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	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

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4 000	Initial Comments A relicensing survey was conducted by the Office of Health Care Assurance on 06/14/22 - 06/17/22. The facility was found not to meet the requirements at Hawaii Administrative Rules, Title 11, Chapter 94.1, Nursing Facilities. The census was 69 residents at the time of entrance.	4 000		
4 089	11-94.1-16(b) Governing body and management (b) The facility shall ensure that: (1) Staff sufficient in number and qualifications shall be on duty twenty-four hours a day to carry out the policies, responsibilities, assessed care needs of the residents and program of the facility; and (2) The numbers and categories of personnel shall be determined by the number, acuity level, and needs of residents. This Statute 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:	4 089	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	8/12/22

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4 089	Continued From page 1 On 06/14/22 at 09:14 AM, an interview was done with Restorative Nurse Aide (RNA)1 in room 209 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.	4 089	assistance on 7/5/22. Identifying appropriate care will result in efficient 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.	

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4 089	Continued From page 2 The DON stated that in addition to the three 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.	4 089		
4 113	11-94.1-27(2) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (2) The right to be free of interference, coercion, discrimination, and reprisal from the facility that shall include the right to be free of chemical or physical restraints not medically indicated; This Statute 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	4 113	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.	8/12/22

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4 113	Continued From page 3 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 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	4 113	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 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.	

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4 113	Continued From page 4	4 113		

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.

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

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4 113	Continued From page 5	4 113		

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.

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

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4 113	Continued From page 6 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. 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	4 113		

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4 113	Continued From page 7 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 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."	4 113		
4 115	11-94.1-27(4) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; This Statute 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)	4 115	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	8/12/22

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4 115	Continued From page 8 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. 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.	4 115	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 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.	
4 131	11-94.1-29(b) Resident abuse, neglect, and misappropriation (b) All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source or origin, and alleged misappropriation of resident property shall be reported immediately to the administrator of the facility, and to other officials in accordance	4 131		7/22/22

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4 131	Continued From page 9 with state law through established procedures. This Statute 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 Alleged Violations Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source, Unusual Occurrences and Misappropriation of	4 131	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.	

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4 131	Continued From page 10 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."	4 131		
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty- first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and	4 149		8/12/22

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4 149	Continued From page 11 summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided. This Statute 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. 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	4 149	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, 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	

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4 149	Continued From page 12 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 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	4 149	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.	

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4 149	Continued From page 13 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 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	4 149		

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4 149	Continued From page 14 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.	4 149		
4 175	11-94.1-43(c) Interdisciplinary care process (c) The overall plan of care shall be reviewed periodically by the interdisciplinary team to determine if goals have been met, if any changes are required to the overall plan of care, and as necessitated by changes in the resident's condition. This Statute 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	4 175	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	8/12/22

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4 175	Continued From page 15 meet his highest potential of physical and psychosocial well-being. This deficient practice has the potential to affect all the residents at the facility. 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	4 175	reinstated 6/24/22. On 6/27/22 the resident's ADL and splinting care plan was restarted. 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.	

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4 175	Continued From page 16 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 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.	4 175		
4 178	11-94.1-44(b) Specialized regabilitation services (b) A written rehabilitative plan of care integrated into the overall plan of care, shall be provided that is based on the attending physician's, physician assistant's, or APRN's orders and assessment of a resident's needs in regard to specialized rehabilitative procedures. It shall be developed by the rehabilitative staff and incorporated in, and regularly reviewed in conjunction with, the overall care plan for the resident. This Statute is not met as evidenced by:	4 178		8/12/22

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4 178	Continued From page 17 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 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	4 178	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. 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.	

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4 178	Continued From page 18	4 178		

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 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

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4 178	Continued From page 19 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.	4 178		
4 182	11-94.1-45(a) Dental services (a) Emergency and restorative dental services shall be available to each resident. This Statute 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:	4 182	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	7/22/22

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4 182	Continued From page 20 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 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.	4 182	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. Any discrepancies will be brought to the quarterly QA/QI Committee meetings for review and follow up.	

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4 203	Continued From page 21	4 203		
4 203	11-94.1-53(a) Infection control (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute is not met as evidenced by: Based on observations and interviews, the facility 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	4 203	On 6/17/22, the staff was briefly 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.	8/15/22

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4 203	Continued From page 22	4 203		

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 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

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) COMPLETE DATE
4 203	Continued From page 23 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 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	4 203		

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

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4 203	Continued From page 24 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 bedside.	4 203		