL IMPLEMENT CORRECTIVE ACTIONS FOR RESIDENT #24 AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: "Resident #24 care plan for paranoia and agitation was reviewed and updated to include non-pharmacologic interventions on 08/11/22. Completed 08/11/22 "Resident has sig change mood and behavior on Psychotropic meds, with Stage 4 pressure sore on Right heel. IDT met, reviewed and updated care plan on 08/11/22. Completed 08/11/22 "IDT conference call with family and resident via Zoom was held on 08/11/22. Completed 08/11/22 HEAD NURSE (HN), NURSING SUPERVISORS (SRN), DIRECTOR OF NURSING (DON), SOCIAL WORKER (SW), LICENSED NURSES (LN), AND MINIMUM DATA SET NURSE (MDS) WILL ASSESS OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: "HN, SRN, DON, and SW will identify all residents with any psychotropic	

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F 656	Continued From page 9	F 656	medications. Start 08/15/22□Completed 09/04/22 "HN and SW will review care plan for residents identified receiving any psychotropic medications to ensure person-centered, non-pharmacological interventions are in place. Start 08/15/22□Completed 09/04/22 HEAD NURSE (HN), NURSING SUPERVISORS (SRN), DIRECTOR OF NURSING (DON), SOCIAL WORKER (SW), LICENSED NURSES (LN), AND MINIMUM DATA SET NURSE (MDS) WILL IMPLEMENT MEASURES TO ENSURE THAT THIS PRACTICE DOES NOT RECUR, INCLUDING: "HN, ED will educate LN during shift reports to update care plans for residents with new orders for psychotropic medications, including orders obtained from Geri-psych consult recommendations. Care plans need to include non-pharmacologic interventions. Start 08/16/22□Completed 09/04/22 "HN will consult with SW on residents with psychotropic medications and their behaviors. SW will refer back to the social history and speak with family or responsible party to gather information specific to resident□s behaviors along with appropriate and effective non-pharmacological interventions and strategies used in the past. Start 08/15/22-Ongoing "HN and SW will develop/update behavior care plan incorporating family□s suggestions and resident□s current state and will include person-centered	

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F 656	Continued From page 10	F 656	non-pharmacologic interventions. Start 08/15/22-Ongoing "LN, HN, SRN will input non-pharmacological interventions in PointClickCare (PCC) behavior monitoring and document behaviors in PCC monitor log every shift. Start 08/15/22-Ongoing "HN will ensure that MDS coordinator/IDT will review and update care plans during quarterly IDT Conference meetings, to ensure that Care plans address individual, person-centered non-pharmacologic interventions and determine whether the care plan is still appropriate. Start 08/15/22-Ongoing HEAD NURSE (HN), NURSING SUPERVISORS (SRN), DIRECTOR OF NURSING (DON), SOCIAL WORKER (SW), AND QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) WILL MONITOR CORRECTIVE ACTIONS TO ENSURE THE EFFECTIVENESS OF THESE ACTIONS, INCLUDING: "HN, SRN and SW will perform monthly review of care plans for residents receiving psychotropic medications that person-centered non-pharmacologic interventions are in place. Start 08/31/22-Ongoing "HN/SRN will submit findings to DON to report to quarterly QAPI Committee. Start 08/31/22	
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		9/4/22

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F 689	Continued From page 11 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to secure a storage room located on the 2 Makai nursing unit. As a result of this failure, the facility put the residents at risk for accident hazards. Findings include: During an observation on 07/19/22 at 10:30 AM, the storage room located on 2 Makai nursing unit was not locked/secured and there was no staff in the immediate vicinity to prevent unauthorized entry to the room. The storage door had a keypad lock installed but the door latch was taped open to prevent the door from being locked. Observer was able to enter the room by just pushing the door open. A review of hazardous contents of the storage room were the following: Hydrogen Peroxide Solution, 3% USP 10 Volume, (4) 16 fluid ounce bottles, Aloe Vesta Daily Moisturizer containing Dimethicone 3% active ingredient, and inactive ingredients water, petrolatum, glycerin, steareth-2, cetyl alcohol, benzyl alcohol, laureth-23, magnesium, aluminum silicate, carbomer, potassium sorbate, sodium hydroxide, Aloe barbadensis leaf powder, Fresh Moment Mouthwash labeled; in case of accidental ingestion, seek professional assistance or contact a Poison Control Center immediately, (5) 4 fluid ounce bottles.	F 689	HEAD NURSE (HN), NURSING SUPERVISOR (SRN), TEMPORARY ASSIGNED NURSE (TA), LICENSED NURSE (LN) WILL IMPLEMENT CORRECTIVE ACTIONS FOR 2MAKAI STORAGE ROOM AFFECTED BY THIS PRACTICE, INCLUDING: "Storage door lock fixed. Completed 07/19/22 "Head nurse placed signage on the door to keep door closed/locked at all times. Completed 07/19/22 "HN reminded staff during shift reports that storage room need to be locked to prevent unauthorized individuals, including residents, from entering and having access to hazardous contents. Completed 07/19/22-7/22/22 HEAD NURSE (HN), LICENSED NURSES, NURSING SUPERVISOR (SRN), TEMPORARY ASSIGNED NURSE (TA) AND OPERATIONS & MAINTENANCE (O&M) WILL ASSESS OTHER STORAGE AREAS HAVING THE POTENTIAL TO BE AFFECTED BY THIS PRACTICE, INCLUDING: "Storage doors on the two other resident units were checked. Both had functional locks and doors were locked. Completed	

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F 689	Continued From page 12 During observations on 07/19/22 at 10:40 AM, two residents were noted be self-propelling their wheelchair pass the storage room, alone with no staff in the immediate vicinity to prevent them from entering the storage room and having access to the hazardous contents as previously mentioned. On 07/19/22 at 10:50 AM, Unit Manager (UM) 2, acknowledged that the storage room should have been locked/secured and stated that they would immediately get it fixed.	F 689	07/19/22 "Facility-wide doors and locks were checked by O&M to ensure doors are locked/secured and door latches were not taped or stuffed with material to prevent locking. Completed 07/19/22 "SRN/TA, HN, and LN will do random rounds to check storage door on shift assignment. Start 07/19/22-Ongoing HEAD NURSE (HN), LICENSED NURSES (LN), NURSING SUPERVISOR (SRN), OPERATIONS & MAINTENANCE (O & M) WILL IMPLEMENT MEASURES TO ENSURE THAT THIS PRACTICE DOES NOT RECUR, INCLUDING: "HNs and SRN/TA will remind staff regarding the importance of keeping storage doors closed/locked for residents safety, during shift reports. Start 07/19/22 Completed 07/22/22 "All staff/employees to follow storage door protocol. Start 07/19/22-Ongoing "HN, SRN/TA, LN, and O & M will conduct audits to ensure that storage doors will be kept closed/locked at all times by checking storage rooms are locked, doors are properly functioning and fixed as appropriate, and door latch is not stuffed or taped. Start 08/01/22-Ongoing HEAD NURSE (HN), NURSING SUPERVISOR (SRN), DIRECTOR OF NURSING (DON) WILL MONITOR CORRECTIVE ACTIONS TO ENSURE THE EFFECTIVENESS OF THESE ACTIONS, INCLUDING: "HNs and SRN will monitor staff compliance and submit audit findings to	

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F 689	Continued From page 13	F 689	DON. Start 08/31/22-Ongoing "O&M will submit audit findings to Administration. 08/01/22-Ongoing "Audit findings will be reported at the QAPI Committee. Start 11/22/22□Ongoing. (Audit plan will be discussed at the next QAPI meeting on Completed 08/16/22)	
F 693 SS=E	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide the appropriate treatment and services to prevent	F 693	HEAD NURSE (HN), LICENSED NURSE (LN), AND EDUCATION NURSE WILL IMPLEMENT CORRECTIVE ACTIONS	9/4/22

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F 693	Continued From page 14 potential complications of enteral tube-feeding (TF) for six residents (Residents 33, 35, 63, 34, 12, and 62) in the sample. The TF tubing was not labeled which would indicate that the tubing is changed every day. As a result of this deficient practice, the facility placed all residents who are on enteral nutrition at risk for avoidable infections and complications. Findings include: 1) On 07/19/22 at 09:02 AM, an observation and concurrent interview were done with Registered Nurse (RN)4 at the bedside of Resident (R)33. Observed that R33's tube-feeding (TF) formula and TF administration set (tubing) were not labeled with the date and time they were hung. RN4 stated that she had started R33's TF at 08:00 AM and had just turned it off and disconnected it (at 09:00 AM). When asked about who was responsible to change the TF tubing out, RN4 reported that "night shift" should change out and date the TF formula and tubing daily. RN4 confirmed that the TF formula and tubing should have been dated, and that she should have checked for that prior to starting the TF at 08:00 AM. RN4 stated that TF tubing should be changed out once a day "due to infection control and clogging" concerns. On 07/21/22 at 11:34 AM, a review of the facility Policy & Procedure Enteral Tube Feedings, dated 07/18/18, noted the following: "G.2. Prepare feeding set. Label bag with resident's name, room number and date, start time and rate. Label tubing with start date and time."	F 693	FOR RESIDENT #33 AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: "Resident # 33 Tubing and tube feeding bottle administered on July 19, 2022 were labeled with licensed staff initial, date and time. Completed 07/19/22 HEAD NURSE (HN), LICENSED NURSE (LN), SUPERVISOR NURSE (SRN), DIRECTOR OF NURSING (DON) WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: "Fourteen Residents receiving tube feeding were identified and the following was done: 1.Tube feeding Formula bottle was labeled with date, time, and initial, and with correct special instructions, if indicated. Completed 07/22/22 2 Tubing was labeled with date and time; and Tube feeding bottle date of expiration was checked. Completed 07/22/22 "HNs checked their respective unit□s tube feeding formula storage to remove outdated formulas. Completed 07/22/22 "Residents with low flow rate were identified to use the 1000ml bottle that will be consumed in a 24-hour period. Completed 07/22/22 DIRECTOR OF NURSING (DON), NURSING SUPERVISOR (SRN), EDUCATION NURSE (ED NURSE), HEAD NURSE (HN), LICENSED NURSE, AND PURCHASING/CSR STAFF WILL	

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F 693	Continued From page 15 On 07/22/22 at 07:55 AM, an observation and concurrent interview were done with the Unit Manager (UM)3 at the bedside of R33. Observed that R33's TF formula and TF tubing were labeled 07/21/22 07:15 AM, and that they were connected and infusing at a rate of 250 ml [milliliters] per hour via a TF pump. Confirmed with UM3 that R33 was due for a TF at 08:00 AM, and that the licensed staff was allowed to start it up to one hour early. UM3 validated that if the licensed staff started the TF any time after 07:15 AM, she should have changed out the TF first because the tubing is only good for twenty-four (24) hours. On 07/22/22 at 08:10 AM, an interview was done with RN5 in the hallway of the third floor. RN5 stated she started R33's TF at 07:45 AM. When asked about the date on the TF tubing, RN5 stated she was aware that TF tubing is only good for 24 hours and acknowledged that she should have changed the TF formula and tubing out before starting it. 2) On 07/19/22 at 09:14 AM, an observation was done at the bedside of R35. Observed that R35's TF formula was labeled "7/18 0720," indicating that it was hung on 07/18/22 at 07:20 AM. When interviewing RN4 in the hallway outside the room at 09:15 AM, RN4 stated that she had turned R35's TF off at 08:00 AM. When asked if she knew when the TF had been hung, RN4 stated that she should have checked when she started the TF around 07:00 AM but did not. On 07/19/22 at 11:45 AM, an observation was done of R35's TF, connected and infusing at a rate of 185 ml [milliliters] per hour via a TF pump. The TF formula was still labeled "07/18 0720" despite the conversation with RN4 about it earlier.	F 693	IMPLEMENT MEASURES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, INCLUDING: "When placing new tube feeding bottle and tubing, LN will check formula expiration date before administering, Complete formula label by writing start date, time, initials, and any special instructions, and Label tubing with start date, time and initials. Start 08/16/22-Ongoing "LN will check tube feeding formula/tubing each time before starting infusion, to ensure tube feeding formula and tubing are properly labeled and not expired. Start 08/16/22-Ongoing "Place order in eTAR to remind LN to check tube feeding formula/tubing expiration every shift. Start 08/10/22 - Ongoing " Enteral Feeding P&P and Skills Checklist was reviewed by DON, HNs, SRNs, and ED Nurse. Revisions were made to emphasize labeling of formula and tubing, checking expiration date of formula, and removing expired formula or tubing. Completed 08/12/22 " ED Nurse will review with the LNs steps in ensuring the above are done. Start 08/16/22 □ Completed 09/04/22 " Purchasing will order tube feeding formula in 1000ml and 1500ml bottles. Start 07/22/22 - Ongoing " Purchasing/CSR staff will check formula expiration date weekly for formula stored in Nursing□s formula storage cabinet. Start 08/11/22-Ongoing DIRECTOR OF NURSING (DON),	

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F 693	Continued From page 16 On 07/20/22 at 12:21 PM, an observation was made of a sealed TF administration set used in the facility. Noted to be a Coviden Epump ENPlus Spike Set with clear printed manufacturer instructions, "Do not use for greater than 24 hours". 3) On 07/19/22 at 09:37 AM, an observation and concurrent interview were done with RN4 at the bedside of R63. Observed that R63's TF formula was labeled "7/17 2100," indicating that it was hung on 07/17/22 at 09:00 PM. RN4 confirmed that she had turned the TF pump off and disconnected it at 08:00 AM. When asked about the date on the TF label, RN4 confirmed that the TF tubing was only good for 24 hours, so it was expired and should have been changed on 07/18/22. On 07/21/22 at 11:00 AM, an interview was done with UM3 in her office. UM3 confirmed that the licensed staff should be checking both the TF formula and the TF tubing before beginning any TF. UM3 also stated that the TF tubing is good for 24 hours, so licensed staff should be changing out the tubing and formula daily and labeling both when it is hung. 4) On 07/19/22 at 10:10 AM, an observation was done at the bedside of R34. R34's TF formula was labeled with instructions that read " ... off at 0700 on at 1100." The TF pump was off and disconnected at the time. At 11:09 AM, observation at the bedside noted the TF pump was still off and disconnected. From 12:29 PM to 02:15 PM, observed R34 in a private family room on the first floor, visiting with his mother. The TF and pump set-up remained on the third floor in	F 693	NURSING SUPERVISOR (SRN), SRN TEMPORARY ASSIGNED (TA), EDUCATION NURSE (ED NURSE), HEAD NURSE (HN), LICENSED NURSE, AND PURCHASING/CSR STAFF WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR. "Audit tool created for HNs, SRN/TAs, ED Nurse, and DON to monitor and provide feedback to staff to correct deficient practices. Completed 08/15/22 "Audit tool created for purchasing to monitor formula on nursing units. Completed 08/11/22 "Purchasing/CSR will audit that formula on the nursing units are not expired. Start 08/11/22-Ongoing "Findings will be submitted to the quarterly QAPI Committee meeting. Start 11/22/22□Ongoing (Audit plan will be discussed at the next QAPI meeting on Completed 08/16/22) HEAD NURSE (HN), LICENSED NURSE (LN), AND EDUCATION NURSE WILL IMPLEMENT CORRECTIVE ACTIONS FOR RESIDENT #35 AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: "Resident #35 Tubing and tube feeding bottle administered on July 19, 2022 at 0745 and 1145 with expired tubing were removed and replaced with new tube feeding bottle and tubing, properly labelled with staff initial, date and time. Completed 07/19/22	

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F 693	Continued From page 17 R34's room. On 07/20/22 at 01:00 PM, during an interview with RN4 in the third-floor hallway, RN4 stated that R34's TF order had changed in April of 2022 to be off from 10:00 AM - 02:00 PM due to daily visits from his mother. On 07/20/22 at 01:22 PM, during an interview with the Unit Manager (UM)3 in her office, UM3 stated that the Unit Clerk created and printed the TF labels for all the residents on the floor. During an interview with the Unit Clerk (UC)3 at the third-floor Nurses' Station at 01:25 PM, UC3 confirmed that she pre-printed pages of TF labels for every resident in the unit and left the labels in a binder above the TF cabinet behind the Nurses' Station. During a concurrent review of the labels in the binder with UC3, it was noted that for R34, there were pages of labels with the old orders on them placed in a clear sheet protector. There was a bright yellow post-it prominently placed in the middle of the sheet protector that read: "HOLD TUBE FEEDING 1000 [sic] AM [right arrow symbol indicating 'to'] 1400 [02:00 PM]." UC3 stated that the post-it was placed there to alert the licensed staff that the order had been changed, and that they needed to manually correct the label prior to hanging the TF. On 07/21/22 at 11:00 AM, an interview was done with UM3 in her office. UM3 confirmed that the licensed staff should be looking at the label and matching it to the order before hanging the TF. If it is different, it is the responsibility of the licensed staff to then change the label prior to hanging the TF. 5) Review of the facility's policy and procedure on	F 693	HEAD NURSE (HN), LICENSED NURSE (LN), SUPERVISOR NURSE (SRN), DIRECTOR OF NURSING (DON) WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: "Fourteen Residents receiving tube feeding were identified and the following was done: 1.Tube feeding Formula bottle was labeled with date, time, and initial, and with correct special instructions, if indicated. Completed 07/22/22 2.Tubing was labeled with date and time; and Tube feeding bottle date of expiration was checked. Completed 07/22/22 "HNs checked their respective unit□s tube feeding formula storage to remove and outdated formulas. Completed 07/22/22 "Residents with low flow rate were identified to use the 1000ml bottle that will be consumed in a 24-hour period. Completed 07/22/22 DIRECTOR OF NURSING (DON), NURSING SUPERVISOR (SRN), EDUCATION NURSE (ED NURSE), HEAD NURSE (HN), LICENSED NURSE, AND PURCHASING/CSR STAFF WILL IMPLEMENT MEASURES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, INCLUDING: "When placing new tube feeding bottle and tubing, LN will check formula expiration date before administering, Complete formula label by writing start	

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F 693	Continued From page 18 enteral tube feedings, policy number "MNUR0007" with an effective date of 07/18/18 documents for open tube feeding delivery systems and closed tube feeding systems, "Check expiration date on formula and integrity of the..." set or formula bottle. On 07/19/22 at 09:57 AM a concurrent observation of R12 at bedside and interview with Registered Nurse (RN) 15 was done. Observed R12's TF formula with a used-by-date of 07/01/22 and labeled indicating it was hung on 07/19/22 at 08:00 AM. RN15 stated R12 had finished a whole bottle of TF formula and at 08:00 AM they put in a new bottle to complete the physician's order administration amount because the previous bottle was not enough. RN15 confirmed the formula administered was past the used-by-date of 07/01/22. 6) On 07/19/22 at 09:59 AM a concurrent observation of R62 at bedside and interview with Registered Nurse (RN) 15 was done. Observed R12's TF formula with a used-by-date of 07/01/22 and labeled indicating it was hung on 07/19/22. RN15 stated the formula was administered at 08:00 AM and confirmed the formula administered was past the used-by-date of 07/01/22. On 07/22/22 at 10:05 AM interview with Director of Nursing (DON) was done. Inquired with DON who is responsible for ensuring the residents are not administered expired or past the used-by-date TF formula, DON explained although staff members in the storeroom check inventory and should check the used-by-date before bringing it to nursing staff, the nurses are responsible for checking the expiration date or used-by-date	F 693	date, time, initials, and any special instructions, and Label tubing with start date, time and initials. Start 08/16/22-Ongoing "LN will check tube feeding formula/tubing each time before starting infusion, to ensure tube feeding formula and tubing are properly labeled and not expired. Start 08/16/22-Ongoing "Place order in eTAR to remind LN to check tube feeding formula/tubing expiration every shift. Start 08/10/22-Ongoing "Enteral Feeding P&P and Skills Checklist was reviewed by DON, HNs, SRNs, and ED Nurse. Revisions were made to emphasize labeling of formula and tubing, checking expiration date of formula, and removing expired formula or tubing. Completed 08/12/22 "ED Nurse will review with the LNs steps in ensuring the above are done. Start 08/16/22□Completed 09/04/22 "Purchasing will order tube feeding formula in 1000ml and 1500ml bottles. Start 07/22/22 Ongoing "Purchasing/CSR staff will check formula expiration date weekly for formula stored in Nursing□s formula storage cabinet. Start 08/11/22-Ongoing DIRECTOR OF NURSING (DON), NURSING SUPERVISOR (SRN), SRN TEMPORARY ASSIGNED (TA), EDUCATION NURSE (ED NURSE), HEAD NURSE (HN), LICENSED NURSE, AND PURCHASING/CSR STAFF WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT	

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F 693	Continued From page 19 before administration. DON stated, "we do not want to cause complication or reactions to an expired product such as GI [gastrointestinal] symptoms."	F 693	PRACTICE IS BEING CORRECTED AND WILL NOT RECUR. "Audit tool created for HNs, SRN/TAs, ED Nurse, and DON to monitor and provide feedback to staff to correct deficient practices. Completed 08/15/22 "Audit tool created for purchasing to monitor formula on nursing units. Completed 08/11/22 "Purchasing/CSR will audit that formula on the nursing units are not expired. Start 08/11/22-Ongoing "Findings will be submitted to the quarterly QAPI Committee meeting. Start 11/22/22 □ Ongoing (Audit plan will be discussed at the next QAPI meeting on Completed 08/16/22) HEAD NURSE (HN), LICENSED NURSE (LN), AND EDUCATION NURSE WILL IMPLEMENT CORRECTIVE ACTIONS FOR RESIDENTS #63 AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: "Resident #63 Tubing and tube feeding bottle administered on July 19, 2022 which RN4 confirmed the pump was stopped and disconnected at 0800. Expired tubing was removed and replaced with new tube feeding bottle and tubing, and properly labelled with staff initial, date and time. Completed 07/19/22 HEAD NURSE (HN), LICENSED NURSE (LN), SUPERVISOR NURSE (SRN), DIRECTOR OF NURSING (DON) WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY	

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MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 693	Continued From page 20	F 693	THIS DEFICIENT PRACTICE, INCLUDING: "Fourteen Residents receiving tube feeding were identified and the following was done: 1.Tube feeding Formula bottle was labeled with date, time, and initial, and with correct special instructions, if indicated. Completed 07/22/22 2.Tubing was labeled with date and time; and Tube feeding bottle date of expiration was checked. Completed 07/22/22 "HNs checked their respective unit□s tube feeding formula storage to remove and outdated formulas. Completed 07/22/22 "Residents with low flow rate were identified to use the 1000ml bottle that will be consumed in a 24-hour period. Completed 07/22/22 DIRECTOR OF NURSING (DON), NURSING SUPERVISOR (SRN), EDUCATION NURSE (ED NURSE), HEAD NURSE (HN), LICENSED NURSE, AND PURCHASING/CSR STAFF WILL IMPLEMENT MEASURES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, INCLUDING: "When placing new tube feeding bottle and tubing, LN will check formula expiration date before administering, Complete formula label by writing start date, time, initials, and any special instructions, and Label tubing with start date, time and initials. Start 08/16/22-Ongoing "LN will check tube feeding	

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F 693	Continued From page 21	F 693		

formula/tubing each time before starting infusion, to ensure tube feeding formula and tubing are properly labeled and not expired. Start 08/16/22-Ongoing
"Place order in eTAR to remind LN to check tube feeding formula/tubing expiration every shift. Start 08/10/22 - Ongoing
"Enteral Feeding P&P and Skills Checklist was reviewed by DON, HNs, SRNs, and ED Nurse. Revisions were made to emphasize labeling of formula and tubing, checking expiration date of formula, and removing expired formula or tubing. Completed 08/12/22
"ED Nurse will review with the LNs steps in ensuring the above are done. Start 08/16/22□Completed 09/04/22
"Purchasing will order tube feeding formula in 1000ml and 1500ml bottles. Start 07/22/22-Ongoing
"Purchasing/CSR staff will check formula expiration date weekly for formula stored in Nursing□s formula storage cabinet. Start 08/11/22-Ongoing

DIRECTOR OF NURSING (DON), NURSING SUPERVISOR (SRN), SRN TEMPORARY ASSIGNED (TA), EDUCATION NURSE (ED NURSE), HEAD NURSE (HN), LICENSED NURSE, AND PURCHASING/CSR STAFF WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR.
"Audit tool created for HNs, SRN/TAs, ED Nurse, and DON to monitor and provide feedback to staff to correct

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deficient practices. Completed 08/15/22
"Audit tool created for purchasing to monitor formula on nursing units. Completed 08/11/22
"Purchasing/CSR will audit that formula on the nursing units are not expired. Start 08/11/22-Ongoing
"Findings will be submitted to the quarterly QAPI Committee meeting. Start 11/22/22 □ Ongoing (Audit plan will be discussed at the next QAPI meeting on Completed 08/16/22)

HEAD NURSE (HN), LICENSED NURSE (LN), AND EDUCATION NURSE WILL IMPLEMENT CORRECTIVE ACTIONS FOR RESIDENTS #34 AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING:
"Resident #34 with tube feeding label instruction off at 0700 on at 1100 was corrected with the updated order to be off from 1000-0200 pm. Completed 07/19/22

HEAD NURSE (HN), LICENSED NURSE (LN), SUPERVISOR NURSE (SRN), DIRECTOR OF NURSING (DON) WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING:
"Fourteen Residents receiving tube feeding were identified and the following was done:
1.Tube feeding Formula bottle was labeled with date, time, and initial, and with correct special instructions, if indicated. Completed 07/22/22

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F 693	Continued From page 23	F 693	2.Tubing was labeled with date and time; and Tube feeding bottle date of expiration was checked. Completed 07/22/22 "HNs checked their respective unit□s tube feeding formula storage to remove and outdated formulas. Completed 07/22/22 "Residents with low flow rate were identified to use the 1000ml bottle that will be consumed in a 24-hour period. Completed 07/22/22 DIRECTOR OF NURSING (DON), NURSING SUPERVISOR (SRN), EDUCATION NURSE (ED NURSE), HEAD NURSE (HN), LICENSED NURSE, AND PURCHASING/CSR STAFF WILL IMPLEMENT MEASURES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, INCLUDING: "When placing new tube feeding bottle and tubing, LN will check formula expiration date before administering, Complete formula label by writing start date, time, initials, and any special instructions, and Label tubing with start date, time and initials. Start 08/16/22 - Ongoing "LN will check tube feeding formula/tubing each time before starting infusion, to ensure tube feeding formula and tubing are properly labeled and not expired. Start 08/16/22-Ongoing "Place order in eTAR to remind LN to check tube feeding formula/tubing expiration every shift. Start 08/10/22-Ongoing "Enteral Feeding P&P and Skills	

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Checklist was reviewed by DON, HNs, SRNs, and ED Nurse. Revisions were made to emphasize labeling of formula and tubing, checking expiration date of formula, and removing expired formula or tubing. Completed 08/12/22

"ED Nurse will review with the LNs steps in ensuring the above are done. Start 08/16/22□Completed 09/04/22

"Purchasing will order tube feeding formula in 1000ml and 1500ml bottles. Start 07/22/22 - Ongoing

"Purchasing/CSR staff will check formula expiration date weekly for formula stored in Nursing□s formula storage cabinet. Start 08/11/22-Ongoing

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"Audit tool created for HNs, SRN/TAs, ED Nurse, and DON to monitor and provide feedback to staff to correct deficient practices. Completed 08/15/22

"Audit tool created for purchasing to monitor formula on nursing units. Completed 08/11/22

"Purchasing/CSR will audit that formula on the nursing units are not expired. Start 08/11/22-Ongoing

"Findings will be submitted to the quarterly QAPI Committee meeting. Start

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F 693	Continued From page 25	F 693	11/22/22 □ Ongoing (Audit plan will be discussed at the next QAPI meeting on Completed 08/16/22) HEAD NURSE (HN), LICENSED NURSE (LN), AND EDUCATION NURSE WILL IMPLEMENT CORRECTIVE ACTIONS FOR RESIDENTS #12 and #62 AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: "Resident #12 and Resident #62 Expired formula was removed from resident□s bedside. Completed 07/19/22 HN counseled RN15, reviewed the protocol/guidelines when a new bottle of formula is administered to residents, which state, to check for expiration dates, discard opened formula bottles after 24 hours and initial and date formula. Completed 07/19/2022 HN and ED nurse conducted huddles and in-serviced licensed staff, including RN5 to: 1.Follow policy on enteral feeding Start 07/20/22 □ Completed 07/22/22 2.Initial, date and time tube feeding formula and tube feeding tubing when starting a new bottle of formula and tubing. Start 07/20/22□Completed 07/22/22 HEAD NURSE (HN), LICENSED NURSE (LN), SUPERVISOR NURSE (SRN), DIRECTOR OF NURSING (DON) WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING:	

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F 693	Continued From page 26	F 693	"Fourteen Residents receiving tube feeding were identified and the following was done: 1.Tube feeding Formula bottle was labeled with date, time, and initial, and with correct special instructions, if indicated. Completed 07/22/22 2.Tubing was labeled with date and time; and Tube feeding bottle date of expiration was checked. Completed 07/22/22 "HNs checked their respective unit□s tube feeding formula storage to remove and outdated formulas. Completed 07/22/22 "Residents with low flow rate were identified to use the 1000ml bottle that will be consumed in a 24-hour period. Completed 07/22/22 DIRECTOR OF NURSING (DON), NURSING SUPERVISOR (SRN), EDUCATION NURSE (ED NURSE), HEAD NURSE (HN), LICENSED NURSE, AND PURCHASING/CSR STAFF WILL IMPLEMENT MEASURES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, INCLUDING: "When placing new tube feeding bottle and tubing, LN will check formula expiration date before administering, Complete formula label by writing start date, time, initials, and any special instructions, and Label tubing with start date, time and initials. Start 08/16/22-Ongoing "LN will check tube feeding formula/tubing each time before starting infusion, to ensure tube feeding formula	

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and tubing are properly labeled and not expired. Start 08/16/22-Ongoing
"Place order in eTAR to remind LN to check tube feeding formula/tubing expiration every shift. Start 08/10/22-Ongoing
"Enteral Feeding P&P and Skills Checklist was reviewed by DON, HNs, SRNs, and ED Nurse. Revisions were made to emphasize labeling of formula and tubing, checking expiration date of formula, and removing expired formula or tubing. Completed 08/12/22
"ED Nurse will review with the LNs steps in ensuring the above are done. Start 08/16/22□Completed 09/04/22
"Purchasing will order tube feeding formula in 1000ml and 1500ml bottles. Start 07/22/22-Ongoing
"Purchasing/CSR staff will check formula expiration date weekly for formula stored in Nursing□s formula storage cabinet. Start 08/11/22-Ongoing

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"Audit tool created for HNs, SRN/TAs, ED Nurse, and DON to monitor and provide feedback to staff to correct deficient practices. Completed 08/15/22
"Audit tool created for purchasing to

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F 693	Continued From page 28	F 693	monitor formula on nursing units. Completed 08/11/22 "Purchasing/CSR will audit that formula on the nursing units are not expired. Start 08/11/22-Ongoing "Findings will be submitted to the quarterly QAPI Committee meeting. Start 11/22/22 Ongoing (Audit plan will be discussed at the next QAPI meeting on Completed 08/16/22)	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761		9/4/22

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F 761	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that the Pneumococcal vaccines (medication given to protect an individual from pneumonia, a lung infection) was properly stored in the nursing unit's refrigerator. This deficient practice could potentially render the Pneumococcal vaccines inactive and affect residentswho receive the pneumococcal vaccine. Findings include: On 07/21/22 at 09:53 AM, an observation of a nursing unit's medication refrigerator was made. The "DAILY TEMPERATURE RECORD MEDICATION REFRIGERATOR" log was checked and the temperature documented for the day shift was 40 degrees Fahrenheit. The proper range identified on the log was documented as "36-40 DEGREES." The Pneumococcal vaccines were kept in a compartment on the refrigerator door that the State Agency (SA) took a few minutes to access because of the difficulty to take them out of the enclosed section. On 07/22/22 at 07:56 AM, a review of the Centers for Disease Control and Prevention's (CDC) website, "Vaccine Storage and Handling Resources" at https://www.cdc.gov/vaccines/hcp/admin/storage/index.html, that produced a storage and handling fact sheet for vaccines, "Storage Best Practices for Refrigerated Vaccines-Fahrenheit (F)" stated, "Don't put vaccines on door shelves or on floor of refrigerator." On 07/22/22 at 08:49 AM, a concurrent	F 761	HEAD NURSE (HN), NURSING SUPERVISOR (SRN), DIRECTOR OF NURSING (DON), WILL IMPLEMENT CORRECTIVE ACTIONS (FOR 2MAKAI) AFFECTED BY THIS PRACTICE, INCLUDING: "2 Makai HN immediately relocated vaccines (Pneumococcal) found stored on refrigerator door to the middle shelf of the refrigerator. Completed 07/22/22 "HN placed signage on top of the refrigerator to remind all license nurses to Store all vaccines on the middle shelf at all times Completed 07/22/22 HEAD NURSE (HN), LICENSED NURSES (LN), NURSING SUEPRVISOR (SRN), TEMPORARY ASSIGNED (TA), EDUCATION NURSE (ED), DIRECTOR OF NURSING (DON) WILL ASSESS OTHER RESIDENTS HAVING HE POTENTIAL TO BE AFFECTED BY THIS PRACTICE, INCLUDING: "HNs of the other two units (2Mauka and 3 Makai) checked their medication refrigerator for vaccines to ensure proper storage on middle shelf. No vaccines found stored on door. Completed 07/22/22 "DON shared at Oahu Region Pharmaceutical & Therapeutics Committee regarding proper storage of vaccines. Medical Director recommended no medications and vaccines to be stored on the refrigerator doors. Completed 08/02/22 "HNs placed signs on medication	

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F 761	Continued From page 30 observation and interview were made with Unit Manger (UM)2 at the nursing station. The refrigerator temperature logged for the day shift was 40 degrees Fahrenheit and was verified by UM2. SA showed UM2 the location of the Pneumococcal vaccines on the refrigerator door and she agreed that the temperature would not be consistently held if the vaccines are stored on the shelf of the refrigerator door. UM2 moved the location of the Pneumococcal vaccines to the middle shelf inside of the refrigerator.	F 761	refrigerator to remind LN. Completed 08/02/22 HEAD NURSE (HN), LICENSED NURSES (LN), SUPERVISOR NURSE (SRN), TEMPORARY ASSIGNED (TA), EDUCATION NURSE (ED), DIRECTOR OF NURSING (DON) WILL IMPLEMENT MEASURES TO ENSURE THAT THIS PRACTICE DOES NOT RECUR, INCLUDING: "ED, HN, SRNs, and DON revised Medication Storage policy and protocol (P&P) to include storage of vaccines in the middle shelf. Completed 08/12/22 "ED, HN, SRNs will educate LN during shift reports regarding revised Medication Storage P&P to properly store vaccines on middle shelf and continue checking/documenting refrigerator temperatures every shift. Start 08/16/22□Completed 09/04/22 "LN to store vaccines on middle shelf of medication refrigerator. Start 07/23/22-Ongoing "HN, ED and SRN/TAs will perform audits of all unit refrigerators to ensure that all medications/vaccines are properly stored and appropriate temperatures are maintained. Start 08/06/22□Ongoing HEAD NURSE (HN), SUPERVISOR NURSE (SRN), EDUCATION NURSE (ED), DIRECTOR OF NURSING (DON), AND QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) WILL MONITOR CORRECTIVE ACTIONS TO ENSURETHE EFFECTIVENESS OF THESE ACTIONS,	

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F 761	Continued From page 31	F 761	INCLUDING: "HNs, SRN, ED will perform audits to check that vaccines are stored in the middle shelf of the medication refrigerators and that appropriate temperatures are maintained. Audits will be submitted to DON. Start 08/31/22 -Ongoing "Audit Plan to be shared at the next QAPI meeting. Completed 08/16/22 "Findings of audits will be submitted to the quarterly QAPI Committee meeting. Start 11/22/22-Ongoing	