STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125029	A. BUILDING _____ B. WING _____	09/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMUEL MAHELONA MEMORIAL HOSPITAL	4800 KAWAIHAU ROAD KAPAA, HI 96746

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on September 27-30, 2022. The facility was not in compliance with 42 CFR 483 Subpart B. Facility Reported Incidents (FRI) ACTS 9485, 9751 was also investigated and unsubstantiated. Survey Census: 53 Sample Size: 23	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and review of policy, the facility failed to accurately record the Resident Assessment Instrument (RAI), Minimum Data Set (MDS) Status of one Resident (R)15 of eight residents sampled. As a result of this deficiency, the facility put R15 at risk for further status inaccuracy. Findings include: During review of R15's most recent MDS, Assessment Reference Date 07/19/22, Section 14800 was inaccurately marked as Yes which meant that R15 had Non-Alzheimer's Dementia (eg. Lewy body dementia, vascular or multi-infarct dementia, mixed dementia, frontotemporal dementia such as Pick's disease and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases). Review of R15's current diagnosis showed Anoxic Brain Injury,	F 641	1a. Immediately modified R16□s MDS for the last two years to remove the dementia diagnosis in section 14800. 1b. LTC DON noted that the dementia diagnosis was in the coding summary and contacted the Health Information Management (HIM or Medical Records) Director to ensure that diagnosis for dementia is removed from the residents problem list. 2a. All residents have the potential to be impacted by this deficient practice of inaccurately recording the MDS status. 2b. RAI Coordinator will monitor the MDS Diagnosis List and the Electronic Medical Record (EMR) Problem List in conjunction with the LTC MD Recertification	11/11/22

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

Electronically Signed | 10/22/2022

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F 641	Continued From page 1 Epilepsy, Dysphagia, Anemia, Hyperlipidemia, Diabetes, Mood Disorder, Benign Prostatic Hyperplasia ... During staff interview on 09/29/22 at 02:00 PM, MDS Coordinator (MDS Coord) acknowledged that R15 was inaccurately marked as Yes in section 14800 indicating a diagnosis of Non-Alzheimer's Dementia. MDS Coord stated that there was no documentation which would have indicated that R15 had that diagnosis. Review of facility policy on Medical Records, Skilled Nursing Facilities, Units, read the following: Purpose, to improve the accuracy, integrity and quality of patient data, ensure minimal variation in coding practices, and improve the quality of the physician documentation within the body of the medical record to support code assignments. Policy ... Procedure, Minimum Data Set (MDS) Completion; the Long-Term Care Head Nurse should establish a protocol for completing Section I.3 of the MDS. This information must be forwarded to the Medical Records Director to provide coding documentation. It is the responsibility of the Medical Records coding staff to assign ICD-9-CM codes for completion of Section I.3. Use the following references when completing Section I.3, HCFA's RAI Version 2.0 Manual, Chapter 3; MDS Items, Section I: Disease Diagnoses.	F 641	Assessment to ensure coding is accurate in the MDS. 2c. The LTC Medical Director will review the Problem List with his assessment and Recertification notes every 60 days to ensure accuracy between both the EMR Problem List and the Recertification notes. 2d. RAI Coordinator is establishing a protocol to use when completing Section I.3 of the MDS to monitor and review the Diagnosis List and Coding for accuracy in consultation with the HIM (Medical Records) Director. 3a. RAI Coordinator will monitor and audit the MDS Diagnosis List and the MD□s Recertification Assessment every 90 days to ensure accuracy prior to submission. Audits that show discrepancies will be further reviewed to determine accurate Diagnosis Codes with corrections made through consultation with LTC Medical Director and HIM Clinical Documentation Integrity (CDI) Specialist. 3b. RAI Coordinator will report discrepancies to the LTC DON and report findings from audit monthly. 4. LTC DON or designee will report findings from quarterly audits to HPIC for the next three consecutive meetings and/or until 100% compliance is achieved.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		11/11/22

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F 656	Continued From page 2	F 656		

§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 local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care

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F 656	Continued From page 3 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 observation, interview, and record review, the facility failed to develop and implement a Comprehensive Care Plan (CP) for two residents (Residents 20 and 16) in the sample. Resident (R)20's CP did not include resident-specific behavior monitoring for impulse control, nor did it include monitoring for signs of tardive dyskinesia (a condition affecting the nervous system causing repetitive, involuntary movements, such as grimacing, tongue thrusting, and eye blinking), despite being treated for both conditions. R16 did not have any careplans to implement that would drive his/her person-centered care to meet goals and preferences and address psychosocial issues that could affect him/her in contact isolation, activities other than watching television, dental issues, unnecessary medications and more. As a result of these deficient practices, both R20 and R16 were placed at risk for a decline in their quality of life and were prevented from attaining their highest practicable well-being. This deficient practice has the potential to affect all the residents at the facility. Findings include: 1) Resident (R)20 is a 45-year-old admitted to the facility on 08/17/21 for long-term care. R20's diagnoses include: anaplastic oligodendroglioma (a rare cancerous tumor) of the frontal lobe, seizure disorder, choreoathetosis (a movement disorder that causes involuntary twitching or	F 656	Comprehensive Care Plan Resident 20: 1. The care plan was immediately entered on 9/30/22 for R20 with specific tasks to address monitoring for symptoms of tardive dyskinesia (increased tremors and uncontrolled movements of jaw and tongue) and also monitoring for Depakote side effects (inappropriate touching and increased hyperactivity). 2a. This deficient practice has the potential to affect all residents at the facility who are on medications/ treatments requiring symptom/side effect monitoring. 2b. Education was completed with the licensed LTC nursing staff to address including targeted behavior monitoring in the Care Plans. 2c. Education was also provided to LTC nursing staff on the follow-up necessary to address any uncontrolled symptoms/side effects by notifying the Charge Nurse, LTC DON and Physician. 3a. LTC DON or designee will audit all current residents with behaviors to ensure documentation of targeted behavior monitoring is included in their Care Plans. Care Plans will be updated if any deficiencies are found.	

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F 656	Continued From page 4 writhing), and impulse control disorder. On 09/27/22 at 11:31 AM, R20 was observed sitting up in bed feeding herself lunch. Repetitive and involuntary head and mouth movements observed, frequent grimacing, but R20 was able to effectively chew and swallow her food. On 09/28/22 at 01:26 PM, R20 was observed wandering in and out of her room and in and out of the Station 2 entrance. Staff seemed used to R20 walking around unmonitored and no redirection of R20 was observed. R20 was observed with repetitive and involuntary head movements, eye blinking, and tongue thrusting. On 09/30/22 at 09:53 AM, during a review of R20's electronic health record (EHR), a Neurological IPOC (individual plan of care) and a Behavioral Symptoms IPOC were noted. A review of the Neurological IPOC revealed the following: "Outcomes ... No Avoidable Complications from Neurological Disease ... Interventions ... Evaluate ... Neurological Signs ... Judgement ...Med [medication]: Depakote [used for impulse control] ... Vimpat [used to prevent and control seizures] ..." There were no specific examples of complications, neurological signs, judgement, or side effects of medications to monitor for. A review of the Behavioral Symptoms IPOC revealed the following: "Interventions ... Evaluate Usual Time, Duration, and Frequency of Behaviors ... Evaluate	F 656	3b. LTC DON or designee will monitor and audit all new Care Plans to ensure that they include resident specific behaviors, side effects of medication to monitor for and desired outcomes. 4. LTC DON or designee will report findings from Care Plan audits to HPIC for 3 consecutive meetings. Resident 16 1a. Upon notification that Care Plans were discontinued inadvertently when level of care changed, Care Plans were re-entered for this resident into the EMR. 2a. All residents who change level of care during their stay have the potential to be impacted by this deficient practice. 2b. Staff re-educated to verify that Care Plans are in place for every resident. Re-education included on how to renew, enter, modify, and discontinue Care Plans. 2c. Night shift staff is assigned to review Care Plans daily on all residents monitoring for completeness. LTC DON re-educated all night shift staff on importance of reviewing that Care Plans are individualized and accurate for each resident. 3a. RAI Coordinator will verify that Care Plans have been entered into the EMR for each resident upon admission and on any	

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F 656	Continued From page 5 Medications for Desired and Adverse Outcomes ...Administer Seroquel [an antipsychotic], Depakote as order ..." There were no specific examples of behaviors, desired or adverse outcomes, or side effects of medications to monitor for. A review of a Psych [Psychiatric] Consult Note, dated 07/29/22, revealed the following: " ... had previously been treated with neuroleptics [antipsychotics] which cause severe TD [tardive dyskinesia] that has been mitigated with starting Ingrezza ... mild tardive tongue protruding movements ... consider uptitration of ingrezza [sic] ... to further improve tardive dyskinesia ..." On 09/30/22 at 10:59 AM, an interview was done with the Director of Nursing (DON) at Station 2. During a concurrent review of R20's CP, the DON agreed that the CP should include specific behaviors to monitor for as targeted behaviors are resident-specific. The DON then confirmed that there was no IPOC or task list to monitor for signs of worsening or improving TD. The DON agreed that without that there was no effective and consistent way to tell if the medication targeting TD should be increased. 2) Resident 16 (R)16 is an 71 year old male who has a history of depression, bipolarism and paraplegia. Observation and concurrent interview with R16 on 09/27/22 at 12:30 PM was done. R16 resides in a contact isolation room. R16's Television (TV) is on but R16 is looking up to the ceiling. Interview with R16 who stated that he can't get up because it hurt him when they tried to get him up in the chair and used the sling. I am refusing to go into	F 656	level of care change. 3b. Inter-Disciplinary-Group (IDG) will review and discuss any episodic Care Plans three times per week. 3c. LTC DON or designee to monitor and audit that Care Plans are updated and accurate weekly. Audit will be documented on the Care Plan Spreadsheet. 4. DON or designee will report findings from quarterly audits to HPIC for the next three consecutive meetings and biannually thereafter.	

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F 656	Continued From page 6 the sling. Observation of a special chair with pillows on chair in room. Light is turned off. Surveyor noted a heap of things lying on the table to the left of the head of the bed. Observation and concurrent interview with R16 done on 09/28/22 at 3:26 PM. R16 stated that he had not been up in a while. He was concerned about his teeth and getting dentures. TV was on. R16 is supine. R16 denied having any skin breakdown. R 16 stated he was depressed and wanted something from his things on the side table instead of watching TV. Resident stated that he has been in isolation for one month. Record review was done on 09/29/22 at 09:49 AM revealed that resident had no careplans on his current electronic record. Interview with Director of Nursing (DON) and Registered Nurse (RN)1 was done on 09/29/22 @ 11:20 AM . Queried if there were any care plans for R16. After searching DON and RN1 stated that their were no care plans that had carried on from his previous record.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657		11/11/22

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F 657	Continued From page 7 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to update and revise Resident (R)22's care plan in a timely manner. This deficient practice influences the decision making about the resident's care and can affect R22's psychosocial and physical well-being. Findings include: Observation was made on 09/28/22 at 09:45 AM for R22. R22 was in bed with lights off. Activities noted in hallway with other residents who are participating in music. Surveyor greeted R22 and resident was in his room with his eyes closed and peeped out at surveyor. After saying hello, R22 stated "I'm sorry, I'm sorry". Observation on 09/29/22 at 08:09 AM - R22 in bed, lights off, television on and R22 did not respond to surveyor's greeting. R22 was peeping	F 657	Resident (22) 1. Nursing staff caring for R22 updated the care plan on 9/29/22 to reflect that the resident□s wife passed away and her date of passing. 2. All residents who have Care Plan changes during their stay have the potential to be impacted by this deficient practice. 2b. LTC licensed staff were re-educated on the need to revise and/or update Care Plans when changes occur in a timely manner. 3a. Inter-Disciplinary-Group (IDG) will review Care Plans three times per week to make sure that are changes are addressing. 3b. RAI Coordinator to monitor and audit	

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F 657	Continued From page 8 at surveyor. Observation at 09/29/22 at 1:35 PM from Nursing station is a straight view to R22's bed. R22 was in bed from 08:00 AM till 03:30 PM. Interview was done of family member (FM) for R22 on 09/29/22 at 3:30 PM. FM stated that "My mom was in the facility and passed away this month". Record review (RR) was done of the Minimum Data Set (MDS) dated 07/29/22 on 09/29/22 at 3:30 PM. MDS noted a significant change recognizing that the resident was slowly declining. Further RR was done of the care plan which stated Spends most of the day in the room, watching TV; enjoys UH sports, talks story about fishing; I am so happy that my wife is now here; we eat together in my room for dinner; help me to facetime my family outside of my room along with my wife; using a headset with the IPAD so I don't bother my roommate. Family is important. Interview was done on 09/29/22 at 3:30 with RN2 regarding R22's care plan. Care plan had not been updated or revised to reflect the death of R22's wife.	F 657	that Care Plans are updated and accurate. Audit will be documented on the Care Plan Spreadsheet with findings reported to LTC DON. 4. LTC DON or designee will report findings from quarterly audits to HPIC for the next three consecutive meetings and/or until 100% compliance is achieved.	
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities,	F 679		11/11/22

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F 679	Continued From page 9 designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to provide an ongoing program to support residents' choices in activities for two (residents)R16 and R22. This deficient practice has the potential to affect the physical, mental, and psychosocial well-being of these two residents and residents who are not able to participate in activities outside of their rooms. Findings include: 1) Observation was made on 09/28/22 at 09:45 AM for R22. R22 was in bed with lights off. Activities noted in hallway with other residents who are participating in music. Surveyor greeted R22 and resident was in his room with his eyes closed and peeped out at surveyor. After saying hello, R22 stated "I'm sorry, I'm sorry". (Ref F657) Observation was done on 09/28/22 at 3:09 PM. R22 was lying in bed. Recreational aide (RA)1was observed to walk by R22's room with a quick glance into R22's room and continued to walk down the hall. Observation on 09/29/22 at 08:09 AM - R22 in bed, lights off, television on and R22 did not respond to surveyor's greeting although R22 was peeping at surveyor. (Ref 657) Observation at 09/29/22 at 1:35 PM from Nursing station is a straightview to R22's bed. R22 was in	F 679	R16 1a. Recreational Aide (RA) saw R16 on 9/30/22 to readdress activity interests. 1a. RA worked with R16 to identify activities he enjoys including: - Read daily newspaper staff were able to obtain reading glasses for him. - Listen to music assist him with music selection and listening devices, ensure he is included in music therapy events. - Socialization staff are spending longer periods of time in his room talking story and assisting with organizing the clutter in his room under his direction. - Art Therapy R16 is very motivated and excited about making a picture collage for his room from pictures that he currently keeps in a suitcase in his room. Staff will assist him. 1b. The care plan has been updated to include more resident specific activities. 2a. All residents who are unable to freely choose and participate in activities have the potential to be impacted by this deficient practice. 2b. Education was provided to the RAs on ways to address 1:1 activities for residents that are bedbound or unwilling to attend group activities. 2c. Education also provided on ways to engage residents even if it appears they	

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F 679	Continued From page 10 bed from 08:00 AM till 03:30 PM. (Ref 657) Interview with RA1 was done on 09/29/22 at 3:30 PM. Interview with RA1 who was queried regarding what activities are offered to R22 who does not come out of his/her room and stays in bed all day? RA1 stated that "I don't go into his room because he is always sleeping. I see him sleeping and I don't go in. Surveyor shared that on encounters during this week, it was noted that R22 appears to be sleeping but greeted surveyor and keeps his/her eyes closed upon greeting, as if to peep who is there. RA1 stated that she will go in and talk with R22. He knows my name. 2)Observation and concurrent interview with R16 on 09/27/22 at 12:30 PM was done. R16 resides in a contact isolation room. R16's Television (TV) is on but R16 is looking up to the ceiling. Interview with R16 who stated that he can't get up because it hurt him when they tried to get him up in the chair and used the sling. I am refusing to go into the sling. Observation of a special chair with pillows on chair in room. Light is turned off. Surveyor noted a heap of things lying on the table to the left side of the head of the bed. (REF 656) Observation and concurrent interview with R16 done on 09/28/22 at 3:26 PM. R16 stated that he had not been up in a while. He was concerned about his teeth and getting dentures. TV was on. R16 is supine. R16 denied having any skin breakdown. R 16 stated he was depressed and wanted something from his things on the side table instead of watching TV. Resident stated that he has been in isolation for one month. Interview was done on 09/29/22 at 11:15 AM with	F 679	are sleeping or disinterested. 2d. RA and nursing staff discussed ways that nursing can assist RA with getting residents up during activity time to encourage them to come out of room and participate. 3a. A new 1:1 Recreational Tracking Log was created to document 1:1 activities offered to residents and their participation in these activities. Education was provided to staff on how to utilize the form. 3b. Activity Coordinator (AC) to review 1:1 Recreational Tracking Log weekly to monitor activity participation by bedbound residents/those unwilling to attend group activities and share findings with Interdisciplinary Group. 3c. Care Plan will be updated to reflect activity preference and include interventions when lack of participation has been identified. 4. AC to report the findings from the 1:1 Recreational Tracking Log to HPIC for 3 consecutive meetings and then biannually thereafter. R22 1a. RA saw R22 on 9/30/22 to readdress activity interests. 1b. Care Plan was updated for R22 to reflect more resident specific activity interests, as well as, activities to encourage resident to get up out of bed and attend the activity program at least 3-5X a week. RAs will work to engage R22 in activities of his interest to improve his quality of life. Family is being	

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F 679	Continued From page 11 Recreational Aide (RA)1. Queried RA1what type of activities were being provided from the Recreational Therapy Department for R16. RA1stated that "We just deliver the paper to him in the afternoons and say hi". We don't usually spend time in his room, just drop off. Surveyor stated to RA1 that R16 had stated that he wanted to reach some of his belongings on the side table, including his computer. RA1 stated that she did not spend time in his room. Interview with social worker (SW) on 09/29/22 at 11:19 AM who stated that she has not seen R16 for a long time. SW stated that she will be revisiting R16 and is trying to get a DVD player for R16. RR and concurrent interview with DON and RN1 was done on 09/29/22 at 11:20 AM. Queried regarding activity careplan for R22. No care plan for activity was available. RN3 stated there was no care plan for R22.	F 679	encourage to visit more frequently. 2a. All residents who are unable to freely choose and participate in activities have the potential to be impacted by this deficient practice. 2b. Education was provided to the RAs on ways to address 1:1 activities for residents that are bedbound or unwilling to attend group activities and also while up in wheelchair. 2c. Education also provided on ways to engage residents even if it appears they are sleeping or disinterested. 2d. RA and nursing staff discussed ways that nursing can assist RA with getting residents up during activity time to encourage them to come out of room and participate. 3a. A new 1:1 Recreational Tracking Log was created to document 1:1 activities offered to residents and their participation in these activities. Education was provided to staff on how to utilize the form. 3b. Activity Coordinator (AC) to review 1:1 Recreational Tracking Log weekly to monitor activity participation by bedbound residents/those unwilling to attend group activities and share findings with Interdisciplinary Group. 3c. Care Plan will be updated to reflect activity preference and include interventions when lack of participation has been identified. 4. AC to report the findings from the 1:1 Recreational Tracking Log to HPIC for 3 consecutive meetings and then biannually	

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F 679	Continued From page 12	F 679	thereafter.	
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the	F 883		11/11/22

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F 883	Continued From page 13 immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and record review (RR), the facility failed to ensure that all residents who were eligible for the influenza immunization received it and/or that their medical record(s) indicated that the resident (R) or resident's representative(s) were provided education regarding the benefits and potential side effects of influenza immunization. Coupled with advanced age and chronic conditions, this deficient practice made three of seven residents sampled vulnerable to the influenza virus and placed them at risk of developing flu-related complications such as pneumonia. This deficient practice has the potential to affect all residents at the facility. Findings include: 1) On 09/29/22 at 08:44 AM, an influenza immunization review was done for Resident	F 883	Flu Immunizations 1. Contacted the families/POA to update them on the flu vaccination information and to obtain consent. Documented consent in the EMR and in the spreadsheet for tracking. Vaccine Information Sheets were mailed to families and or POAs and provided to residents. Documentation of education completed in the EMR. 2a. All residents have the potential to be affected by this deficient practice. 2b. Education provided to staff to ensure that we document that education was provided to resident, their families and/or POA concerning Flu Vaccination in the EMR. Nurses instructed to document date of refusal if it occurs. Nursing also	

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F 883	Continued From page 14 (R)30. The resident's electronic health record (EHR) was reviewed for documentation that the resident was offered, provided education regarding the benefits and potential side effects of influenza immunization, and either received or refused it. R30 is a 58-year-old female admitted to the facility on 07/07/20. Review of R30's EHR revealed that although she was offered and refused the influenza immunization in the past year, there was no documentation found that R30, either directly or through her representative, had been provided education regarding the immunization. On 09/29/22 at 02:20 PM, the Director of Nursing (DON) provided an influenza declination signed by R30 on 10/10/20, and an Influenza Vaccine Information Summary (VIS), also signed by R30 on 10/10/20, that clearly documented the provision of education she received at that time. The DON confirmed that similar documentation could not be found for 2021. A review of the facility's Influenza and Pneumococcal Prevention Plan, last revised 04/11/22, revealed the following: "III. Procedure: ... B. Nursing Facility Residents: ... 1. Influenza Vaccination ... c. All residents offered vaccination will be given a copy of the applicable Vaccination [sic]Information Summary (VIS) (see Attachment B) for signing after a verbal explanation of the	F 883	educated that we must re-offer vaccination within 5 days and if refusal continues, we will re-educate and offer monthly during Flu season. 3. LTC DON or designee will monitor and audit the charts for compliance with documentation that the vaccine information sheets were provided and consent received or refusal made on the Vaccination spreadsheet. This data will be collected monthly during flu season. 4. LTC DON or designee will report findings from monthly audits during Flu season to HPIC for the next three consecutive meetings.	

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risks and benefits and a copy of the signed VIS shall be placed in the medical record."

2) On 09/29/22 at 03:04 PM, the sample was expanded to include two closed record influenza immunization reviews (for R52 and R104).

R52 was a 75-year-old male admitted to the facility on 04/27/12. On 09/29/22 at 03:04 PM, the facility was asked to produce documentation regarding R52's influenza immunization status for 2021.

On 09/30/22 at 07:58 AM, the DON stated that after her review of R52's medical record, she found that although he was offered and refused the influenza immunization several times in the past year, there was no documentation that R52, either directly or through his representative, had been provided education regarding the immunization. The DON also confirmed that there was no signed Influenza VIS form for 2021 found.

3) R104 was a 92-year-old male admitted to the facility on 04/08/19. On 09/29/22 at 03:04 PM, the facility was asked to produce documentation regarding R104's influenza immunization status for 2021.

On 09/30/22 at 07:58 AM, the DON stated that after her review of R104's medical record, she could find no documentation that R104 had been offered the influenza vaccine or provided education, either directly or through his representative, regarding the immunization. The DON also confirmed that there was no signed Influenza VIS form for 2021 found.

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F 887	Continued From page 16	F 887		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and	F 887		11/11/22

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F 887	Continued From page 17 (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and record review (RR), the facility failed to ensure that 3 of 7 residents who were eligible for the COVID-19 vaccination received it and/or that their medical record(s) documented that they were provided education regarding the potential benefits and potential risks associated with COVID-19 vaccination. Coupled with advanced age and chronic conditions, this deficient practice placed these residents at an increased risk of developing a COVID-19 infection. This deficient practice has the potential to affect all residents at the facility.	F 887	Covid Vaccination 1. Contacted the families or POA to update on COVID vaccination information and to obtain consent. Documented consent in the EMR and in the spreadsheet for tracking. Vaccine Information Sheets were mailed to families and or POAs and provided to residents. Documentation of education completed in the EMR. 2a. All residents have the potential to be affected by this deficient practice.	

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F 887	Continued From page 18 Findings include: 1) On 09/29/22 at 08:44 AM, a COVID-19 vaccination review was done for the following residents: Resident (R)30, R6, and R12. The residents' electronic health records (EHRs) were reviewed for documentation that they were offered the COVID-19 vaccine, provided education regarding the benefits, risks, and potential side effects of the vaccination, and either received or refused it. R30 is a 58-year-old female admitted to the facility on 07/07/20. Review of R30's EHR revealed that although she was offered and refused the COVID-19 vaccination, there was little to no documentation found that R30, either directly or through her representative, had been provided education regarding the vaccination. On 09/29/22 at 02:20 PM, the Director of Nursing (DON) provided a COVID-19 Vaccination FAQs [frequently asked questions] document signed by R30 on 06/08/21 that indicated her refusal. The document is a facility form that lists six (6) common side effects of the vaccine, however, does not describe the potential benefits and risks of vaccination. On 09/30/22 at 07:58 AM, the DON provided documentation via a Nursing Narrative Note, dated 12/30/20, that R30 had refused the offer of COVID-19 vaccination (which had been verbally consented to by her resident representative on 12/23/20). There was no documentation of the provision of education provided to either R30 or her representative on either date. The DON confirmed that a review of R30's medical record produced no other documentation of the	F 887	2b. Education provided to staff to ensure that we document in the EMR that education was provided to resident, their families and/or POA concerning COVID Vaccination. Nurses instructed to document date of refusal if it occurs. 3. LTC DON or designee will monitor and audit the charts for compliance with documentation that the Vaccine Information Sheets were provided and that consent was received or refused made on the Vaccination Spreadsheet. This data will be collected quarterly. 4. LTC DON or designee will report findings from quarterly audits to HPIC for the next three consecutive meetings and/or until 100% compliance is achieved.	

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F 887	Continued From page 19	F 887		

COVID-19 vaccine being offered to R30, either directly or through her representative.

2) R6 is a 99-year-old female admitted to the facility on 06/27/17. Review of R6's EHR revealed that although she had accepted the initial two vaccinations of a 2-part series, and was offered and refused two booster shots, there was no documentation found that R6 had been provided education regarding the benefits/risks of the boosters.

On 09/30/22 at 07:58 AM, the DON provided documentation via a Nursing Narrative Note, dated 09/15/22, that R6 had refused the offer of a COVID-19 booster. There was no documentation of what the provision of education provided to R6 was. The DON confirmed that a review of R6's medical record produced no other documentation of the COVID-19 boosters being offered to R6, either directly or through her representative.

3) R12 is an 87-year-old female admitted to the facility on 01/24/20. Review of R12's EHR revealed that although she had accepted the initial two vaccinations of a 2-part series, and was offered and refused the first booster, there was no documentation found that R12 had been provided education regarding the benefits/risks of the booster or had been offered a second booster.

On 09/30/22 at 07:58 AM, the DON provided documentation via a Nursing Narrative Note, dated 11/04/21, that R12 had refused an offer of a COVID-19 booster. There was no documentation of what the provision of education provided to R12 was. The DON confirmed that a review of R12's medical record produced no other

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F 887	Continued From page 20 documentation of the COVID-19 booster being offered to R12, either directly or through her representative.	F 887		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and review of policy the facility failed to secure the Biohazard Room located in the hallway near Nurse Station 2. As a result of this deficiency, the facility put the safety and well-being of the residents of exposure to potentially infectious materials and infectious isolation waste. Findings include: On 09/27/22 at 11:30 AM, the Biohazard Room near Nurse Station 2 was not secured and several surveyors were able to open the door and enter the room. A keypad lock was installed on the door, but the door was still not secured. The room contained two Biohazard bags of material, a gallon of Neutral Disinfectant Cleaner, one waste container, one basket, and a stair step device. During an observation on 09/27/22 at 01:00 PM, several residents were seen walking by the Biohazard Room with no staff in the immediate vicinity to prevent the residents from entering the room. During staff interview on 09/27/22 at 02:55 PM,	F 921	1a. The biohazard door that was found to be unlocked by the surveyor on 9/27/22 at 11:30am was immediately locked to ensure the safety of the residents and staff. 1b. Biohazard door was then checked daily by the EVS supervisor to ensure it continued to stay locked. 1c. Immediately following the verbal notification of the citation, the Regional Safety Officer sent an email to all staff reminding them of the policy that biohazard doors must be kept locked to help prevent the occurrence of infection within the hospital. 2a All Residents that are able to walk independently have the potential to be affected by this deficient practice. 2b. To ensure that this does not happen again, a log has been created by the Regional Safety Officer and sent to the LTC DON and the EVS Supervisor. This log is a daily door check that will be spot checked at different times/shifts to ensure the door is always secured.	11/11/22

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SAMUEL MAHELONA MEMORIAL HOSPITAL	4800 KAWAIHAU ROAD KAPAA, HI 96746

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F 921	Continued From page 21 Assistant Director of Nursing acknowledged that the Biohazard Room door should have been secured and always kept secured to prevent resident and/or visitor entry. Review of facility policy on Collection, Storage and Disposal of Regulated Waste read the following: Purpose, to prevent the occurrence of infection within the hospital by providing an organized management system for the collection, storage and disposal of regulate waste, potentially infectious materials, and infectious isolation waste. Policy, a regulated waste, potentially infectious materials, and infectious isolation waste must be placed in a red biohazard bag and removed from the patient area to a biohazard labeled receptacles located in a designated locked storage room ... Procedure, each nursing unit will have a designated storage area, which is identified with a biohazard sign, and shall remain locked at all times.	F 921	2c. Initially, to ensure that the door remained locked at all times, the inside latch was removed from the lock so that staff could not set the door to remain unlocked. 2d. A fire resistant lock, which does not have the ability to be unlocked, was installed on 10/19/22 to replace the door lock. 3a. The review of General Safety Policy 122-02-05 and Collection, Storage, and Disposal of Regulated Waste Policy 125-13/122-04-10 were assigned to all LTC and EVS staff through Relias (Learning Management System) to record review and attestation of understanding. Both policies mention that biohazard doors must be locked at all times. 3b. Biohazard Door Check Log implemented to track the daily audits. The audits will be done on different shifts each day by either the Regional Safety Officer, EVS Supervisor, of the Charge Nurse. 4. Findings from monthly audits will be reported to HPIC for next 3 consecutive meetings.	