STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	**919 LEHUA AVENUE** **PEARL CITY, HI 96782**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 06/14/22 through 06/17/22. The facility was found not to be in substantial compliance with 42 CFR §483, Subpart B. Two facility-reported incidents (ACTS #9420 and #9327) were investigated during the survey. ACTS #9420 was substantiated at F609 Reporting of Alleged Violations, and ACTS #9327 was unsubstantiated. Survey Dates: 06/14/22 - 06/17/22 Survey Census: 69 Sample Size: 17	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550		8/12/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 07/21/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to protect Resident (R)41's dignity by ensuring her catheter bag (urine collection bag) was covered and not visible. This deficient practice has the potential to affect all residents in the facility who have urinary catheters. Findings Include: On 06/14/22 at 11:56 AM observed on the side of R41's bed, an uncovered catheter bag, halfway filled with urine, visible from outside of her room. Observed R41's dignity bag (used to cover the catheter bag) on top of her wheelchair seat. The wheelchair was placed on the side of R41's bed.	F 550	On 06/17/22, the urinary drainage bag was placed in a vanity cover to be used on the wheelchair when the resident is being transported within or out of the facility, and at bedside. Staff was trained at bedside on initial use of the vanity cover. The staff will be educated by the staff educator on the use of the bag, how and when to sanitize, and placement of the bag by 8/12/22. All other residents were assessed for similar situations. Five (5) other residents were found to have drainage bags that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 On 06/14/22 at 12:02 PM concurrent observation and interview with Registered Nurse (RN) 1 was done. Inquired with RN1, from outside of R41's room door, if R41 has a dignity bag and if her catheter bag should be covered, observed RN1 looking into the room and comment it was not on. RN1 stated she did not know if the dignity bag should be covering the catheter bag at all times and proceeded to go into R41's room to look for R41's dignity bag. On 06/16/22 at 10:06 AM interview with Training Coordinator (TC) was done. TC confirmed catheter bags should be covered at all times.	F 550	were not properly covered to preserve resident dignity. Those residents were issued similar vanity bags to be used. New admissions and current residents who have introduced foley, or similar bags, will be issued a vanity cover for their drainage bag. Bi-weekly audits will be conducted by the Director of Nursing or designee to ensure foley bags are covered to preserve resident dignity. This will be done for 3 months, and reported at the next quarterly QA/QI Committee meeting. If the deficient practice continues, the audit will be continued for an additional quarter.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		7/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 3 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a homelike environment for residents that minimized institutional practices, as evidenced by the unnecessary use of disposable meal containers and trays for the residents on the second floor. This deficient practice affected all residents at the facility on the second floor. Findings include: On 06/14/22 at 08:54 AM, observations were done on the second floor of the facility. When stepping off the elevator, it was immediately visible that there was a large metal meal cart, a 10-gallon trash can, and a large clear trash bag filled with disposable meal trays sitting next to the	F 584	The use of regular tableware was re-instituted on the floor with no active COVID-19 cases (red zones). The use of disposables will be left for only emergency/disaster events. Since this practice affected all residents on the same floor, no additional discovery was necessary. The Food Service Department reviewed their policies and practices. The Infection Control consultant met with the Food Service Department to review proper infection control procedures on July 19, 2022. They were educated on the correct	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE, PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 4 Nurses' Station. Surrounding the Nurses' Station in the hallway were eight (8) female residents, in various stages of completing breakfast. The few residents who were still eating breakfast were observed to be eating from disposable containers and trays, using disposable utensils. On 06/14/22 at 12:24 PM, while observing lunch pass on the second floor, it was noted that all the residents' meals arrived on disposable trays with disposable containers and utensils. As residents completed their meals, the containers and trays were collected in a large clear trash bag next to the Nurses' Station. On 06/16/22 at 09:15 AM, an interview was done with the Training Coordinator (TC) next to the second-floor Nurses' Station. The TC stated that the facility had identified a COVID-positive resident on the fourth floor on 06/08/22, and as a result had quarantined that entire floor and were using disposable containers for their meals. When asked about the disposable containers being used on the second floor as well, the TC stated she had "no idea" why the second floor was started on or still had disposable containers for meals. She stated, "I told ... [the lead cook], second floor don't need that."	F 584	usage and handling of used disposable tableware/utensils/containers and placement of trash bins. The Food Services Manager or designee will audit random meal times to ensure proper tableware is being used. This audit will be done for breakfast, lunch, and dinner weekly for three months and results reported to the quarterly QA/QI Committee meeting. If deficient practice continues, re-education will occur with audits continuing until next quarterly QA/QI Committee meeting.	
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not	F 604		8/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 5 required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with family and staff members, the facility failed to ensure one of five residents (Resident (R) 26) sampled was free from physical restraints imposed for the purpose of convenience and not required to treat the resident's medical symptoms, as evidenced by R26 placed between a table and column, restricting her from standing up or leaving; R26 positioned in bed to prevent her from getting up; and the use of bed rails on R26's bed. The deficient practice has the potential to affect all residents at the facility from ensuring they are free from physical restraints not required to treat	F 604	The resident has been relocated to a no-barrier location while in the activity/dining room. The activity care plan has been updated on 7/14/22 to address resident's interests and areas for participation. Resident's position in bed was corrected to only 30 degrees at the head, and pillows under the resident's feet and/or 10 - 15 degrees elevated. (6/24/22) Resident's bed rails are being assessed for necessity and safety, and a trial with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	**919 LEHUA AVENUE PEARL CITY, HI 96782**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 604

Continued From page 6

medical symptoms.

Findings Include:

R26 was admitted to the facility on 07/23/21 with diagnoses not limited to displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, unspecified dementia without behavioral disturbance, pain in right hip, cognitive communication deficit, muscle wasting and atrophy not elsewhere classified right thigh, muscle weakness, difficulty in walking not elsewhere classified.

On 06/14/22 at 09:20 AM observed R26 sleeping in her bed. R26 had full-size bed rails on both sides of her bed and her bed was positioned with her head and feet both higher than her hips at an approximate 30-degree angle. The bottom of R26's bed was not positioned to bend at the knee but straight up to an approximate 30-degree angle.

On 06/14/22 at 09:57 AM observed R26 in the dining room for activities. R26 was observed sitting in her wheelchair and placed between a column (behind her), on the wall closest to the window, and the dining room table (in front of her). R26's leg rests attached to her wheelchair were up. From 09:57 AM to 11:28 AM, between interactions with staff members, observed R26 use her arms to push away from the table in front of her without success due to the column behind her and wall to the left of her restricting her movement. At 10:03 AM observed R26 attempt to stand up from her wheelchair but was unable to move due to the raised leg rests and the table in front of her.

F 604

foam noodles on both sides is being conducted.

All other residents were assessed. No other residents were placed against table with back barrier. No further residents placed in beds with excessive angles. (6/24/22)

Investigation was done on all residents for appropriate use of restraints, permissions, medical indications, assessment on admission, quarterly, and annually, less restrictive techniques, care plans, and care plan reviews. For those missing any required documents, nursing to complete. (6/24/22)

Nursing will develop personalized care plans and routines for residents who display behaviors.

Staff will be in-serviced on restraints by 8/12/22. Policies and procedures will be reviewed to ensure appropriate usage.

At Care Conferences, or interdisciplinary team meetings, staff will review appropriate use of restraints, including less restrictive methods, consent, necessity and physician orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	**919 LEHUA AVENUE PEARL CITY, HI 96782**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 7	F 604		

Further observations of R26, placed between the column and table in the dining room with restrictions of movement from standing up and pushing away from the dining room table were done on 06/14/22 at 03:34 PM during activities, on 06/15/22 from 12:01 PM to 12:22 PM during lunch (at 12:10 PM and 12:19 PM observed R26 attempt to stand up) and on 06/16/22 at 01:13 PM.

On 06/14/22 at 02:08 PM interview with Family Member (FM) 1 was done. FM1 reported on 12/22/21 another family member, FM2, went to visit R26 and reported she found R26 restrained to her bed, she was struggling and unable to get out of bed. FM1 stated she did not witness it herself but called the facility the next day to inquire what FM2 reported to her. FM1 reported a nursing staff informed her R26 has a hard time sleeping at night and is restless, she tends to get out of bed. FM1 reported nursing staff explained the restraint use was standard practice and is also using bed rails to prevent R26 from falls. FM2 stated she is R26's representative and did not sign a consent for any restraint or bed rail use.

On 06/15/22 at 01:14 PM interview with FM2 was done. FM2 stated she visited R26 in December 2021 after 04:00 PM and found R26 restrained to her bed. FM2 described a short cord attached to the back of R26 and reportedly observed R26 trying to get out of bed but was unsuccessful. FM2 stated it was not the bed alarm because the next visit she had with R26, R26 had a bed alarm. FM2 was not able to recall further details of the incident and stated she did not talk to staff about it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 8	F 604		

On 06/16/22 at 08:13 AM observed R26 sleeping in her bed and R26's full-size bed rails up on both sides. R26's bed was positioned with her head and feet both higher than her hips. R26's head was at an approximate 30-degree angle and the bottom of R26's bed was not positioned to bend at the knee but straight up to an approximate 20-degree angle.

On 06/16/22 at 08:20 AM concurrent observation of R26 and interview with Certified Nursing Aide (CNA) 3 was done in R26's room. Inquired with CNA3 regarding the position of R26's bed, CNA3 stated it is due to R26 having leg pain and because " ...when she is awake, she tries to get out of bed ..." CNA3 confirmed it is to prevent R26 from getting up.

On 06/16/22 at 01:16 PM concurrent observation of R26 and interview with Activities Assistant (AA) 1 was done in the dining room. Inquired about R26's leg rests on her wheelchair positioned up while sitting at a 90 degree angle, AA1 was not able to explain the reason for R26's leg rests positioned up and stated she sometimes puts the leg rests down. AA1 confirmed R26 attempts to stand up while sitting in the wheelchair. Further inquired with AA1 about R26's placement at the dining room between the column and table, AA1 stated it is because R26 moves a lot.

On 06/16/22 at 01:26 PM interview with Registered Nurse (RN) 1 was done. Inquired with RN1 regarding the full-size bed rails and observed positioning of R26 in bed, RN1 stated R26 sometimes has behaviors at night and rolls in her bed. RN1 confirmed R26 has no medical diagnosis or reason for her legs to be elevated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	**919 LEHUA AVENUE PEARL CITY, HI 96782**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 9	F 604		

Continued From page 9

On 06/16/22 at 02:15 PM concurrent review of R26's Electronic Health Record (EHR) and interview with Director of Nursing (DON) was done. DON stated the facility had started making a list of residents identified with bed rail restraints and identified R26 as one of the residents. DON further stated the facility's goal is to stay away from restraints that are not necessary. Concurrent review of R26's EHR with DON, DON confirmed R26 does not have a medical symptom or a medical necessity requiring the use of bed rails, does not have physician orders for bed rail use and the facility does not have a signed consent to use bed rails from the resident or resident representative. Inquired about R26's bed position observed on 06/14/22 and 06/16/22, DON stated there is " ...no medical reasons for her legs to be elevated ...it could be a reason to restrain someone to try to get out of bed." Inquired with DON what was observed in the dining room on 06/14/22 and 06/16/22 and R26's placement, DON stated R26's placement between the column and table could be considered a restraint if she is trying to get out of the area and unable to. DON further explained when a resident is in a wheelchair and it is parked, the legs rests should be put down, the leg rests positioned up " ...is restricting her movement." DON further stated, although R26 has poor safety awareness she can walk using a walker and wheel herself in the wheelchair.

Review of the facility's policy and procedure "Physical Restraints" revised on 05/2010 documents "Restraints are used only when necessary under limited medical circumstances or symptoms to prevent injury to the resident and/or to others. The decision to apply restraints

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	**919 LEHUA AVENUE PEARL CITY, HI 96782**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 10 shall be based on a comprehensive assessment and care planning which shall include assessment of the resident's capabilities, causes of behavior, evaluation of least restrictive alternatives, and ruling out of restrain use. The resident shall participate in the care planning and the right to refuse/accept restraint use shall be addressed by informed consent. Restraints may not be applied for the purpose of discipline or staff convenience. The attending physician must order restraints for a specified and limited period of time."	F 604		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609		7/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 11 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of the facility's policy and procedures and staff interview, the facility failed to immediately report allegation of abuse, including injury of an unknown source, to the adult protective services (APS) in accordance with State Law for Resident (R) 219. This deficient practice has the potential to affect all residents with injuries of an unknown source. Findings Include: On 03/29/22 the facility submitted a completed Event Report to the State Agency regarding an injury of unknown source. On 03/23/22 at 12:15 AM, the facility reported R219 "...was found with swelling and yellowish discoloration on her right hip..." X-ray showed an acute displaced intertrochanteric fracture of the proximal femur, fracture to the right hip. The facility's completed investigation documented in the Event Report stated, "Resident with no history of attempting to get out of bed, restlessness, or ability to independently conduct bed mobility, Resident not at risk to fall from bed. All other care, resident total dependent from staff." A review of the facility's "Incident Report" and "Event Report" submitted by the facility found this allegation was not reported to APS. A review of the facility's policy and procedure for abuse and neglect entitled "Investigation of	F 609	The facility was deficient in providing notification to APS for an event that occurred with a resident. APS will be notified of the case by 7/22/22. The facility will comply as required to submit reports to State of Hawaii, Department of Health, Office of Health Care Assurance, and State of Hawaii, Department of Human Services, Adult Protective Services as necessary. Management and staff were reminded on 6/19/22 to send reports to APS regardless of whether abuse has been substantiated or not. The Administrator will be responsible for ensuring that the reports are sent to APS in a timely manner as the Administrator is the last to review all reports before submitting to DOH, OHCA.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING _____ B. WING _____	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	**919 LEHUA AVENUE PEARL CITY, HI 96782**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 12 Alleged Violations Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source, Unusual Occurrences and Misappropriation of Resident Property", revised on 03/2007, documents "The facility ensures that all alleged violations involving neglect, abuse, injuries of unknown source and misappropriation of resident property, are reported immediately to the Administrator of the facility. Such violations shall also be reported to State agencies in accordance with State Law." On 06/16/22 at 01:44 PM interview with the Director of Nursing (DON) was done. DON confirmed the facility concluded they were unable to determine the cause of R219's right hip fracture. Inquired if the facility reported the incident to APS, DON stated he did not know he had to and "...it would make sense to report to APS too. It's because we don't know the cause of it... it could be considered abuse to the resident."	F 609		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section;	F 623		6/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 13 and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 14 to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 15 relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide proper notification of discharge/transfer to four residents in the sample. Residents (R)31, 2, 41, and 10 were discharged or transferred without receiving written notification of their discharge, their right to appeal the discharge, or contact information for the Office of the State LTC [long-term care] Ombudsman (LTCO). This deficient practice has the potential to affect all residents at the facility who are discharged or transferred. Findings include: 1) Resident (R)31 is a 54-year-old male admitted to the facility on 11/22/2000 for long-term care. During a review of his electronic health records (EHR) on 06/15/22 at 09:00 AM, it was noted that R31 was discharged to an acute care hospital on 03/27/22. There was no discharge notification found in the EHR for this discharge. On 06/16/22 at 02:58 PM, during an interview with the Licensed Social Worker (LSW) in the Conference Room, the LSW confirmed that the facility practice did not include providing written notification to the resident and/or family representative regarding transfers/discharges. 2) On 06/15/22 at 09:00 AM, review of EHR for R2 indicated that R2 was transferred to the hospital emergency department on 05/07/22 for low oxygen saturation and fast heart rate. EHR also indicated that R2's Power of Attorney (POA) was informed of the hospitalization.	F 623	The Social Services Director reviewed residents 31, 2, 41, and 10 and identified that the notice to the Ombudsman's Office about the hospitalization were faxed to the Ombudsman's Office on the date of the transfer or soon thereafter. The facility was negligent in mailing the notice to the responsible parties. The Social Services Director, in consultation with the Administrator, decided that mailing the notices to the responsible parties at this time may confuse them. Effective June 17, 2022, the Ombudsman's Transfer/Discharge Notice and the Notice of Involuntary Discharge have been set in place and all further transfer/discharges from the facility will have the notices mailed to the responsible parties by the Social Services Director. In-services were held by the Social Services Director with the nursing staff on 6/17/22, 6/20/22, 6/21/22, and 6/22/22 to remind them of the facility practice and policy pertaining to the Transfer/Discharge Notice and Notice of Involuntary Discharge, dated 5/31/21. To prevent future missed notices, nursing will include orientation on the notification during their nursing training on the units. The Director of Social Services will track transfer/discharges from the facility to ensure proper notices are mailed out to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 623

Continued From page 16

On 06/17/22 at 10:00 AM, Licensed Social Worker (LSW) stated that the facility did not provide a written notice of transfer to R2 or the POA. LSW also stated that the facility was not aware of this regulation.

Review of the facility's policy and procedure "Transfer/Discharge of a Resident" revised on 04/15/08 documents the Administrator is to provide "A written notice...to the resident and/or responsible party, family member or legal representative in accordance with State and Federal regulations. Unless an emergency exists, notice shall be given at least 30 days in advance of the transfer or discharge."

3) On 06/15/22 at 09:13 AM review of R41's EHR indicated R41 was transferred to the hospital on three occasions, on 02/16/22, 03/04/22, and 03/16/22. On 02/16/22, R41 was hospitalized for eight days due to sepsis Urinary Tract Infection (UTI), discharged on 02/24/22. On 03/04/22, she was hospitalized for four days due to urosepsis, discharged on 03/08/22. On 03/16/22, she was hospitalized for five days due to deep vein thrombosis (DVT) on lower extremity, discharged on 03/21/22.

On 06/17/22, requested the facility to provide copies of the written notification of transfer to the hospital that was provided to R41 or her representative for the three hospitalizations. Licensed Social Worker (LSW) left a signed note to surveyor documenting the facility did not provide written notice of transfer to R41 or her representative for the three hospitalizations.

4) On 06/16/22 at 12:48 PM, a review of R10's

F 623

the Ombudsman' Office and responsible party.

The Social Services Director will log transfer/discharges on the newly created Transfer/Discharge Tracking Form and report results at the quarterly QA/QI Committee meetings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 17 EHR indicated R10 was transferred to the hospital on 04/13/22. R10 was initially transferred to the hospital for a gastrostomy tube replacement but was later admitted for further treatment after R10 was found to have gastrointestinal bleeding. R10 was hospitalized for seven days, and then discharged on 04/20/22. On 06/17/22 at 09:45 AM, Licensed Social Worker (LSW) was interviewed. LSW stated that the facility did not provide a written notice of transfer to R10 or her representative for R10's hospitalization.	F 623		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		8/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	**919 LEHUA AVENUE PEARL CITY, HI 96782**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 18 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 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 observations, record review and interviews, the facility failed to develop and implement comprehensive care plans for: 1) Resident (R) 12's end stage renal disease, depression and 2) R20's nutrition and hydration. As a result of this deficiency, R12 and R20 were not able to attain or maintain their highest practicable physical, mental, and psychosocial well-being. Findings Include: 1) A record review on 06/15/22 of R12's "Discharge Summary" dated 05/10/22, documented that R12 was discharged from the hospital and readmitted to the facility on 05/10/22. R12 was readmitted to the facility after being hospitalized for a cardiac arrest sustained during an offsite hemodialysis session on 04/26/22.	F 656	1) Resident's ESRD and wound care plans were updated and completed on 6/20/22. Resident has since passed away on 7/1/22 prior to the development of the behavior care plan. 1) Audits were performed of current resident care plans by the Director of Nursing and designated licensed nurses. Care plans were checked to ensure they address the resident's medical, physical, mental, and psychosocial needs. 1) Staff will be in-serviced by 8/12/22 on the process of comprehensive care planning for new admissions and current residents. Staff will be also in-serviced on better utilization of the electronic medical records system to process updates, edits,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 19 R12's diagnoses include Type 2 diabetes, functional quadriplegia (paralysis of all four limbs), end stage renal disease on dialysis three times a week, congestive heart failure, dysphagia (difficulty swallowing) with a gastrostomy tube placed on 02/7/2020 for feedings, history of stroke with right-sided hemiplegia (weakness on one side of the body), prior history of cardiac arrest, depression, and "pressure injury of buttock, stage 2-present upon admission (to the hospital)." Minimum Data Set Discharge Assessment with assessment reference date 04/27/22, indicated that R12 requires extensive assistance for bed mobility and is completely dependent on staff for transfers and incontinence care. "Health Status Note" on 06/15/22 at 06:05 AM stated that R12 is "Alert and oriented to self". Review of R12's care plan stated that R12 is unable to verbalize her needs. On 06/15/22 at 03:06 PM, a concurrent record review and interview was done with the Director of Nursing (DON). DON confirmed that R12 had physician orders for the antidepressant "Escitalopram Oxalate Tablet 5 mg. Give 1 tablet via G-tube (gastrostomy tube) one time a day for depression." DON reviewed the physician orders and confirmed that there were no orders to monitor for specific behaviors related to R12's depression nor any orders to monitor for side effects from administering Escitalopram and that these orders should be included. DON stated that R12's daily behavior was documented on the "Monitor-Behavior Symptoms" task sheet once a shift by the nurses. DON reviewed the "Monitor-Behavior Symptoms" task sheet and confirmed that there were no specific behaviors identified on the task sheet to monitor for R12's depression. DON also reviewed R12's	F 656	and deletions of resident conditions. Policies will also be reviewed by the Director of Nursing and updated if necessary. 1) Care plans will be audited at the care conferences. Findings will be discussed with the interdisciplinary team at the time of the conference. 2) Resident's care plan related to mealtimes and food preferences was completed to reflect the resident's/responsible party's requests. 2) Audits were performed of current resident care plans by the Director of Nursing and designated licensed nurses. Care plans were checked to ensure they address the resident's medical, physical, mental, and psychosocial needs. 2) Staff will be in-serviced by 8/12/22 on the process of comprehensive care planning for new admissions and current residents. Staff will be also in-serviced on better utilization of the electronic medical records system to process updates, edits, and deletions of resident conditions. Policies will also be reviewed by the Director of Nursing and updated if necessary. 2) Care plans will be audited at the care conferences. Findings will be discussed with the interdisciplinary team at the time of the conference.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	**919 LEHUA AVENUE PEARL CITY, HI 96782**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 20	F 656		

medication administration record (MAR) and treatment administration record and confirmed that there was no documentation regarding monitoring for side effects caused by R12 receiving an antidepressant.

On 06/16/22 at 11:45 AM, an interview was done with the DON. DON stated that R12 was originally started on Escitalopram 5mg on 05/05/2021 for depression symptoms of flat affect and crying and the next gradual dose reduction attempt is due in August 2022. DON stated that R12's behavior of flat affect and crying will be linked to R12's MAR so that the nurses will be able to start charting on those specific behaviors tonight.

On 06/17/22 at 11:13 AM, a concurrent record review and interview was done with the DON and the Training Coordinator (TC). DON confirmed that R12 received dialysis treatment offsite three times a week. DON noted that the care plan only included interventions to monitor weights before and after hemodialysis sessions, and that R12 would receive tube feedings as ordered. When asked if R12's care plan was adequate for addressing R12's end stage renal disease, DON stated that the care plan was not adequate and should include interventions such as monitoring labs for electrolytes, monitoring vitals before and after hemodialysis sessions, and using a foam cushion on R12's wheelchair when R12 leaves for dialysis.

2) During observation of R20 on 06/14/22 at 12:30 PM, R20's lunch tray was noted on the bedside table but not set up so R20 could eat. At around 01:30 PM, Certified Nursing Assistant (CNA)6 went to assist R20 with setting up her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	**919 LEHUA AVENUE PEARL CITY, HI 96782**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 21 food for eating. CNA6 said she thought someone else was helping R20. During observation on 06/16/22 at 01:00 PM, R20 was noted to be lying in bed with her lunch tray set up in front of her. However, R20 appeared to be asleep, her lunch tray not touched, with no staff around to assist or encourage her to eat or drink. A second observation on 06/16/22 at 02:30 PM showed no change with R20 lying in bed appearing to be asleep with her lunch tray set up in front of her, not touched, with no staff around to assist or encourage her to eat or drink. On 06/16/22 at 03:30 PM, a review of R20's Comprehensive Care Plan read the following: at risk for dehydration as does not meet 80% of fluid goal, encourage fluids to goal 1000 - 1400 mL/d, water pitcher at bedside, at nutrition risk due to unplanned significant weight loss, specific instructions provided by family regarding feeding, offered supplements as ordered; Glucerna 1.5 at least 240 mL/shift and if requested by resident, eating; able to feed self with set up, encourage to eat and offer an alternative menu item, encourage physical activity to stimulate appetite, offer snacks of choice throughout the day, offer substitutes for foods not eaten, encourage good nutrition and hydration in order to promote healthier skin, encourage fluids during the day to promote prompted voiding responses.	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	F 657		8/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	**919 LEHUA AVENUE** **PEARL CITY, HI 96782**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 22 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. (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 review and revise the Comprehensive Care Plan (CP) for Resident (R)31 to effectively address his status, and condition. As a result of this deficient practice, staff did not have the information necessary to adequately care for R31 so that he could safely meet his highest potential of physical and psychosocial well-being. This deficient practice has the potential to affect all the residents at the facility.	F 657	Resident's care plan was reviewed and updated on 6/24/22, and brought current to reflect most recent admission of 4/28/22. Resident was re-assessed by rehab department, and the RNA program was reinstated 6/24/22. On 6/27/22 the resident's ADL and splinting care plan was restarted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 657

Continued From page 23

Findings include:

Resident (R)31 is a 54-year-old male admitted to the facility on 11/22/2000 for long-term care. His admitting and current diagnoses include, but are not limited to, spastic quadriplegic cerebral palsy (a disorder of posture or movement, caused by an abnormality of the brain, affecting all four limbs, the trunk, and the face), encephalopathy (damage or disease that affects the brain), and contractures of his hands and fingers on both sides.

On 06/14/22 at 09:06 AM, observed R31 lying in bed, awkwardly positioned. R31 was non-verbal in response to greetings and questions but made eye contact and smiled broadly while being spoken to. Observed contracted hands and fingers on both sides. Did not observe any hand splints, hand rolls, or adaptive equipment on either hand, on his bed, or at the bedside, to address the contractures.

On 06/16/22 at 08:06 AM, observed R31 lying in bed with no hand splints, hand rolls, or adaptive equipment on either hand, on his bed, or at the bedside.

On 06/16/22 at 09:22 AM, an interview was done with Restorative Nurse Aide (RNA)1 in the therapy room on the second floor. When asked about R31's RNA program, RNA1 stated that it has been on hold since he returned from the acute care hospital in April 2022. RNA1 stated that because R31 had been hospitalized for over a month, his needs had changed, and he needed to be re-evaluated by the Rehabilitation (rehab) Team so that his rehab recommendations and care plan could be updated. RNA1 confirmed

F 657

Audits were performed of current resident care plans by the Director of Nursing and designated licensed nurses. Care plans were checked to ensure they address the resident's medical, physical, mental, and psychosocial needs.

Staff will be in-serviced by 8/12/22 on the process of comprehensive care planning for new admissions and current residents. Staff will be also in-serviced on better utilization of the electronic medical records system to process updates, edits, and deletions of resident conditions. Policies will also be reviewed by the Director of Nursing and updated if necessary.

Care plans will be audited at the care conferences. Findings will be discussed with the interdisciplinary team at the time of the conference.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 24 that R31 should have hand splints and/or hand rolls for his contractures but could not say when she had last seen them used. On 06/16/22 at 11:30 AM, a review of R31's comprehensive care plan (CP) was done. The following was noted as interventions for his self-care deficit: "Both UE [upper extremity] shoulder flexion ... elbow flexion ... wrist/digits [fingers] gentle stretching ...," last revised on 10/23/21. "Perform PROM [passive range of motion] on bilateral [both sides] UE [upper extremities] of all joints. Apply finger separator for both hands ...," last revised 12/22/21. " ... bedfast all or most of the time. Up in reclining chair daily in AM ...," last revised 08/09/21. "Apply hand splints to both hands for 6 hours Q [every] shift ...," last revised 08/09/21.	F 657		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews, the facility failed to provide treatment and care of Moisture-Associated Skin Damage (MASD) for Resident (R) 12 in accordance with professional standards of practice and	F 684	Staff were called together to discuss findings for resident and provide education by the Education Coordinator on the importance of following protocol for treatment on 6/20/22.	7/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 25 comprehensive care plan, resulting in the progressive worsening of R12's sacrum wound. Findings Include: Cross reference to F656. A record review on 06/15/22 of R12's "Discharge Summary" dated 05/10/22, documented that R12 was discharged from the hospital and readmitted to the facility on 05/10/22. R12 was readmitted to the facility after being hospitalized for a cardiac arrest sustained during an offsite hemodialysis session on 04/26/22. R12's diagnoses include Type 2 diabetes, functional quadriplegia (paralysis of all four limbs), end stage renal disease on dialysis three times a week, congestive heart failure, dysphagia (difficulty swallowing) with a gastrostomy tube placed on 02/7/2020 for feedings, history of stroke with right-sided hemiplegia (weakness on one side of the body), prior history of cardiac arrest, depression, and "pressure injury of buttock, stage 2-present upon admission (to the hospital)." Minimum Data Set Discharge Assessment with assessment reference date 04/27/22, indicated that R12 requires extensive assistance for bed mobility and is completely dependent on staff for transfers and incontinence care. "Health Status Note" on 06/15/22 at 06:05 AM stated that R12 is "Alert and oriented to self". Review of R12's care plan stated that R12 is unable to verbalize her needs. On 06/14/22, surveyor observed R12 in her room at 09:03 AM, 11:45 AM and 02:11 PM. At each observation, R12 was laying in her bed on her back with the head of the bed elevated at 30 degrees. R12 had a pillow underneath her head.	F 684	An alternating air mattress was ordered for the resident and arrived on 6/16/22. A ROHO pillow was ordered on 6/16/22, and arrived on 6/24/22. Resident's ESRD and wound care plan was updated and completed on 6/20/22. The facility will collaborate with wound consultants in identification, treatment, and follow-up for new admissions and current residents as appropriate. EHR has been updated on 7/19/22 to provide charting for direction of turning (right or left) to avoid confusion when staff reposition resident. Manual log will still be utilized until staff are comfortable with the new system. The Director of Nursing will continue discussions with wound consultants at weekly quality of care meetings. In-services will be done with staff by 7/29/22 to ensure usage of new EHR charting and identifying and reporting wounds found while performing care with residents. All residents were checked to identify any other wounds that were not attended to properly. None were found. (6/24/22) Facility will continue to do weekly skin checks by the licensed staff. Any identifying skin issues will be reported to the attending physician, and if necessary, will consult the wound consultants.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 26 R12 had a wedge underneath her left shoulder and a wedge underneath her left waist. Her legs were elevated with a pillow. At each observation, R12's eyes were either opened or closed, and R12 did not attempt to move her position or respond to surveyor's greetings. On 06/15/22 at 04:00 PM, a record review of R12's "Monitor-Turn and reposition" task sheet for 06/14/22 documented that R12 was turned at 09:05 AM, 11:19 AM, and 01:00 PM. Surveyor did not observe a change in R12's position after these documented times. On 06/15/22, surveyor observed R12 in her room at 08:10 AM, 10:34 AM, 12:49 PM, and 03:21 PM. At each observation, R12 was laying in her bed on her back with the head of the bed elevated 30 degrees. R12 had a wedge underneath her right shoulder and a wedge underneath her right waist. R12 had a pillow underneath her head and a pillow underneath her left shoulder. Her legs were elevated on a pillow. On 06/16/22 at 04:10 PM, a record review of R12's "Monitor-Turn and reposition" task sheet for 06/15/22 documented that R12 was turned and repositioned at 09:00 AM, 11: 00 AM, 12:38 PM, and 03:00 PM. Surveyor did not see a change in R12's position after 09:00 AM, 12:38 PM, and 03:00 PM. On 06/16/22 at 08:02 AM, surveyor observed R12 lying in bed on her back with the head of the bed elevated at 30 degrees. R12 had a pillow underneath her head and a pillow underneath her right shoulder. R12 had a wedge underneath her left shoulder and a wedge underneath her left waist. Her legs were elevated on a pillow.	F 684	The Director of Nursing or designee to continue to conduct weekly rounds at bedside with wound consultants. Audits for positioning will be done weekly x 4 weeks, then bi-weekly x 1 month, then monthly x 3 months, then randomly checked. Concerns will be brought up immediately with the interdisciplinary team to ensure resident's needs are met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 27	F 684		

On 06/16/22 at 09:21 AM, surveyor observed Physician Assistant (PA) 1 perform R12's weekly wound assessment with Training Coordinator (TC) and Registered Nurse (RN) 5. Surveyor observed R12 in the same position that was observed at 08:02 AM that morning. RN5 and staff turned R1 to her left side without any assistance from R12. PA1 observed R12's sacrum area. PA1 stated that R12's wound was a result of MASD (moisture-associated skin damage or skin erosion cause by prolonged exposure to moisture) and was not a pressure ulcer. PA1 stated that R12's wound looked bigger this week but was not infected. The wound appeared beefy red with no drainage. PA1 measured the wound to be 3.5 cm in length, 3.5 cm width, and 0.1 cm depth. PA1 recommended that R12's brief be changed more frequently and that she be turned and offloaded more frequently. When PA1 asked whether R12's air mattress overlay had come in yet, TC replied that the mattress hadn't come yet due to supply shortages. TC stated that the air mattress overlay would help with offloading of R12's wound. PA1 also recommended a ROHO (pressure relief) seat cushion to replace R12's current foam wheelchair cushion and to be used on R12's wheelchair during dialysis sessions to help with offloading. A wedge was then placed under R12's right shoulder and both legs were elevated on a pillow. A pillow was placed underneath her left shoulder. R12 was laying on her back with the head of the bed elevated 30 degrees.

On 06/16/22 at 10:54 AM, a concurrent observation and interview was done with Certified Nursing Assistant (CNA) 9. Surveyor observed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 28	F 684		

R12 in the same position that she was in after her wound assessment at 09:21 AM (wedge under right shoulder). CNA9 stated that she would check R12 every 2 hours and reposition and turn her. When surveyor asked what turning meant, CNA9 stated that if R12 was facing right then they would turn her left and that they would also change the position of the wedges to the opposite side. CNA9 stated that she would chart when she turned R12 but there was no option to chart what direction R12 was turned to.

At 06/16/22 at 11:12 AM, RN5 came into R12's room and performed R12's wound dressing change and peri care with CNA9's assistance. R12 needed total assistance from staff to perform peri care and repositioning in bed. After the dressing change, surveyor observed RN5 ask CNA9 what position to place R12 in but CNA9 stated that she couldn't remember R12's previous position. CNA9 and RN5 positioned R12 with a wedge under her right shoulder and a wedge underneath her right waist. A pillow was placed underneath her left shoulder. R12's legs were elevated on a pillow. A pillow was placed underneath her head and the head of her bed was elevated at 30 degrees. R12 was lying on her back. Surveyor observed that R12 was placed in the same position prior to this dressing change (wedges under right shoulder and right waist).

At 06/16/22 at 01:15 PM, surveyor observed R12 in her room. The wedge remained under her right shoulder and a wedge underneath her right waist. A pillow was underneath her left shoulder. Her legs were elevated on a pillow. A pillow was placed underneath her head and the head of her bed was elevated at 30 degrees. R12 was lying

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 29	F 684		

on her back with her eyes closed.

On 06/17/22 at 08:00 AM, a record review of R12's "Monitor-Turn and reposition" task sheet for 06/16/22 documented that R12 was turned at 08:12 AM, 12:41 PM, and 01:00 PM. Except for R12 being turned to a different position after her wound assessment at 09:21 AM, surveyor did not observe R12 in a different position after these documented times.

On 6/17/22 at 09:45 AM, a record review of "Weekly Skin Observation Tool" dated 05/22/22 documented "Right buttock w/ dry open area, 4 x 1 cm, left buttock w/ dry open area, 0.5 cm x 0.5 cm."

A record review on 06/17/22 of R12's "Wound Care SNF Consult Service Progress Note" dated 05/26/22, PA1 stated "History of Present Illness: Wound located on Sacrum. Wound occurred by MASD mechanism over the past 1-2 months ...Wound assessment: Yellow (fibrinous slough), length 2.5 cm, width 6 cm, and depth 0.2 cm ...Air mattress overlay requested on 05/26/22..counseled staff in regards to nutrition, offloading, and elevation ...Follow-Up in one week for re-evaluation and wound assessment."

A record review on 06/17/22 of "Physician Orders" stated that an order dated 05/26/22 for "Triad Hyrophilic wound Dress Paste (wound dressings) Apply to Sacrum area topically every day shift for open wound r/t (related to) MASD. Cleanse with NS (normal saline), pat dry, and apply paste."

A record review on 06/17/22 of R12's "Wound care SNF Consult Service Progress Note" dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING _____ B. WING _____	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 30	F 684		

06/02/22, PA1 stated "Wound assessment: Red, Wound length 0.5 cm, width 0.3 cm, and depth 0.15 cm ...Air mattress overlay requested 05/26/22, pending as of 06/02/22."

A record review on 06/17/22 of R12's "Wound care SNF Consult Progress Note dated 06/09/22, PA1 stated "Wound located on sacrum is larger with small bruising noted. Air mattress pending ...Wound Assessment: yellow (fibrinous slough), 2.5 cm length, 2.2 cm width, 0.2 cm depth ...air mattress overlay requested 05/26/22, pending as of 06/09/22 ...Counseled staff in regard to nutrition, offloading, elevation."

A record review on 06/18/22 of R12's "Wound care SNF Consult Service Progress Note" dated 06/16/22, PA1 stated "Wound located on sacrum is again larger this week, no bruising noted. Air Mattress pending ...Wound assessment: Yellow (fibrinous slough), length 3.5 cm, width 3.5 cm, and depth 0.1 cm... Air mattress overlay requested 05/26/22, pending as of 06/16/22 ...Wheelchair foam cushion in use. 06/16/22 ROHO cushion ordered to use in wheelchair and while at HD (hemodialysis). Limited ability to offloading buttocks/sacrum due to HD status ...Counseled staff in regard to nutrition, offloading, elevation."

On 06/17/22 at 11:13 AM, a concurrent interview and record review was done with the Director of Nursing (DON) and TC. DON stated that the facility staff had met on 04/05/22 and noted that R12 had a wound to the left buttock that was being treated with Mupirocin Ointment. DON stated that the same wound continued to be treated until R12 was hospitalized on 04/26/22. DON reviewed R12's "Discharge Summary"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 684 Continued From page 31 F 684

dated 05/10/22 and confirmed that she had her sacrum wound upon readmission to the facility on 05/10/22 and that wound consultations with PA1 started on 05/26/22. DON and TC confirmed that R12's sacrum ulcer had increased in size since 05/26/22. DON confirmed that the air mattress overlay had been ordered by the PA1 on 05/26/22, but there was a delay in the facility ordering the mattress because the employee who is responsible for ordering supplies was on maternity leave. DON stated that the facility is now working with a third company party to obtain wound supplies and that the DON contacted the company two days ago regarding R12's overlay mattress. When surveyor asked if an alternative could have been found for the overlay air mattress due to the delay, DON stated that they could look in-house for an inflatable mattress until R12's air overlay mattress arrived.

On 06/17/22 at 11:20 AM, DON and TC reviewed R12's care plan and confirmed that there was no care plan to address R12's sacrum wound. DON stated that a care plan for R12's wound should be included and that an intervention for turning R12 every 2 hours should also be included in the care plan. DON and TC reviewed "Braden Scale for Predicting Pressure Ulcer Risk" assessment dated 05/10/22 and confirmed that R12 was at very high risk for pressure ulcers and that clinical suggestions listed on the assessment to "turn and reposition at least every 2 hours while in bed" should be followed and included in R12's care plan. When surveyor asked what the definition of turning every 2 hours for R12 was, DON stated that R12's body would be turned to the opposite side every 2 hours and any wedges would also be repositioned to the opposite side. DON and TC then reviewed R12's "Monitor-Turn and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE, PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 32 Reposition" task sheet and confirmed that there was no documentation showing what side R12 was turned to whenever she was documented as turned by staff. When surveyor explained how CNA9 and RN5 put R12 in the same position (wedges under the right side of R12's body) after her dressing change on 06/16/22 at 11:12 AM, DON stated that CNA9 and RN5 should have positioned R12 and her wedges on her opposite side (left side) instead.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure Resident (R)31 received the appropriate treatment, equipment, and services to increase or prevent further decrease in range of motion (ROM) in his	F 688	Resident's care plan was reviewed and updated on 6/24/22, and brought current to reflect most recent admission of 4/28/22.	8/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 688

Continued From page 33

hands and arms. As a result of this deficient practice, R31 is unable to reach his highest practicable well-being. This deficient practice has the potential to affect all the residents at the facility with ROM deficits.

Findings include:

Resident (R)31 is a 54-year-old male admitted to the facility on 11/22/2000 for long-term care. His admitting and current diagnoses include, but are not limited to, spastic quadriplegic cerebral palsy (a disorder of posture or movement, caused by an abnormality of the brain, affecting all four limbs, the trunk, and the face), encephalopathy (damage or disease that affects the brain), and contractures of his hands and fingers on both sides.

On 06/14/22 at 09:06 AM, observed R31 laying in bed, awkwardly positioned. R31 was non-verbal in response to greetings and questions but made eye contact and smiled broadly while being spoken to. Observed contracted hands and fingers on both sides. Did not observe any hand splints, hand rolls, or adaptive equipment on either hand, on his bed, or at the bedside, to address the contractures.

On 06/15/22 at 09:30 AM, a phone interview was done with R31's mother (M1). M1 stated that the last care conference meeting for her son was done in May 2022, and she did not feel that the facility had addressed all of her concerns. M1 stated that she always asks about getting R31 up to his reclining wheelchair regularly, and about ensuring that he has consistent hand rolls for his fingers and hands. Would like R31 to be transferred to his wheelchair at least twice a day

F 688

Resident was re-assessed by rehab department, and the RNA program was reinstated 6/24/22.

On 6/27/22 the resident's ADL and splinting care plan was restarted.

On 7/19/22 the rehab department assessed the resident to see if a rehabilitation program was necessary. After further evaluation, it was determined that the hand splints were sufficient for the resident and still fit appropriately.

All residents were reviewed for usage of adaptive equipment on 6/24/22. For any resident that did not have their adaptive equipment applied, reminded staff to use it.

In-service will be done with staff by 8/12/22 on the importance of applying the hand splints and other adaptive equipment.

Nursing to create a spreadsheet by 7/29/22 for all residents who require use of adaptive equipment. This will help with the audit to be done weekly x 3 months by the Director of Nursing or designee.

Discrepancies will be reported to the quarterly QA/QI Committee meeting and follow up if necessary.

F 688 Continued From page 34 F 688

but has been told that "it's a staffing issue." M1 stated that there used to be signs posted in R31's room requesting care such as "transfer to wheelchair twice a day," but was told that due to privacy concerns, those signs had to be taken down.

On 06/16/22 at 08:06 AM, observed R31 laying in bed with no hand splints, hand rolls, or adaptive equipment on either hand, on his bed, or at the bedside.

On 06/16/22 at 09:22 AM, an interview was done with Restorative Nurse Aide (RNA)1 in the therapy room on the second floor. When asked about R31's RNA program, RNA1 stated that it has been on hold since he returned from the acute care hospital in April 2022. RNA1 stated that because R31 had been hospitalized for over a month, his needs had changed, and he needed to be re-evaluated by the Rehabilitation (rehab) Team so that his rehab recommendations and care plan could be updated. When asked if she knew how often R31 was being transferred out of bed, RNA1 stated R31 received showers twice a week, so she believed he was getting out of bed at least that often but could not recall when she had last seen him up out of bed. RNA1 acknowledged that the facility had a "problem with short staff," and that at times R31 would receive a bed bath instead of a shower. RNA1 also confirmed that R31 should have hand splints and/or hand rolls for his contractures but could not say when she had last seen them used.

On 06/16/22 at 11:30 AM, a review of R31's comprehensive care plan (CP) was done. The following was noted as interventions for his self-care deficit:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 35 "Both UE [upper extremity] shoulder flexion ... elbow flexion ... wrist/digits [fingers] gentle stretching ...," last revised on 10/23/21. "Perform PROM [passive range of motion] on bilateral [both sides] UE [upper extremities] of all joints. Apply finger separator for both hands ...," last revised 12/22/21. " ... bedfast all or most of the time. Up in reclining chair daily in AM ...," last revised 08/09/21. "Apply hand splints to both hands for 6 hours Q [every] shift ...," last revised 08/09/21. Cross-reference to F725 Sufficient Nursing Staff.	F 688		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, record review and policy review, the facility failed to provide adequate pain management services for Resident (R) 9. As a result of this deficiency, R9 experienced excessive pain. Findings include: Electronic Health Record (EHR) showed R9 was admitted on 03/25/21 with the following	F 697	The resident's care plan to address pain was updated on 6/15/22. Physician was contacted for increased pain medication. Resident's behavior care plan was updated on 7/5/22. A care conference was conducted with the family on 7/5/22 with the interdisciplinary team. The hospice company was contacted to provide assistance with pain and behavior management on 7/5/22.	7/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 36 diagnoses: Fall with Traumatic Hemorrhage of Cerebrum, Cerebrovascular Disease, Hypertension, Dementia with Behavioral Disturbance, Peripheral Vascular Disease, Chronic Atrial Fibrillation, Palliative Care. R9 was receiving Palliative Care through Hospice Services and had indicated to receive Comfort Measures Only. On 06/15/22 at 10:30 AM, R9 was observed moaning, yelling in severe pain. Staff members were at bedside but R9 was still experienced excruciating pain. Pain medications were administered by Registered Nurse (RN) 5 but R9 continued to experience excruciating pain for more than an hour. On 06/16/22 at 01:00 PM, R9 again was observed moaning, yelling in severe pain. Staff members were attending to R9 but he still experienced excruciating pain for up to two hours. During staff interview, on 06/16/22 at 01:30 PM, RN5 stated that R9 has pain almost every day and that R9 has moments where the moaning, yelling in severe pain goes on for a long time. During an interview, on 06/16/22 at 02:30 PM, Training Coordinator (TC) stated that recent changes that were made to R9's medication regimen has shown some improvement in pain management. Review of R9's Comprehensive Care Plan related to pain included the following: Goal, resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain, resident will not have an interruption in normal activities due to pain, resident will display a decrease in behaviors	F 697	A pain tool assessment has been implemented for all new admissions and current residents as a baseline. Based on the pain assessment, there will be follow-up with recommended treatment (i.e. pharmacological and non-pharmacological interventions). Hospice company was contacted on 7/1/22 to review expectations and discuss further involvement with resident and family to ensure resident needs are met. This would apply to all current and future interactions with this particular hospice. The Director of Nursing or designee will audit the pain tool assessment for all new admissions and current residents monthly and at every care conference. Discrepancies will be reported to the quarterly QA/QI Committee meeting and followed up on.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	**919 LEHUA AVENUE PEARL CITY, HI 96782**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 37 of inadequate pain control (irritability, agitation, restlessness, grimacing, perspiring, hyperventilation, groaning, crying). Interventions/Task, administer analgesia as ordered by physician. Give ½ hour before treatments or care, anticipate the resident's need for pain relief and respond immediately to any complaint of pain, evaluate the effectiveness of pain interventions, review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition, identify and record previous pain history management of that pain and impact of function, identify previous response to analgesia including pain relief, side effects and impact on function, monitor resident's existing health conditions which may increase pain and or discomfort, monitor document for probable cause of each pain episode, remove, limit causes where possible. Review of facility policy on Pain Management stated the following: Policy, all patients should be assessed for pain factors and history, initially upon being admitted to the facility, then subsequently thereafter according to assessment finding. All patients should receive treatment for pain relief as warranted and monitored for effectiveness.	F 697		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial	F 725		8/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 725 Continued From page 38 F 725

well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure there was sufficient nursing staff to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, in addition to their physical, mental, and psychosocial well-being. As a result of this deficient practice, the residents experienced a decreased quality of life and were unable to attain their highest practicable well-being.

Findings include:

On 06/14/22 at 09:14 AM, an interview was done with Restorative Nurse Aide (RNA)1 in room 209

Provider's Plan of Correction:

Upon review of the residents affected, it was noted that several of the residents prefer to dine in their rooms and only require setup of their trays as the residents are able to feed themselves. The day of the survey observation, the floor was staffed with agency staff and they were unaware they did not have to feed those residents. The staff have since been reminded on how to check feeding preferences.

The Dietician and nursing staff identified current residents who require feeding assistance on 7/5/22. Identifying appropriate care will result in efficient

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ____ B. WING ____	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725		F 725		

Continued From page 39
as she assisted a resident with breakfast. RNA1 stated that although assisting with feeding is not part of her duties, "they [the facility] are a little short" so she was helping feed a resident to free up staff to assist other residents.

On 06/14/22 at 12:05 PM, the following dining observations were done on the second floor as the first meal cart arrived.

At 12:24 PM, the spouse of Resident (R)42 came out of her room looking for her lunch tray, stating, "lunch is really late today ... [R42] is hungry."

At 12:33 PM, observed a Certified Nurse Aide (CNA) deliver a lunch tray to R42.

At 12:36 PM, observed CNA2 deliver a lunch tray to R18, then stood beside his bed as she assisted feeding him.

At 01:04 PM, observed dietary staff come to pick up the metal meal cart. CNA3 reported to the dietary staff, "I have 3 more in there." Dietary staff left the cart where it was.

At 01:21 PM, observed tray passed by CNA2 to the last resident on the floor ready to eat. There were two lunch trays remaining on the cart for residents that were not interested in eating yet.

On 06/17/22 at 09:49 AM, an interview was done with the Administrator, Training Coordinator (TC) and the Director of Nursing (DON) in the Administrator's office. When informed about lunch pass observations from 06/14/22, the Administrative Team agreed that it should not have taken 75 minutes to complete lunch pass. The DON stated that in addition to the three

delegation of duties for staff.

Care plans for those who prefer to dine in their rooms have been added on 7/5/22.

The Food Service Director or designee and nursing staff to review and revise the feeding schedule by 8/12/22 for residents who require assistance while adhering to the regulations for time between meals. The nursing units to be provided with a list of residents requiring assistance with feeding and/or tray setup in their rooms so that agency and new staff are aware.

The Director of Nursing will collaborate with rehab contractors and restorative aides to include feeding assistance for residents identified.

Audits to be conducted by the Director of Nursing, Food Service Director, or designees weekly x 4 weeks, then bi-weekly x 2 months, to ensure meal pass times are acceptable and efficient and that no one is waiting an excessive time beyond their planned meal time to receive their food.

Discrepancies to be brought to the interdisciplinary team for review and discussion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 40 CNAs scheduled, the licensed nurses and activities staff usually help pass meal trays as time allows. The DON confirmed that of the 39 residents on the second floor, "more than half" require feeding assistance, so that is a consideration for how long it takes to complete a meal service. The Administrative Team acknowledged that due to the COVID-19 outbreak amongst residents and staff in the facility, they were experiencing challenges with staffing.	F 725		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to designate a registered nurse (RN) to serve as the Director of Nursing (DON) on a full-time basis. Specifically, the DON served as the designated Charge Nurse (CN) while on duty, thereby making him unable to focus his attention on the DON role for 35 or more hours a week.	F 727	In the interview with the survey team, the Director of Nursing mistakenly said that, "he has been the designated CN for the day shift." All nursing staff are trained to be Charge Nurses for the shift they are on. The Director of Nursing meant to say that he is the "House Charge" for the day shift. During the evening and night shift,	6/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 727	Continued From page 41 Findings include: On 06/15/22 at 04:20 PM, during a review of the nursing schedules, it was noted that it was unclear who was the designated CN on any shift. On 06/16/22 at 12:30 PM, an interview was done with RN2 at the second-floor Nurses' Station. When asked who the designated CN was, RN2 stated they did not have a Nursing Supervisor for the day shift anymore, "only the evening and nights." On 06/17/22 at 08:23 AM, an interview was done with the DON in his office. The DON confirmed that since February 2022 when he began as the DON, he has been the designated CN for the day shift. The DON further stated that on weekends and holidays, plus evenings and nights, there is a Nursing Supervisor scheduled who is then the designated CN. The DON was not aware that the DON should not be the designated CN if the average daily census is 60 or above.	F 727	one of the unit nurses (RN) is designated as the "House Charge" to be the person responsible for the "house." The Charge Nurse on shifts are regularly scheduled for each shift. The Director of Nursing continues to oversee the duties and performance of the nursing department. The Nursing Admin Assistant will monitor and ensure there are Charge Nurses, who are not the Director of Nursing, each shift.	
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed	F 732		7/1/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 42 vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and interview the facility failed to update the nurse staffing data daily and at the beginning of each shift for one of two units. Findings Include: On 06/16/22 at 09:11 AM on the second floor, observed the daily nurse staffing data posted on the bulletin board dated 06/14/22, two days ago. On 06/17/22 at 08:16 AM concurrent observation and interview with Registered Nurse (RN) 8 and RN9 was done. RN8 and RN9 confirmed the date	F 732	The posting has been modified to remove the restorative aides from the daily nursing count. (6/24/22) The night shift House Charge nurse will be responsible to post the daily nurse staffing at midnight for each floor. Instructions and forms used will be available in the House Charge binder on the units. (7/1/22) Audits will be done by the Unit Clerks daily to ensure nurse staffing posting is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 43 of the posted daily nursing data was 06/14/22, 3 days ago. RN9 stated it should be changed daily.	F 732	updated daily per requirement and that accurate numbers are reflected. The Health Information Associate will review audits done by Unit Clerks and report discrepancies to the quarterly QA/QI Committee Meeting for further follow up.	
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and	F 790		7/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 790	Continued From page 44 (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide or obtain from their dental consultant, routine dental services to meet the resident's needs. As a result of this deficient practice, there was no documentation of when Resident (R)5 last received routine dental services, resulting in an inability for R5 to reach her highest practicable well-being. This deficient practice has the potential to affect all residents currently residing in the facility. Findings include: Resident (R)5 is a 93-year-old female admitted to the facility on 02/11/14. On 06/14/22 at 09:28 AM, observed R5 laying in bed with her mouth open. R5 had many decayed teeth and/or missing teeth visible. On 06/15/22 at 03:38 PM, during a review of her electronic health record (EHR), it was noted that no documentation was found indicating when R5 had last received routine dental services. On 06/16/22 at 12:27 PM, during a review of R5's hard (paper) chart, it was noted that the last	F 790	The dentist came and provided services to the resident affected on 7/2/22. Routine dental services were provided to all residents on the 2nd floor on 7/2/22, and the 4th floor on 6/25/22. All new admission will be included in the routine dental services within a year, or the next closest dental visit. Whichever comes first. Emergent dental needs will continue to be scheduled on an as-needed basis. A spreadsheet will be created on 7/22/22 by the Medical Records Department with all residents per floor and dates of most recent dental services. The Unit Clerks will contact and schedule with the dentist as necessary. The spreadsheet audit will be done by the Health Information Associate monthly to determine if routine dental service needs are being met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE, PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 790	Continued From page 45 dental assessment documented was done on 10/30/19 by a Registered Nurse (RN). The dental assessment listed that R5 had missing teeth in the right upper and left lower areas of her mouth and needed total assistance for oral care and dental hygiene. No documentation was found in her hard chart that indicated when R5 had last received routine dental services. On 06/17/22 at 09:49 AM, an interview was done with the Administrator, Training Coordinator (TC) and the Director of Nursing (DON) in the Administrator's office. The administrative team could not say when the facility dentist had last visited the facility for routine dental services but stated that it had been prior to the COVID-19 public health emergency (PHE) beginning in 2020. The TC stated that prior to the PHE, routine dental exams/services occurred annually. On 06/17/22 at 10:30 AM, during an interview with the DON in his office, the DON confirmed he also could not find documentation in R5's hard chart or EHR of when she had last received routine dental services.	F 790	Any discrepancies will be brought to the quarterly QA/QI Committee meetings for review and follow up.	
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a	F 838		8/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 838	Continued From page 46	F 838		

substantial modification to any part of this assessment. The facility assessment must address or include:

§483.70(e)(1) The facility's resident population, including, but not limited to,
(i) Both the number of residents and the facility's resident capacity;
(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 838	Continued From page 47 services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on review of the current Facility Assessment, interview with the Director of Nursing (DON), and review of policy, the facility failed to review and update that Facility Assessment on an annual basis. As a result of this deficiency, the facility did not update their determination for resources necessary to care for its residents. Findings include: On 06/16/22 at 09:00 AM, a review of the Facility Assessment Tool revealed the following: date of last update was 10/27/20, date assessment last reviewed with QAA/QAPI committee was 01/21/21. During an interview on 06/17/22 at 01:00 PM, DON acknowledged that the Facility Assessment was not updated on an annual basis. Review of facility policy on Facility Assessment stated Preface, it is the policy of this facility that it must conduct and document an individualized facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations	F 838	The Facility Assessment was reviewed by staff involved and determined to be out of date. (6/24/22) The Facility Assessment will be amended to reflect current assessment of the facility. (8/15/22) The Facility Assessment will be reviewed annually by staff involved at the January quarterly QA/QI Committee meetings. If changes should be necessary, the Facility Assessment will be modified by the department responsible. The Administrator will be responsible to ensure the Facility Assessment will be updated and reviewed annually at the January QA/QI Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 838	Continued From page 48 and emergencies. The facility assessment will be conducted at the facility level and may incorporate input from the governing body/ownership. The facility will review and update the facility assessment annually and as necessary whenever there is, or the facility plans for, any change that would require a substantial modification to any part of the assessment.	F 838		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		8/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	**919 LEHUA AVENUE PEARL CITY, HI 96782**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 49 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility	F 880	On 6/17/22, the staff was briefly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	**919 LEHUA AVENUE PEARL CITY, HI 96782**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 50 failed to ensure appropriate protective and preventive measures for COVID-19 and other communicable diseases and infections as evidenced by staff not performing proper donning and doffing of Personal Protective Equipment (PPE) when entering and exiting Resident (R) (Resident 12, 29, and 61)'s rooms which were under transmission-based precautions. In addition, the facility failed to dedicate personal equipment (a vitals cart) for R29, who had tested positive and had been isolated for COVID-19. As a result of this deficiency, residents and staff were put at risk for the transmission and spread of COVID-19. Findings Include: On 06/14/22 at 08:13 AM, Training Coordinator (TC) was interviewed. TC stated that Resident (R) 29 had tested positive for COVID-19 on 06/08/22 and was quarantined in a private room in the "Red Zone" on the 4th floor. TC stated that the "Red Zone" required staff to don an N95 respirator, a face shield, gown, and gloves before entering R29's room. TC stated that after exiting the Red Zone, the N95 respirator needed to be changed and the face shield also needed to be cleaned. TC stated that since the outbreak, all the 4th floor residents were considered as "Persons under Investigation" and the 4th floor was now the "Yellow zone". TC stated that the "Yellow zone" required the staff to don a respirator, face shield, gown, and gloves before entering a resident's room. At 06/14/22 at 09:38 AM, Medical Doctor (MD) 1 was observed on the 4th floor wearing a respirator. MD1 entered R12's room which was in the "Yellow Zone". MD1 did not don a face	F 880	in-serviced on proper infection control when interacting with a Red Zone. On 7/19/22 the Infection Control Consultant in-serviced the staff on proper infection control techniques. Per CMS's Directed Plan of Correction (DPOC), staff will view the videos with the links provided on the DPOC notice. Staff will also be in-serviced by 8/12/22 based on requirements set forth in DPOC. Should a future outbreak occur, notices will be posted in the lobby and on the units to designate the zoning of the floor (i.e. red, yellow), and to check with the nurses' station prior to visiting residents to get the information. Training attendance sheets and copies of documents will be provided to State of Hawaii, Department of Health, Office of Health Care Assurance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	**919 LEHUA AVENUE PEARL CITY, HI 96782**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 51	F 880		

shield, gloves, or gown before entering R12's room to talk to a staff member. A yellow sign with the words "Yellow Zone" was posted in front of R12's room. A PPE cart was also located in front of R12's room.

At 06/14/22 at 09:39 AM, MD1 exited R12's room and entered R61's room and started examining R61. R61's room was in the "Yellow Zone". MD1 did not don a face shield, gloves, or gown before entering R61's room. A yellow sign with the words "Yellow Zone" was posted in front of R61's room. A PPE cart was also located in front of R61's room.

On 06/14/22 at 09:50 AM, MD1 left R61's room. An interview was done with MD1 and TC. Surveyor asked if MD1 was aware that the 4th floor was a "Yellow Zone" and about the PPE requirements for the "Yellow Zone". MD1 stated that he was not aware that the 4th floor was a "Yellow zone". TC stated to MD1 that the 4th floor was now a "Yellow Zone" since 06/08/22 when R29 tested positive for COVID-19. TC stated that all staff needed to wear a respirator, face shield, gown, and gloves before entering a resident's room located in the "Yellow Zone". MD1 stated that he had not been to the facility since 06/08/22 so he was not aware of the new PPE requirements on the 4th floor.

On 06/14/22 at 04:19 PM, Certified Nursing Assistant (CNA) 11 was observed exiting R29's room. CNA11 had doffed her gown and gloves inside of R29's room which is a "Red Zone" (COVID-19 positive) room. She then exited R29's room, leaving R29's door approximately one foot open. CNA11 sanitized her hands. CNA11 removed her face shield and placed it on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 52 a bedside table located outside of R29's room. CNA11 then removed and disposed her N95 respirator and then sanitized her hands. CNA11 then donned a new N95 respirator. CNA11 then donned gloves and used Sani-cloth wipes to clean her face shield and bedside table. CNA11 then disposed her gloves, sanitized her hands, and donned her clean face shield. CNA11 then grabbed some Sani-cloth wipes, re-entered R29's room, grabbed the vitals cart, exited the room, and closed R29's door. CNA11 then wiped down the vitals cart with the Sani-cloth wipes and pushed it to the other side of the hallway. CNA11 then disposed of the wipes. CNA11 then sanitized her hands and walked down the hallway. On 06/17/22 at 08:30 AM, an interview was done with the Director of Nursing (DON) who is also the facility's Infection Preventionist, the TC, and the facility's Infection Control Preventionist Consultant (ICPC). ICPC and TC confirmed that MD1 should have also worn a face shield, gown, and gloves when entering R12 and R61's rooms located in the "Yellow Zone". ICPC also confirmed that CNA11 should have donned a gown and new gloves when re-entering R29's room located in the "Red Zone". ICPC stated that an employee should clean their face shield every time an employee exits a "Red Zone" room and that an N95 respirator should be discarded or placed in a paper bag after exiting a "Red Zone" Room. ICPC also stated that the vitals cart should have been left in R29's room for R29's use only or to find an alternative where R29 can have his own designated equipment to prevent the spread of COVID-19. DON stated that they can look for a portable blood pressure monitor and a spare stethoscope to keep at R29's	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 53 bedside.	F 880		
F 883 SS=D	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		8/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 54 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 their second pneumococcal vaccine were offered or received it. Coupled with advanced age and chronic conditions, this deficient practice made two out of the five residents (Residents 42 and 5) sampled unnecessarily vulnerable to the bacteria that causes pneumonia. This deficient practice has the potential to affect all residents at the facility. Findings include: 1) Resident (R)42 is a 77-year-old female admitted to the facility on 02/08/18. On 06/17/22 at 07:57 AM, during a review of Resident (R)42's electronic health record (EHR), it was noted that R42 was documented as receiving a pneumococcal vaccination on 03/23/10, shortly	F 883	1) Resident's immunization record updated on 6/17/22. Hospital sent information regarding the resident's second dose. No further vaccination offered. 2) Resident offered second dose and received on 7/8/22. All residents' records will be reviewed and those found affected will be offered pneumococcal vaccinations. (8/12/22) Nursing will be in-serviced on policy and procedure regarding pneumococcal vaccinations and offering upon admission by 8/12/22. Nursing admission checklist reviewed to ensure pneumococcal vaccinations present.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE, PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 55 after turning 65 years old. There was no documentation in her EHR of being evaluated, offered, or receiving a second dose upon admission. 2) R5 is a 93-year-old female admitted to the facility on 02/11/14. On 06/17/22 at 08:03 AM, during a review of R5's EHR, it was noted that R5 was documented as receiving a pneumococcal vaccination on 06/07/94, shortly after turning 65 years old. There was no documentation in her EHR of being evaluated, offered, or receiving a second dose upon admission. On 06/17/22 at 10:30 AM, during an interview with the Director of Nursing (DON) in his office, the DON confirmed he could not find documentation of either resident being evaluated for a second dose of pneumococcal vaccination. During a review of the facility's pneumococcal vaccination policy and procedure, titled: Immunizations of Adult Residents 2/2022 Section 6, the following was noted: "All new residents must be assessed for pneumococcal vaccine status upon admission. The facility will have in the "Admission Standing Orders," authorization to administer ...the pneumococcal vaccine at the time of admission if not already given and/or revaccination with pneumococcal vaccine after the age of 65."	F 883	Medical Records Department will review all new admissions checklist monthly to ensure pneumococcal and other vaccinations were offered. Any discrepancies will be reported to the quarterly QA/QI Committee meetings.	
F 885 SS=E	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must—	F 885		6/17/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 885	Continued From page 56 §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to inform the representatives and families of 17 of 42 residents sampled (Resident (R) 14, 19, 66, 62, 54, 49, 43, 3, 58, 67, 1, 15, 10, 7, 46, 38, and 61) by 05:00 PM the next calendar day following the occurrence of a confirmed COVID-19 case in the facility along with mitigating actions. This failure had the potential to affect any family member or representative that may have been in the facility or planned a visit to the facility. Findings include: 1) On 06/14/22 at 08:13 AM, Training Coordinator	F 885	The COVID-19 outbreak was resolved and no one in the building is currently under investigation. The Social Services Director developed a script 6/17/22 to notify responsible parties about COVID outbreaks. When a resident turns COVID positive, the Unit Clerks and Social Services Director or designee will contact the responsible party on record to inform them of the situation. The Social Services Director will review procedures pertaining to COVID notifications and update as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 885	Continued From page 57 (TC) was interviewed. TC stated that Resident (R) 29 had tested positive for COVID-19 on 06/08/22 and was quarantined in a private room in the "Red Zone" on the 4th floor. TC stated that since the outbreak, all the 4th floor residents were quarantined to their rooms and considered as "Persons under Investigation" until they were cleared to be released from their rooms. On 06/16/22 at 01:17 PM, Resident (R) 12's family member was interviewed at R12's bedside. R12's family member stated that he wasn't informed last week that there was a confirmed COVID-19 case in the facility. R12's family member stated that he visits R12 at the facility before her dialysis sessions on Tuesday, Thursday and Saturday and staff did not inform him of anyone in the facility testing positive for COVID-19. On 06/17/22 at 08:30 AM, a concurrent interview and record review was done with TC and the Director of Nursing (DON) who is also the facility's Infection Preventionist. TC stated that she instructed the Licensed Social Worker (LSW) to inform all residents' families or representatives of a confirmed COVID-19 case in the facility. TC stated that LSW called the residents' representatives and left a message to call back but due to confidentiality concerns, LSW did not leave any information that there had been a confirmed COVID-19 case in the facility. DON stated that a letter informing residents' families about the confirmed COVID-19 case was currently being drafted and would be mailed the following Monday to residents' families. TC and DON reviewed the email "Notification to Families" dated 06/09/22 at 03:04 PM. In the email, LSW stated to TC that the resident representatives	F 885	When a COVID outbreak is determined, signs will be put up by the nursing department in the lobby area and on the units to identify that there is an active COVID case in the facility. The Director of Nursing and Administrator will ensure that notifications are given to family members in a timely manner and that signs are placed to notify entering people.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING ______ B. WING ______	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	**919 LEHUA AVENUE** **PEARL CITY, HI 96782**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 885	Continued From page 58	F 885		

were left messages to return LSW's call for the following residents:

Residents (R) 14, R19, R66, R62, R54, R49, R43, R3, R58, R67, R1, R15, R10, R7, R46, R38, and R61.

On 06/17/22 at 01:45 PM, a concurrent interview and record review was done with LSW. LSW reviewed her email "Notification to Families" dated 06/09/22 at 03:04 PM. LSW confirmed that she had called the resident representatives listed on the email and left them a message to call the facility back.

2) On 06/14/22 at 10:06 AM, an interview was done with the spouse of R42 at her bedside. R42's spouse stated that despite visiting almost daily, he was not notified of the COVID-positive resident identified on 06/08/22 until 06/11/22. R42's spouse reported that he found out because he went up to the 4th floor on 06/11/22 "to order food" and was told by staff up there "what you doing [sic] here ... you cannot be here, there's COVID." R42's spouse confirmed that he was not called, he was not told at screening, nor did he see any additional signs or information posted. R42's spouse stated he feels he should have been told earlier, "especially since I'm always here."