	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		125009	B. WING		07/22/2022	
NAME OF PR	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
MALUHIA				1027 HALA DRIVE		
				HONOLULU, HI 96817		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	. ,	
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			-			
F 000	INITIAL COMMENT	S	F 00	0		
	Office of Health Car	vey was conducted by the e Assurance (OHCA) on y was not in substantial				
		CFR §483 subpart B.				
	Survey dates: 07/1	9/22 to 07/22/22.				
	Survey Census: 79					
	Sample Size: 19					
F 635 SS=D	Admission Physicia CFR(s): 483.20(a)	n Orders for Immediate Care	F 63	5	9/4/22	
	§483.20(a) Admissi					
	must have physicial immediate care.	sident is admitted, the facility n orders for the resident's				
	This REQUIREMEN	IT is not met as evidenced				
	•	view and interview with staff		DIRECTOR OF NURSING (DON),	HEAD	
		r failed to follow the oon admission regarding ations for one Resident (R)31		NURSE (HN), SOCIAL WORKER (S AND INTERDISCIPLINARY TEAM (IDT)WILL IMPLEMENT CORRECT	SW)	
	in the sample of five result of this deficie	e residents investigated. As a nt practice,all residents who		ACTIONS FOR RESIDENT 31 AFFECTED BY THIS DEFICIENT		
		ppic medications in the facility ining and improving their		PRACTICE, INCLUDING: "HN and DON reviewed resident # Admission MD order in facility solutions of the solution	31⊡s	
	Findings Include:			electronic medical record (EMR). Resident was admitted with Citalopr and EMR order entered that all	am	
		admitted to the facility on		psychotropic medications will be		
		noses that included		discontinued 14 days from admissio		
	unspecified single e disorder.	pisode major depressive		unless reassess and reordered was done. Completed 07/21/22		
		ectronic Health Record (EHR)		"IDT to review/assess and discuss resident #31⊡s condition and if		

**Electronically Signed** 

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

08/15/2022

### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 125009 B. WING 07/22/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1027 HALA DRIVE MALUHIA HONOLULU, HI 96817 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 635 Continued From page 1 F 635 documents R31 had admission physician orders antidepressant medication is needed. If of Citalopram Hydrobromide (an antidepressant) needed and appropriate, HN/LN will tablet 10 milligrams (mg), give 1 tablet by mouth collaborate with resident s physician to one time a day and "all psychotropic medications obtain order to continue medication. If not will be discontinued 14 days from admission, needed, will obtain order to discontinue unless reassessed and reordered by medication or suggest gradual dose provider/attending MD [physician] or psychiatry reduction. Completed 08/11/22 consult," ordered on 05/11/22. Review of R31's "HN and SW will arrange for Medication Administration Record (MAR) and Geri-psychiatrist consult. Appointment scheduled for 08/18/22 EHR documents R31 administered Citalopram daily starting 05/12/22 in May, June, and July with no documentation found that indicated the order DIRECTOR OF NURSING (DON), was discontinued after 14 days of admission, or NURSING SUPERVISOR (SRN), HEAD the physician reassessed and reordered the NURSE (HN), LICENSED NURSES (LN) medication. WILL ASSESS OTHER RESIDENTS HAVING THE POTENTIAL TO BE Review of the facility's policy and procedure on AFFECTED BY THIS PRACTICE, psychotropic drug use, policy number INCLUDING: "ORNUR009", with an effective date of 09/01/18, "DON, SRN, HN reviewed the documents major categories of psychotropic Psychotropic P&P and Admission medication including antidepressants and Physician Order. EMR order template was documents "All antipsychotic medications will be changed to reflect updated P&P and Admission Physician Order (effective date discontinued 14 days from admission, unless reassessed and reordered by provider/attending 09/01/2018) stating all antipsychotic MD or psychiatry consult." medications and PRN psychotropic medications will be discontinued 14 days On 07/21/22 at 01:50 PM interview with Unit from admission, unless reassessed and Manager (UM) 2 confirmed the facility did not reordered by provider/attending or follow the physician's order to discontinue all psychiatry consult. Completed 07/22/22 psychotropic medications including Citalopram for "HNs discontinued all residents with R31, 14 days of admission, and the physician did psychotropic admission orders and not reassess the medication. 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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		MEDICAID SERVICES				0.0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		125009	B. WING		07/	22/2022
NAME OF P	ROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 027 HALA DRIVE IONOLULU, HI 96817	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 635	Continued From page	>2	F 635	HEAD NURSE (HN), LICENSED NUF (LN), EDUCATION NURSE (ED), SO WORKERS (SW), MINIMUM DATA S NURSE (MDS), INTERDISCIPLINAR 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 sto orders, monitor log in PCC and initiati care plan to address use of psychotro medications Start 08/16/22 □ Complete 09/04/22 "LN to review list of medications ord on admission/readmission, place stop order and re-assesses need after 14 of for all antipsychotic medications and I psychotropic medications. Start 08/16/22-Ongoing "HN, LN and SW will discuss each admission with psychotropic medicati determine if Geri-psychiatrist consult necessary. If deemed necessary, HN LN will obtain order from provider or attending doctor for Geri-psych consu 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 will review list of medications resident admitted/readmitted with. Documenta and behavior monitoring log will be reviewed to determine residents□ cur status and appropriateness of antipsychotic and PRN psychotropic	CIAL ET Y S ong pic ed ered days PRN on to s and It to VIDT is tion	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

Event ID: UCEH11

Facility ID: HI02LTC5009

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PRINTED: 08/22/2022

OMB NO. 0938-0391

FORM APPROVED

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
NNU PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		125009	B. WING		07/22/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MALUHIA				1027 HALA DRIVE HONOLULU, HI 96817	
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F 635	Continued From pay	ge 3	F 635		eAD (SW), s), MANCE UITOR URE otics or ew s from c hys, C Meds. o with c ys s

Event ID: UCEH11

Facility ID: HI02LTC5009

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# FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 125009 B. WING 07/22/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1027 HALA DRIVE MALUHIA HONOLULU, HI 96817 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 635 Continued From page 4 F 635 at next 08/16/22 meeting. Develop/Implement Comprehensive Care Plan F 656 9/4/22 F 656 SS=D 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

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	OF DEFICIENCIES	MEDICAID SERVICES		דוסי ר	CONSTRUCTION		D. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	, í			· · ·	PLETED
		125009	B. WING			07	/22/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MALUHIA					027 HALA DRIVE IONOLULU, HI 96817		
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F 656	Continued From page	e 5	F	656			
	-	s and/or other appropriate					
	entities, for this purpo						
		in the comprehensive care					
		in accordance with the					
	. ·	h in paragraph (c) of this					
	section.	F :					
		Γ is not met as evidenced					
	by: Based on record rev	iews and interviews, the			HEAD NURSE (HN), NURSING		
	facility failed to devel	-			SUPERVISORS (SRN), DIRECTOR C	)F	
		ans (CP) for two of 19			NURSING (DON), SOCIAL WORKER		
		Resident (R) 80 and R24).			(SW), LICENSED NURSES (LN), AND		
		ot developed to address			MINIMUM DATA SET NURSE (MDS)		
	problems identified for	or R80. Non-pharmacological			WILL IMPLEMENT CORRECTIVE		
		ess behaviors related to the			ACTIONS FOR RESIDENT #80		
	use of psychotropic n				AFFECTED BY THIS DEFICIENT		
	-	As a result of this deficiency,			PRACTICE, INCLUDING:		
		sk of potential negative			"DON, SW, MDS reviewed Resident	<b>c</b> 1	
		es and not reaching their			#80 s care plan where problem identi		
	well-being.	hysical and psychosocial			I refused care at times, yells or screan during care was initiated on 05/03/202		
	weil-beilig.				and incomplete. Goal and intervention		
	Findings include:				were NOT documented in the care pla		
					In addition, we concur that problems w		
	1) On 07/20/22 at 11:	:49 AM, a record review (RR)			not identified such as resident with		
	of R80's electronic he	ealth record (EHR) was			dementia, new/unfamiliar environment	t	
		year old resident admitted to			and needing isolation. IDT reviewed th		
	-	22 for advanced dementia (a			incomplete care plan and citation, and		
	-	paired ability to remember,			concurred that care should have been		
		ons that interferes with daily			completed to address resident s	(ad	
		were unable to care for R80 ased care needs. R80's CP			problems/needs/behavior. UM3 review 7/21, DON, SW, MDS coordinator/IDT		
		em identified, "I refused care			reviewed on 08/10/22		
		ams during care," initiated					
	-	goal or interventions outlined			HEAD NURSE (HN), NURSING		
		blems for having come from			SUPERVISORS (SRN), DIRECTOR C	)F	
		, admitted to the facility with			NURSING (DON), SOCIAL WORKER		
		ng isolation for COVID-19			(SW), LICENSED NURSES (LN), AND	C	
	propoutione wore ale	o not identified on R80's CP.			MINIMUM DATA SET NURSE (MDS)		1

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#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING \_\_\_\_ 125009 B. WING 07/22/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1027 HALA DRIVE MALUHIA HONOLULU, HI 96817 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 656 Continued From page 6 F 656 WILL ASSESS OTHER RESIDENTS On 07/21/22 at 2:45 PM, a concurrent interview HAVING THE POTENTIAL TO BE and RR were done with Unit Manager (UM)3 in AFFECTED BY THIS DEFICIENT her office. UM3 confirmed that no goal and PRACTICE, INCLUDING: interventions were identified for the problem, "I "Residents admitted/readmitted and refused care at times, vells or screams during currently placed in isolation have been care." UM3 identified that behavior interventions identified. Completed 08/08/22 are present on the "MONITORS" flowsheet that "MDS and IDT will review care plans to only the registered nurses have access to, but no ensure it is complete with resident s other disciplines have access to this and problems/needs, goals, and interventions. therefore would not know how to effectively and Start 08/15/22-Ongoing individually care for R80's behaviors. UM3 stated that R80's problem with coming from a home HEAD NURSE (HN), NURSING environment and transitioning into a facility with SUPERVISORS (SRN), DIRECTOR OF dementia and being isolated for COVID-19 NURSING (DON), SOCIAL WORKER precautions should have been identified on the (SW), LICENSED NURSES (LN), AND care plan and interventions developed to provide MINIMUM DATA SET NURSE (MDS) the optimal care for R80. WILL IMPLEMENT MEASURES TO ENSURE THAT THIS PRACTICE DOES On 07/22/22 at 08:00 AM, the facility's NOT RECUR, INCLUDING: "Comprehensive Care Plan Guideline" was "MDS and IDT will create a Care plan for reviewed. It stated under "Procedure:...2. This all New Admissions/Readmissions, where resident will be placed on quarantine or comprehensive care plan will address resident goals, actual and potential problems, needs, isolation. This care plan will address strengths and individual preferences of the Potential for isolation / Psychosocial resident." issues that include observations for feelings of isolation, sadness or feeling 2) R24 was admitted to the facility on 10/06/21 alone or lonely, difficulty of adjustment to with diagnoses of inadequate sleep hygiene and new environment, lifestyle or homelike unspecified dementia without behavior environment and to address any disturbance. behaviors that are observed or the resident exhibits. This care plan will be Record review of a psychiatry consult dated separate from the covid-19 infection care 05/12/22 documents reason for visit, "behavioral plan. Started 08/11/22-Ongoing problems", and vascular dementia with behavioral "Based on the CAAS that are triggered, problems as the psychiatric diagnosis evaluated. MDS coordinator will ensure that an The consult further documents R24's history appropriate care plan will be in place for "...nursing notes that patient [R24] has been new admissions/readmissions and for all reasonably calm although period where he will comprehensive assessments. Care plans

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		405000				
	ROVIDER OR SUPPLIER	125009			07/22/2022	
MALUHIA				STREET ADDRESS, CITY, STATE, ZIP CODE 1027 HALA DRIVE HONOLULU, HI 96817		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIC	
F 656	Continued From pag	e 9	F 65	6 medications. Start 08/15/22 □ Comp 09/04/22 "HN and SW will review care plan residents identified receiving any psychotropic medications to ensure person-centered, non-pharmacolog interventions are in place. Start 08/15/22 □ Completed 09/04/22 HEAD NURSE (HN), NURSING SUPERVISORS (SRN), DIRECTOF NURSING (DON), SOCIAL WORKI (SW), LICENSED NURSES (LN), A MINIMUM DATA SET NURSE (MD3 WILL IMPLEMENT MEASURES TO ENSURE THAT THIS PRACTICE D NOT RECUR, INCLUDING: "HN, ED will educate LN during sh reports to update care plans for res with new orders for psychotropic medications, including orders obtain from Geri-psych consult recommendations. Care plans need include non-pharmacologic interver Start 08/16/22 □ Completed 09/04/2 "HN will consult with SW on reside with psychotropic medications and behaviors. SW will refer back to the social history and speak with family responsible party to gather informa specific to resident□s behaviors ald with appropriate and effective non-pharmacological interventions strategies used in the past. Start 08/15/22-Ongoing "HN and SW will develop/update behavior care plan incorporating fat suggestions and resident□s curren and will include person-centered	for e- pical ROF ER NDD S) DOES hift idents ned d to htions. 2 ents their e or tion Dog and	

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Facility ID: HI02LTC5009

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ATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
D PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		125009	B. WING		07/22/2022	
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IALUHIA				1027 HALA DRIVE HONOLULU, HI 96817		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETI	
F 656	Continued From page	e 10	F 650	<ul> <li>non-pharmacologic interventions. S 08/15/22-Ongoing</li> <li>"LN, HN, SRN will input non-pharmacological interventions PointClickCare (PCC) behavior mo and document behaviors in PCC m log every shift. Start 08/15/22-Ongo "HN will ensure that MDS coordinator/IDT will review and upo care plans during quarterly IDT Conference meetings, to ensure that plans address individual, person-cet non-pharmacologic interventions and determine whether the care plan is appropriate. Start 08/15/22-Ongoin</li> <li>HEAD NURSE (HN), NURSING SUPERVISORS (SRN), DIRECTOR NURSING (DON), SOCIAL WORKI (SW), AND QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) WILL MONITOR CORRECT ACTIONS TO ENSURE THE EFFECTIVENESS OF THESE ACT INCLUDING:</li> <li>"HN, SRN and SW will perform me review of care plans for residents receiving psychotropic medications person-centered non-pharmacologi interventions are in place. Start 08/31/22-Ongoing</li> <li>"HN/SRN will submit findings to D report to quarterly QAPI Committee 08/31/22</li> </ul>	in nitoring onitor bing late at Care entered nd still g R OF ER E TIVE TIONS, onthly that ic	
	Free of Accident Haz CFR(s): 483.25(d)(1)	ards/Supervision/Devices (2)	F 689		9/4/22	

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 125009 B. WING 07/22/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1027 HALA DRIVE MALUHIA HONOLULU, HI 96817 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 689 Continued From page 11 F 689 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 HEAD NURSE (HN), NURSING SUPERVISOR (SRN), TEMPORARY facility failed to secure a storage room located on the 2 Makai nursing unit. As a result of this ASSIGNED NURSE (TA), LICENSED failure, the facility put the residents at risk for NURSE (LN) WILL IMPLEMENT accident hazards. CORRECTIVE ACTIONS FOR 2MAKAI STORAGE ROOM AFFECTED BY THIS Findings include: PRACTICE, INCLUDING: "Storage door lock fixed. Completed During an observation on 07/19/22 at 10:30 AM, 07/19/22 the storage room located on 2 Makai nursing unit "Head nurse placed signage on the door to keep door closed/locked at all times. was not locked/secured and there was no staff in Completed 07/19/22 the immediate vicinity to prevent unauthorized entry to the room. The storage door had a "HN reminded staff during shift reports keypad lock installed but the door latch was taped that storage room need to be locked to prevent unauthorized individuals, including open to prevent the door from being locked. Observer was able to enter the room by just residents, from entering and having pushing the door open. A review of hazardous access to hazardous contents. Completed 07/19/22-7/22/22 contents of the storage room were the following: Hydrogen Peroxide Solution, 3% USP 10 Volume, (4) 16 fluid ounce bottles, Aloe Vesta Daily HEAD NURSE (HN), LICENSED Moisturizer containing Dimethicone 3% active NURSES, NURSING SUPERVISOR ingredient, and inactive ingredients water, (SRN), TEMPORARY ASSIGNED petrolatum, glycerin, steareth-2, cetyl alcohol, NURSE (TA) AND OPERATIONS & MAINTENANCE (O&M) WILL ASSESS benzyl alcohol, laureth-23, magnesium, aluminum silicate, carbomer, potassium sorbate, sodium OTHER STORAGE AREAS HAVING THE hydroxide, Aloe barbadensis leaf powder, Fresh POTENTIAL TO BE AFFECTED BY THIS Moment Mouthwash labeled; in case of PRACTICE, INCLUDING: accidental ingestion, seek professional "Storage doors on the two other resident assistance or contact a Poison Control Center units were checked. Both had functional immediately, (5) 4 fluid ounce bottles. locks and doors were locked. Completed

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PRINTED: 08/22/2022 FORM APPROVED

# DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 125009 B. WING 07/22/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1027 HALA DRIVE MALUHIA HONOLULU, HI 96817 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 689 Continued From page 12 F 689 07/19/22 During observations on 07/19/22 at 10:40 AM, "Facility-wide doors and locks were two residents were noted be self-propelling their checked by O&M to ensure doors are wheelchair pass the storage room, alone with no locked/secured and door latches were not staff in the immediate vicinity to prevent them taped or stuffed with material to prevent from entering the storage room and having locking. Completed 07/19/22 access to the hazardous contents as previously "SRN/TA, HN, and LN will do random mentioned. rounds to check storage door on shift assignment. Start 07/19/22-Ongoing On 07/19/22 at 10:50 AM, Unit Manager (UM) 2, acknowledged that the storage room should have HEAD NURSE (HN), LICENSED been locked/secured and stated that they would NURSES (LN), NURSING SUPERVISOR immediately get it fixed. (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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		MEDICAID SERVICES			OMB NO. 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		125009	B. WING		07/22/2022	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
MALUHIA						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIO	
F 689	Continued From page	e 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 th QAPI Committee. Start 11/22/22 Ongoing. (Audit plan will h discussed at the next QAPI meeting Completed 08/16/22)	be	
F 693 SS=E	Tube Feeding Mgmt/ CFR(s): 483.25(g)(4)	•	F 693	,	9/4/22	
	both percutaneous en percutaneous endoso enteral fluids). Based	c and gastrostomy tubes, ndoscopic gastrostomy and copic jejunostomy, and l on a resident's ssment, the facility must				
	eat enough alone or enteral methods unle condition demonstrat	lent who has been able to with assistance is not fed by ss the resident's clinical es that enteral feeding was id consented to by the				
	means receives the a services to restore, if and to prevent compl including but not limit diarrhea, vomiting, de abnormalities, and na	lent who is fed by enteral appropriate treatment and possible, oral eating skills ications of enteral feeding ted to aspiration pneumonia, ehydration, metabolic asal-pharyngeal ulcers.				
	Based on observation review, the facility fai	n, interview, and record led to provide the t and services to prevent		HEAD NURSE (HN), LICENSED N (LN), AND EDUCATION NURSE W IMPLEMENT CORRECTIVE ACTIO	ILL	

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#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING \_\_\_\_ 125009 B. WING 07/22/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1027 HALA DRIVE MALUHIA HONOLULU, HI 96817 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 693 Continued From page 14 F 693 potential complications of enteral tube-feeding FOR RESIDENT #33 AFFECTED BY (TF) for six residents (Residents 33, 35, 63, 34, THIS DEFICIENT PRACTICE, 12, and 62) in the sample. The TF tubing was not INCLUDING: labeled which would indicate that the tubing is "Resident # 33 Tubing and tube feeding changed every day. As a result of this deficient bottle administered on July 19, 2022 were practice, the facility placed all residents who are labeled with licensed staff initial. date and on enteral nutrition at risk for avoidable infections time. Completed 07/19/22 and complications. HEAD NURSE (HN), LICENSED NURSE Findings include: (LN), SUPERVISOR NURSE (SRN), DIRECTOR OF NURSING (DON) WILL 1) On 07/19/22 at 09:02 AM, an observation and IDENTIFY OTHER RESIDENTS HAVING concurrent interview were done with Registered THE POTENTIAL TO BE AFFECTED BY Nurse (RN)4 at the bedside of Resident (R)33. THIS DEFICIENT PRACTICE, Observed that R33's tube-feeding (TF) formula INCLUDING: and TF administration set (tubing) were not "Fourteen Residents receiving tube labeled with the date and time they were hung. feeding were identified and the following RN4 stated that she had started R33's TF at was done: 08:00 AM and had just turned it off and 1. Tube feeding Formula bottle was disconnected it (at 09:00 AM). When asked labeled with date, time, and initial, and about who was responsible to change the TF with correct special instructions, if tubing out, RN4 reported that "night shift" should indicated. Completed 07/22/22 change out and date the TF formula and tubing 2 Tubing was labeled with date and daily. RN4 confirmed that the TF formula and time; and Tube feeding bottle date of tubing should have been dated, and that she expiration was checked. Completed should have checked for that prior to starting the 07/22/22 TF at 08:00 AM. RN4 stated that TF tubing "HNs checked their respective unit s should be changed out once a day "due to tube feeding formula storage to remove infection control and clogging" concerns. outdated formulas. Completed 07/22/22 "Residents with low flow rate were On 07/21/22 at 11:34 AM, a review of the facility identified to use the 1000ml bottle that will Policy & Procedure Enteral Tube Feedings, dated be consumed in a 24-hour period. 07/18/18, noted the following: Completed 07/22/22 "G.2. Prepare feeding set. Label bag with DIRECTOR OF NURSING (DON), resident's name, room number and date, start NURSING SUPERVISOR (SRN), time and rate. Label tubing with start date and EDUCATION NURSE (ED NURSE), time." HEAD NURSE (HN), LICENSED NURSE, AND PURCHASING/CSR STAFF WILL

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#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 125009 B. WING 07/22/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1027 HALA DRIVE MALUHIA HONOLULU, HI 96817 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 693 Continued From page 16 F 693 NURSING SUPERVISOR (SRN), SRN On 07/20/22 at 12:21 PM, an observation was TEMPORARY ASSIGNED (TA), made of a sealed TF administration set used in EDUCATION NURSE (ED NURSE), the facility. Noted to be a Coviden Epump HEAD NURSE (HN), LICENSED NURSE, ENPlus Spike Set with clear printed manufacturer AND PURCHASING/CSR STAFF WILL instructions. "Do not use for greater than 24 MONITOR ITS CORRECTIVE ACTIONS hours". TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND 3) On 07/19/22 at 09:37 AM, an observation and WILL NOT RECUR. concurrent interview were done with RN4 at the "Audit tool created for HNs, SRN/TAs, bedside of R63. Observed that R63's TF formula ED Nurse, and DON to monitor and was labeled "7/17 2100," indicating that it was provide feedback to staff to correct hung on 07/17/22 at 09:00 PM. RN4 confirmed deficient practices. Completed 08/15/22 that she had turned the TF pump off and "Audit tool created for purchasing to disconnected it at 08:00 AM. When asked about monitor formula on nursing units. the date on the TF label. RN4 confirmed that the Completed 08/11/22 TF tubing was only good for 24 hours, so it was "Purchasing/CSR will audit that formula expired and should have been changed on on the nursing units are not expired. Start 07/18/22. 08/11/22-Ongoing "Findings will be submitted to the On 07/21/22 at 11:00 AM. an interview was done quarterly QAPI Committee meeting. Start with UM3 in her office. UM3 confirmed that the 11/22/22 Ongoing (Audit plan will be licensed staff should be checking both the TF discussed at the next QAPI meeting on formula and the TF tubing before beginning any Completed 08/16/22) TF. UM3 also stated that the TF tubing is good for 24 hours, so licensed staff should be changing HEAD NURSE (HN), LICENSED NURSE out the tubing and formula daily and labeling both (LN), AND EDUCATION NURSE WILL IMPLEMENT CORRECTIVE ACTIONS when it is hung. FOR RESIDENT #35 AFFECTED BY 4) On 07/19/22 at 10:10 AM, an observation was THIS DEFICIENT PRACTICE, done at the bedside of R34. R34's TF formula INCLUDING: was labeled with instructions that read " ... off at "Resident #35 Tubing and tube feeding 0700 on at 1100." The TF pump was off and bottle administered on July 19, 2022 at disconnected at the time. At 11:09 AM, 0745 and 1145 with expired tubing were observation at the bedside noted the TF pump removed and replaced with new tube was still off and disconnected. From 12:29 PM to feeding bottle and tubing, properly labelled 02:15 PM, observed R34 in a private family room with staff initial, date and time. on the first floor, visiting with his mother. The TF Completed 07/19/22 and pump set-up remained on the third floor in

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 125009 B. WING 07/22/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1027 HALA DRIVE MALUHIA HONOLULU, HI 96817 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 693 Continued From page 19 F 693 before administration. DON stated, "we do not PRACTICE IS BEING CORRECTED AND want to cause complication or reactions to an WILL NOT RECUR. expired product such as GI [gastrointestinal] "Audit tool created for HNs, SRN/TAs, symptoms." 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

FORM CMS-2567(02-99) Previous Versions Obsolete

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/22/2022 MAPPROVED D: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		125009	B. WING _			07/	22/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 017	
MALUHIA				10	27 HALA DRIVE		
	1			н	ONOLULU, HI 96817		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 693	Continued From page	e 20	F 6	593	THIS DEFICIENT PRACTICE, INCLUDING: "Fourteen Residents receiving tube feeding were identified and the followin 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 stube feeding formula storage to remov and outdated formulas. Completed 07/22/22 "Residents with low flow rate were identified to use the 1000ml bottle that 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 NUR AND PURCHASING/CSR STAFF WIL IMPLEMENT MEASURES TO ENSUF THAT THE DEFICIENT PRACTICE W NOT RECUR, INCLUDING: "When placing new tube feeding bott and tubing, LN will check formula expiration date before administering, Complete formula label by writing star date, time, initials, and any special instructions, and Label tubing with star date, time, and initials. Start 08/16/22-Ongoing "LN will check tube feeding	t	

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	OF DEFICIENCIES	MEDICAID SERVICES		E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		125009	B. WING		07/22/2022
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•
MALUHIA				1027 HALA DRIVE HONOLULU, HI 96817	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIC
F 693	Continued From pag	je 21	F 693	formula/tubing each time before s infusion, to ensure tube feeding for and tubing are properly labeled ar expired. Start 08/16/22-Ongoing "Place order in eTAR to remind L check tube feeding formula/tubing expiration every shift. Start 08/10/ Ongoing "Enteral Feeding P&P and Skills Checklist was reviewed by DON, SRNs, and ED Nurse. Revisions w made to emphasize labeling of for and tubing, checking expiration da formula, and removing expired for tubing. Completed 08/12/22 "ED Nurse will review with the LN in ensuring the above are done. S 08/16/22 □Completed 09/04/22 "Purchasing will order tube feedi formula in 1000ml and 1500ml bo Start 07/22/22-Ongoing "Purchasing/CSR staff will check expiration date weekly for formula in Nursing□s formula storage cab Start 08/11/22-Ongoing DIRECTOR OF NURSING (DON) NURSING SUPERVISOR (SRN), TEMPORARY ASSIGNED (TA), EDUCATION NURSE (ED NURSI HEAD NURSE (HN), LICENSED AND PURCHASING/CSR STAFF MONITOR ITS CORRECTIVE AC TO ENSURE THAT THE DEFICIE PRACTICE IS BEING CORRECT WILL NOT RECUR. "Audit tool created for HNs, SRN ED Nurse, and DON to monitor ar provide feedback to staff to correc	ormula nd not LN to 22 - HNs, were mula ate of mula or Ns steps start ng ttles. stored inet. , SRN E), NURSE, WILL STIONS ENT ED AND I/TAs, nd

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ,	LE CONSTRUCTION	OMB NO. 0938-0
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	<u> </u>	COMPLETED
		125009 B. WING			07/22/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MALUHIA				1027 HALA DRIVE HONOLULU, HI 96817	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETI
F 693	Continued From pag	je 22	F 69	<ul> <li>deficient practices. Completed 08/ "Audit tool created for purchasing monitor formula on nursing units. Completed 08/11/22 "Purchasing/CSR will audit that for on the nursing units are not expired 08/11/22-Ongoing</li> <li>"Findings will be submitted to the quarterly QAPI Committee meeting 11/22/22  Ongoing (Audit plan wi discussed at the next QAPI meetin Completed 08/16/22)</li> <li>HEAD NURSE (HN), LICENSED N (LN), AND EDUCATION NURSE V IMPLEMENT CORRECTIVE ACTIVE FOR RESIDENTS #34 AFFECTED THIS DEFICIENT PRACTICE, INCLUDING: "Resident #34 with tube feeding la instruction off at 0700 on at 1100 w corrected with the updated order to from 1000-0200 pm. Completed 0</li> <li>HEAD NURSE (HN), LICENSED N (LN), SUPERVISOR NURSE (SRN DIRECTOR OF NURSING (DON) IDENTIFY OTHER RESIDENTS H THE POTENTIAL TO BE AFFECTI THIS DEFICIENT PRACTICE, INCLUDING: "Fourteen Residents receiving tult feeding were identified and the foll was done: 1.Tube feeding Formula bottle w labeled with date, time, and initial, with correct special instructions, if indicated. Completed 07/22/22</li> </ul>	abel vas be off 7/19/22 NURSE VILL ONS D BY abel vas be off 7/19/22 NURSE N, WILL IAVING ED BY be owing was

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
		125009	B. WING		07/22/2022		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1027 HALA DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	HONOLULU, HI 96817 PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETIO		
F 693	Continued From pag	je 23	F 65	<ul> <li>2. Tubing was labeled with da time; and Tube feeding bottle da expiration was checked. Complet 07/22/22</li> <li>"HNs checked their respective tube feeding formula storage to and outdated formulas. Complet 07/22/22</li> <li>"Residents with low flow rate w identified to use the 1000ml bottl be consumed in a 24-hour perio Completed 07/22/22</li> <li>DIRECTOR OF NURSING (DON NURSING SUPERVISOR (SRN EDUCATION NURSE (ED NURS HEAD NURSE (HN), LICENSEE AND PURCHASING/CSR STAF IMPLEMENT MEASURES TO E THAT THE DEFICIENT PRACTINOT RECUR, INCLUDING:</li> <li>"When placing new tube feedin and tubing, LN will check formul expiration date before administer Complete formula label by writin date, time, initials, and any speci instructions, and Label tubing wi date, time and initials. Start 08/10/Ongoing</li> <li>"LN will check tube feeding formula/tubing each time before infusion, to ensure tube feeding and tubing are properly labeled expired. Start 08/16/22-Ongoing</li> <li>"Place order in eTAR to remino check tube feeding formula/tubing each time before infusion every shift. Start 08/10/22-Ongoing</li> </ul>	ate of eted unit □s remove ted vere the that will d. N), ), SE), D NURSE, F WILL ENSURE ICE WILL ing bottle a ering, ng start cial ith start 16/22 - starting formula and not g		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIPI	E CONSTRUCTION	OMB NO. 0938-	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED	
		125009	B. WING		07/22/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MALUHIA				1027 HALA DRIVE HONOLULU, HI 96817		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLE	
F 693	Continued From pag	je 24	F 693	<ul> <li>Checklist was reviewed by DON, H SRNs, and ED Nurse. Revisions w made to emphasize labeling of forr and tubing, checking expiration dat formula, and removing expired forr tubing. Completed 08/12/22</li> <li>"ED Nurse will review with the LN in ensuring the above are done. St 08/16/22 Completed 09/04/22</li> <li>"Purchasing will order tube feedin formula in 1000ml and 1500ml bott Start 07/22/22 - Ongoing</li> <li>"Purchasing/CSR staff will check expiration date weekly for formula in Nursing s formula storage cabin Start 08/11/22-Ongoing</li> <li>DIRECTOR OF NURSING (DON), NURSING SUPERVISOR (SRN), S TEMPORARY ASSIGNED (TA), EDUCATION NURSE (ED NURSE HEAD NURSE (HN), LICENSED N AND PURCHASING/CSR STAFF N MONITOR ITS CORRECTIVE ACT TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTE WILL NOT RECUR.</li> <li>"Audit tool created for HNs, SRN/ ED Nurse, and DON to monitor and provide feedback to staff to correct deficient practices. Completed 08/7</li> <li>"Audit tool created for purchasing monitor formula on nursing units.</li> <li>Completed 08/11/22</li> <li>"Purchasing/CSR will audit that for on the nursing units are not expired 08/11/22-Ongoing</li> <li>"Findings will be submitted to the quarterly QAPI Committee meeting</li> </ul>	ere nula te of nula or s steps art g des. formula stored het. SRN ), IURSE, WILL FIONS NT ED AND TAs, d 15/22 to prmula d. Start	

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	OF DEFICIENCIES			OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
			A. BUILDING		
		125009	B. WING		07/22/2022
NAME OF P	E OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1027 HALA DRIVE			DDE	
MALUHIA				HONOLULU, HI 96817	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE COMPLE HE APPROPRIATE DATE
F 693	Continued From page 25		F 69	3 11/22/22 □ Ongoing (Audit discussed at the next QAPI Completed 08/16/22)	
				HEAD NURSE (HN), LICEN (LN), AND EDUCATION NU IMPLEMENT CORRECTIVI FOR RESIDENTS #12 and AFFECTED BY THIS DEFIC PRACTICE, INCLUDING: "Resident #12 and Reside formula was removed from bedside. Completed 07/19/2 HN counseled RN15, review protocol/guidelines when a formula is administered to re which state, to check for exidiscard opened formula bot hours and initial and date for Completed 07/19/2022 HN and ED nurse conducte in-serviced licensed staff, in to: 1.Follow policy on entered 07/20/22  Completed 07/2 2.Initial, date and time tu formula and tube feeding tu starting a new bottle of form tubing. Start 07/20/22  Com 07/22/22	URSE WILL E ACTIONS #62 CIENT nt #62 Expired resident⊡s 22 ved the new bottle of esidents, piration dates, tles after 24 vrmula. d huddles and acluding RN5 al feeding Start 22/22 be feeding bing when pula and
				HEAD NURSE (HN), LICEN (LN), SUPERVISOR NURS DIRECTOR OF NURSING IDENTIFY OTHER RESIDE THE POTENTIAL TO BE AF THIS DEFICIENT PRACTIC INCLUDING:	E (SRN), (DON) WILL :NTS HAVING FFECTED BY

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	AS FOR MEDICARE & OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
ND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		125009	B. WING		07/22/2022	
NAME OF F	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
MALUHIA						
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETI	
F 693	Continued From pag	e 26	F 69	<ul> <li>3</li> <li>"Fourteen Residents receiving the feeding were identified and the forwas done: <ol> <li>Tube feeding Formula bottle labeled with date, time, and initiat with correct special instructions, indicated. Completed 07/22/22</li> <li>Tubing was labeled with data time; and Tube feeding bottle date expiration was checked. Complete 07/22/22</li> <li>"HNs checked their respective of tube feeding formula storage to rand outdated formulas. Complete 07/22/22</li> <li>"Residents with low flow rate we identified to use the 1000ml bottle be consumed in a 24-hour period Completed 07/22/22</li> </ol> DIRECTOR OF NURSING (DON NURSING SUPERVISOR (SRN) EDUCATION NURSE (ED NURSE HEAD NURSE (HN), LICENSED AND PURCHASING/CSR STAFFI IMPLEMENT MEASURES TO EITHAT THE DEFICIENT PRACTION NOT RECUR, INCLUDING: "When placing new tube feeding and tubing, LN will check formula expiration date before administer Complete formula label by writing date, time and initials. Start 08/16/22-Ongoing "LN will check tube feeding formula/tubing each time before a infusion, to ensure tube feeding formula/tubing each time before a infusion, to ensure tube feeding formula/tubing each time before a infusion, to ensure tube feeding formula/tubing each time before a infusion, to ensure tube feeding formula/tubing each time before a infusion.</li></ul>	bllowing e was il, and if te and te of ted unit s remove ed ere e that will 1. i), b, b, D, NURSE, F WILL NSURE CE WILL g bottle a ring, g start al th start starting	

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TATEMENT	CENTERS FOR MEDICARE & MEDICAID SERVICES           TATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           ND PLAN OF CORRECTION         IDENTIFICATION NUMBER:		(X2) MULTIP	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
			A. BUILDING			
	ROVIDER OR SUPPLIER	125009	B. WING		07/22/2022	
MALUHIA				1027 HALA DRIVE HONOLULU, HI 96817		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORF PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AF DEFICIENCY)		IOULD BE COMPLET	
F 693	Continued From pag	e 27	F 69	<ul> <li>and tubing are properly labeled and expired. Start 08/16/22-Ongoing "Place order in eTAR to remind LN check tube feeding formula/tubing expiration every shift. Start 08/10/22-Ongoing "Enteral Feeding P&amp;P and Skills Checklist was reviewed by DON, H SRNs, and ED Nurse. Revisions we made to emphasize labeling of form and tubing, checking expiration date formula, and removing expired form tubing. Completed 08/12/22 "ED Nurse will review with the LNs in ensuring the above are done. Sta 08/16/22 Completed 09/04/22 "Purchasing will order tube feeding formula in 1000ml and 1500ml bottl Start 07/22/22-Ongoing "Purchasing/CSR staff will check f expiration date weekly for formula si n Nursing s formula storage cabin Start 08/11/22-Ongoing</li> <li>DIRECTOR OF NURSING (DON), NURSING SUPERVISOR (SRN), S TEMPORARY ASSIGNED (TA), EDUCATION NURSE (ED NURSE) HEAD NURSE (HN), LICENSED N AND PURCHASING/CSR STAFF V MONITOR ITS CORRECTIVE ACT TO ENSURE THAT THE DEFICIEN PRACTICE IS BEING CORRECTE WILL NOT RECUR.</li> <li>"Audit tool created for HNs, SRN/" ED Nurse, and DON to monitor and provide feedback to staff to correct deficient practices. Completed 08/1</li> </ul>	Ns, ere hula e of hula or s steps art g es. formula stored et. SRN , URSE, VILL IONS IT D AND TAS, 1 5/22	

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL				OMB NC	0. 0938-0391	
AND PLAN OF CORRECTION	o. ``	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
125009	B. WING			07/	22/2022	
NAME OF PROVIDER OR SUPPLIER	I	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•••		
MALUHIA		10	027 HALA DRIVE			
		H	ONOLULU, HI 96817			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FUL TAG REGULATORY OR LSC IDENTIFYING INFORMATION			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 693       Continued From page 28         F 761       Label/Store Drugs and Biologicals         SS=E       CFR(s): 483.45(g)(h)(1)(2)         §483.45(g) Labeling of Drugs and Biologicals         Drugs and biologicals used in the facility must         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 a         biologicals in locked compartments under pro         temperature controls, and permit only authoriz         personnel to have access to the keys.         §483.45(h)(2) The facility must provide separa         locked, permanently affixed compartments for         storage of controlled drugs listed in Schedule         the Comprehensive Drug Abuse Prevention an         Control Act of 1976 and other drugs subject to         abuse, except when the facility uses single un         package drug distribution systems in which th         quantity stored is minimal and a missing dose         be readily detected.	and per zed ately II of nd o iit e	761	monitor formula on nursing units. Completed 08/11/22 "Purchasing/CSR will audit that formu on the nursing units are not expired. St 08/11/22-Ongoing "Findings will be submitted to the quarterly QAPI Committee meeting. Sta 11/22/22 Ongoing (Audit plan will be discussed at the next QAPI meeting on Completed 08/16/22)	art art	9/4/22	

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#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 125009 B. WING 07/22/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1027 HALA DRIVE MALUHIA HONOLULU, HI 96817 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 761 Continued From page 29 F 761 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record HEAD NURSE (HN), NURSING review, the facility failed to ensure that the SUPERVISOR (SRN), DIRECTOR OF Pneumococcal vaccines (medication given to NURSING (DON), WILL IMPLEMENT protect an individual from pneumonia, a lung CORRECTIVE ACTIONS (FOR 2MAKAI) infection) was properly stored in the nursing unit's AFFECTED BY THIS PRACTICE, refrigerator. This deficient practice could INCLUDING: potentially render the Pneumococcal vaccines "2 Makai HN immediately relocated inactive and affect residentswho receive the vaccines (Pneumococcal) found stored on refrigerator door to the middle shelf of the pneumococcal vaccine. refrigerator. Completed 07/22/22 Findings include: "HN placed signage on top of the refrigerator to remind all license nurses to On 07/21/22 at 09:53 AM, an observation of a Store all vaccines on the middle shelf at nursing unit's medication refrigerator was made. all times Completed 07/22/22 The "DAILY TEMPERATURE RECORD MEDICATION REFRIGERATOR" log was HEAD NURSE (HN), LICENSED NURSES (LN), NURSING SUEPRVISOR checked and the temperature documented for the (SRN), TEMPORARY ASSIGNED (TA), day shift was 40 degrees Fahrenheit. The proper EDUCATION NURSE (ED), DIRECTOR range identified on the log was documented as "36-40 DEGREES." The Pneumococcal vaccines OF NURSING (DON) WILL ASSESS were kept in a compartment on the refrigerator OTHER RESIDENTS HAVING HE door that the State Agency (SA) took a few POTENTIAL TO BE AFFECTED BY THIS minutes to access because of the difficulty to take PRACTICE, INCLUDING: them out of the enclosed section. "HNs of the other two units (2Mauka and 3 Makai) checked their medication On 07/22/22 at 07:56 AM, a review of the Centers refrigerator for vaccines to ensure proper for Disease Control and Prevention's (CDC) storage on middle shelf. No vaccines website, "Vaccine Storage and Handling found stored on door. Completed Resources" at 07/22/22 https://www.cdc.gov/vaccines/hcp/admin/storage/i "DON shared at Oahu Region ndex.html, that produced a storage and handling **Pharmaceutical & Therapeutics** fact sheet for vaccines, "Storage Best Practices Committee regarding proper storage of vaccines. Medical Director recommended for Refrigerated Vaccines-Fahrenheit (F)" stated, "Don't put vaccines on door shelves or on floor of no medications and vaccines to be stored refrigerator." on the refrigerator doors. Completed 08/02/22 On 07/22/22 at 08:49 AM, a concurrent "HNs placed signs on medication

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 125009 B. WING 07/22/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1027 HALA DRIVE MALUHIA HONOLULU, HI 96817 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 761 Continued From page 30 F 761 refrigerator to remind LN. Completed observation and interview were made with Unit Manger (UM)2 at the nursing station. The 08/02/22 refrigerator temperature logged for the day shift was 40 degrees Fahrenheit and was verified by HEAD NURSE (HN), LICENSED UM2. SA showed UM2 the location of the NURSES (LN), SUPERVISOR NURSE Pneumococcal vaccines on the refrigerator door (SRN), TEMPORARY ASSIGNED (TA), and she agreed that the temperature would not EDUCATION NURSE (ED), DIRECTOR be consistently held if the vaccines are stored on OF NURSING (DON) WILL IMPLEMENT the shelf of the refrigerator door. UM2 moved the MEASURES TO ENSURE THAT THIS location of the Pneumococcal vaccines to the PRACTICE DOES NOT RECUR, INCLUDING: middle shelf inside of the refrigerator. "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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CENTERS FOR MEDICARE & MEDICAID SERVICES           TATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           ND PLAN OF CORRECTION         IDENTIFICATION NUMBER:		(X2) MULTIPL	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED			
	JUNECHUN	IDENTIFICATION NUMBER:	A. BUILDING		COWFLETED	
		125009		STREET ADDRESS, CITY, STATE, ZIP CODE	07/22/2022	
NAME OF PROVIDER OR SUPPLIER						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	HONOLULU, HI 96817 PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLÉTIO	
F 761	Continued From page	ge 31	F 761	INCLUDING: "HNs, SRN, ED will perform au check that vaccines are stored in middle shelf of the medication refrigerators and that appropriate temperatures are maintained. At be submitted to DON. Start 08/3 -Ongoing "Audit Plan to be shared at the QAPI meeting. Completed 08/16 "Findings of audits will be subm the quarterly QAPI Committee m Start 11/22/22-Ongoing	n the e udits will 1/22 next 5/22 nitted to	

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