STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	125011		09/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE NANI REHABILITATION AND NURSING CENTER	1677 PENSACOLA STREET HONOLULU, HI 96822

(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/complaint investigation survey was conducted by the Office of Health Care Assurance (OCHA) on 09/19/2022 to 09/23/2022. The facility was not in compliance with 42 CFR 483 Subpart B. Three facility-reported incidents were investigated (ACTS #HI9622 and #HI9744 were unsubstantiated, and ACTS #HI9443 was substantiated with deficiency). One complaint was investigated (ACTS #HI9126) and was unsubstantiated. Survey date: 09/19/2022-09/23/2022 Census: 264 Sample size: 38	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to ensure the call light was kept within a resident's reach to enable the resident to call for assistance when needed for 1 (Resident #202) of 35 residents reviewed for accommodation of needs. Findings included:	F 558	Resident #202 care plan has been updated to reflect current behavioral interventions, call light clip has been placed at bedside. Resident was discharged to the community on 10/1/22 Current residents have the potential to be affected by this practice. Facility conducted a house wide audit on 9/23/22 to validate that resident□s call lights have	10/17/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/17/2022

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.

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F 558	Continued From page 1 Review of an undated facility policy titled, "Resident Call System," revealed, "The facility will be equipped to enable residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area." Review of an "Admission Record" revealed the facility admitted Resident #202 on 08/22/2022 with diagnoses that included muscle weakness, cognitive communication deficit, and unspecified dementia. Review of an admission Minimum Data Set (MDS), dated 08/24/2022, revealed Resident #202 scored 12 on a Brief Interview for Mental Status (BIMS), which indicated the resident was cognitively intact. The MDS indicated the resident required extensive assistance with bed mobility, transfers, and toilet use. Per the MDS, the resident was frequently incontinent of urine and always incontinent of bowel. The MDS also revealed the resident had not had any falls since admission, reentry, or the prior assessment. Review of a care plan, dated as initiated on 08/23/2022, revealed the resident was at risk for falls related to generalized weakness and gait/balance problems. A planned intervention for this care plan problem was to keep the resident's call light within reach and encourage the resident to use it for assistance as needed. The care plan indicated the resident needed prompt response to all requests for assistance. Observations on 09/19/2022 revealed the following: - At 2:33 PM, Resident #202 was in bed in his/her room. The call light was on top of the blankets at	F 558	clips at bedside. DON/designee initiated re-education to staff on 9/23/22 regarding call lights being within reach of residents DON/designee will complete random observations on each unit to validate that call lights are within reach and residents needs are being attended to. 5 observations weekly X4 weeks then 5 observations monthly X2 months. DON/designee will present findings at the facility□s Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency.	

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F 558	Continued From page 2 the foot of the bed, out of the resident's reach. - At 2:36 PM, Resident #202 yelled out two times. Staff did not respond. - At 2:41 PM, Resident #202 had his/her hand inside the incontinence brief. There was fecal matter smeared on the overbed table. Observation on 09/21/2022 at 10:43 AM, revealed Resident #202 in bed in his/her room. The call light was on the floor. Observation on 09/21/2022 at 11:55 AM, revealed Resident #202 was able to demonstrate the use of the call light. During an interview on 09/21/2022 at 1:37 PM, Certified Nursing Assistant (CNA) #11 stated Resident #202 was able to press the call light to ask for his/her brief to be changed. During an interview on 09/23/2022 at 8:49 AM, Unit Director (UD) #1 stated staff should make sure call lights were in place before they left a room. During an interview on 09/23/2022 at 10:43 AM, the Director of Nursing (DON) stated call lights should be within reach and easy for residents to use. During an interview on 09/23/2022 at 1:16 PM, the Administrator stated all residents should have a call light, and that the facility had clips to ensure the call lights would stay in place. During an interview on 09/23/2022 at 2:38 PM, the Administrator stated a clip was added to Resident #202's call light, so that it would stay near the resident.	F 558		

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F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any	F 582		10/17/22

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F 582	Continued From page 4 deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to issue a Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) to a resident prior to the end of Medicare Part A covered services for 1 (Resident #430) of 3 sampled residents reviewed for advanced beneficiary notification. Findings included: Review of an undated facility policy titled, "Medicaid/Medicare Coverage/Liability Notice," revealed, "The NOMNC [Notice of Medicare Non-Coverage] is issued when all covered services end for coverage reasons. If after issuing the NOMNC and the SNF [skilled nursing facility] expects the beneficiary to remain in the facility in a non-covered stay, either the SNFABN or Denial Letter must be issued to inform the beneficiary of potential liability for the non-covered stay." Review of an "Admission Record" revealed the facility admitted Resident #430 on 07/02/2022	F 582	Resident #430 has been discharged from facility Current residents requiring an advanced beneficiary notice are at risk. Facility conducted an audit on 10/7/22 for residents requiring an ABN in the last 30 days. Social Services were educated on 10/10/22 and 10/17/22 regarding notification and issuance of advanced beneficiary notices to residents and/or responsible parties in a timely manner. Administrator/Designee will complete 5 random audits weekly X4 weeks then 5 audits monthly X2 months to validate that advanced beneficiary notices are being issued in a timely manner. Administrator/designee will present findings at the facility□s Quality Assurance and Performance Improvement meeting monthly until QAPI	

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F 582	Continued From page 5 with diagnoses that included weakness, type 2 diabetes mellitus with diabetic chronic kidney disease, and spinal stenosis (a narrowing of the spinal column which compresses the spinal cord). Review of a "Social Services Note," dated 08/02/2022, revealed, "NOMNC issued with resident. Notified resident that last coverage date is 8/4/22 and discharge date is 8/5/22." Review of a SNF Part A discharge Minimum Data Set (MDS), dated 08/04/2022, revealed the end of Resident #430's most recent Medicare stay was 08/04/2022. Review of a "Census List" revealed Resident #430 had a payer change on 08/05/2022. A review of a "Progress Note," dated 08/05/2022, revealed Social Services followed up with a caregiver from a senior support service. The caregiver was willing to accept the resident. The note indicated the resident declined the caregiver. The note revealed Social Services informed the resident that if a decision regarding placement was not made that day, the resident would have financial liability (for a continued stay in the facility). The note indicated the resident understood and stated he/she would reconsider and contact the caregiver. Review of a statement dated 08/08/2022, revealed Resident #430 had a balance owed of $2,016.00 from 08/05/2022 through 08/08/2022 for "Private Pay Room & [and] Board." Review of a statement dated 08/16/2022, revealed Resident #430 had a balance owed of $11,592.00 from 08/09/2022 through 08/31/2022	F 582	team recommends a lesser frequency	

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F 582	Continued From page 6 for "Private Pay Room & Board." Review of a discharge-return not anticipated MDS, dated 08/19/2022, revealed Resident #430 scored 15 on a Brief Interview for Mental Status (BIMS), which indicated the resident was cognitively intact. The MDS indicated the resident discharged to the community on 08/19/2022. During an interview on 09/20/2022 at 2:35 PM, the Administrator (NHA) stated he was not sure if Resident #430 was made aware that he/she would be private pay beginning on 08/05/2022. During an interview on 09/20/2022 at 2:51 PM, the Administrator stated he could not find the advanced beneficiary notice (ABN) for Resident #430. During an interview on 09/21/2022 at 9:12 AM, the Social Services Director (SSD) stated the ABN should have been issued in this case. During an interview on 09/21/2022 at 11:01 AM, the SSD stated she could not find a copy of the ABN for Resident #430. During an interview on 09/23/2022 at 1:15 PM, the Administrator stated Social Services should have provided an ABN when there was a payer change. During an interview on 09/23/2022 at 2:11 PM, the Director of Nursing (DON) stated Social Services was responsible for ABNs, and residents should be given those notices prior to the last covered day of services.	F 582		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation	F 610		10/17/22

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F 610	Continued From page 7 CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her 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 record review, interviews, and facility policy review, the facility failed to ensure an injury of unknown origin was thoroughly investigated for 1 (Resident #423) of three sampled residents reviewed for abuse. Findings included: Review of a facility policy titled, "Freedom from Abuse, Neglect and Exploitation Facility Requirements for Reporting and Investigating Allegations," revised 05/2018, revealed, "4. The facility will report allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property within two (2) hours of the allegation being made if the allegation involves abuse or	F 610	Resident #423 has been discharged from facility. Current residents have the potential to be affected by this practice. An audit was conducted on 10/14/22 to review facility reported incidents in the past 30 days to validate they were appropriately investigated RNC provided education to Administrator and DON about completing a thorough investigation on 10/11/22. RNC/designee will be notified of state reportable incidents and abuse allegations. RNC will validate that facility has completed thorough investigation(s).	

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F 610	Continued From page 8 results in serious bodily injury. 5. If the allegation does not involve abuse and does not result in serious bodily injury the facility will report the allegation within 24 hours." The policy also indicated, "The facility Administrator / designee will conduct thorough investigations of alleged violations and report the findings to the State agency within 5 working days of the allegation." Review of a facility policy titled, "Freedom from Abuse, Neglect and Exploitation Abuse Policies," dated 11/2017, revealed, "Investiation 1. Each allegation of abuse will be thoroughly investigated in an effort to determine if abuse, neglect, exploitation and/or mistreatment occurred. The investigation will attempt to identify any person involved or who may have knowledge of the investigation. 2. The investigation will include interviews with the alleged victim, alleged perpetrator, witnesses, and other [sic] who may have knowledge of the allegations, to the extent possible. 3. The administrator / designee will be responsible for the investigation of allegations." The policy also indicated, "6. A record of the investigation will be maintained, including interviews with involved people." Review of an "Admission Record" revealed Resident #423 had diagnoses which included fracture of the fourth lumbar vertebra (a bone that is part of the spinal column in the lower back), Alzheimer's disease, cognitive communication deficit, end stage renal disease (ESRD), and pain. Review of a five-day Minimum Data Set (MDS), dated 04/21/2022, revealed Resident #423 had a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. The	F 610	RNC/designee will review abuse investigations for 3 months to validate facility has conducted thorough investigation(s). Findings will be reported to the facility□s QAPI committee monthly x3 months. If needs are identified, audits will be replicated until compliance is achieved.	

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F 610	Continued From page 9 MDS indicated the resident required extensive assistance with bed mobility and transfers and had not fallen since admission/reentry or the prior assessment. Review of a "Care Plan," dated as initiated 03/05/2022 and revised 05/26/2022, revealed Resident #423 was at risk for falls related to generalized weakness, gait and balance problems, and multiple medical conditions. Interventions included putting the resident's bed in a low position after providing care, ensuring commonly used items were within the resident's reach, and ensuring the resident was wearing appropriate footwear (non-skid shoes/socks) prior to transfers. Review of "Progress Notes," dated 04/09/2022, revealed the facility received a call from the dialysis center because Resident #423 had not yet arrived. The nurse called the transport service and was told Resident #423 had collapsed on the way to dialysis and was taken to the emergency room (ER). Review of "Progress Notes," dated 04/09/2022, revealed the ER nurse contacted the facility and stated the resident was being admitted to the hospital for a compression fracture. Review of a "Radiology Report," dated 04/09/2022, indicated a computed tomography (CT) scan of the abdomen and pelvis revealed Resident #423 had a "new moderate compression fracture of L4 [fourth lumbar vertebra] with mild retropulsion [displacement of a fracture fragment into the spinal canal]." Review of an Office of Health Care Assurance	F 610		

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F 610	Continued From page 10 (OHCA) "Event Report," dated as submitted to the state survey agency on 04/10/2022, revealed Resident #423 fell from the wheelchair during transport to dialysis. The van driver called 911, and the resident was transferred to the hospital. The report indicated the resident was admitted with a compression fracture of L4 (vertebra). According to the review of the cameras on the Handi Van, Resident #423 had not fallen. The detailed description on the report indicated the Director of Nursing (DON) interviewed the van driver, who reported the resident "did not fall" and that no one was near the resident when the incident occurred. The report further revealed that prior to calling 911, the van driver checked on the resident. The resident reported pain, and the driver questioned the resident as to whether he/she would like to go to the hospital. The report indicated "camera and video statement review" revealed no accident or abuse concerns. The facility's conclusion was that abuse and neglect were ruled out. Review of an "Investigation Report," dated 04/10/2022 through 04/16/2022, revealed the facility's investigation included interviews with two Occupational Therapists (OT), a Medical Records employee, the Social Services Director, two Licensed Nurses, the assigned Unit Manager, the van service supervisor, the Physiatrist's Physician Assistant (PA), and a Physical Therapist (PT). The timeline of events indicated that during transport to dialysis, the resident collapsed. The report indicated a camera/video statement review was completed by the van service supervisor, who confirmed that the van driver did not harm the resident. The facility was unable to obtain a copy of the video footage but requested that the footage be retained in case it was needed in the	F 610		

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F 610	Continued From page 11 future. Per the report, interviews with Certified Nursing Assistants (CNAs), licensed nurses, and involved therapy staff revealed no concerns regarding care for this resident. The facility concluded that the "investigation was unsubstantiated" and determined that education should "continue regarding fall prevention and pain management." Review of "Progress Notes," dated 04/15/2022, revealed the resident was readmitted to the facility with diagnoses including acute respiratory failure with hypoxia (low oxygen levels in the blood) and a closed fracture of the fourth lumbar vertebra. The resident was to receive physical therapy (PT), occupational therapy (OT), and speech therapy (ST). During an interview on 09/21/2022 at 3:31 PM, the DON stated Resident #423 did not have any falls while in the facility. The DON acknowledged he did not speak to Resident #423's family during the investigation of the fracture. He stated the van driver indicated the resident was waving for assistance, and the driver approached the resident. The DON indicated the resident did not fall; he/she was sitting upright in the wheelchair. The van driver was certain the resident did not fall. Review of "Witness Interview Notes," dated 04/11/2022, revealed the DON interviewed Registered Nurse (RN) #6 about the day the resident was diagnosed with a fracture. During an interview on 09/22/2022 at 10:04 AM, the DON stated he asked RN #6 questions about what happened in general but did not have the information written in an interview. The DON	F 610		

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F 610	Continued From page 12 stated he also interviewed a PT about Resident #423's pain on 04/15/2022. The DON stated there was no interview with PT about the resident's status prior to the fracture diagnosis. Review of "Witness Interview Notes," dated 4/11/2022, revealed Occupational Therapist (OT) #1 noted Resident #423's bed mobility and transfer status, reports of pain, and therapy activities. The DON documented there were no incidents or accidents reported. During an interview on 09/23/2022 at 10:13 AM, the DON stated there was an interview with OT #1, but the OT wanted to review her notes and write a statement, so the interview was not written down. Review of "Witness Interview Notes," dated 04/12/2022, revealed that RN #7 stated in an interview with the DON that Resident #423 had complained of back and hip pain prior to the hospitalization during which the fracture was identified. During an interview on 09/23/2022 at 10:13 AM, the DON stated RN #7 was unable to specify when Resident #423 had complained of pain prior to the fracture being identified. Review of "Witness Interview Notes" revealed the DON interviewed Physician's Assistant (PA) #1 on 04/15/2022. Further review of "Witness Interview Notes," dated between 04/11/2022 and 04/15/2022, revealed no Certified Nursing Assistants (CNAs) were interviewed during the investigation into the fracture of unknown origin.	F 610		

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F 610	Continued From page 13 During an interview on 09/23/2022 at 10:13 AM, the DON stated he interviewed PA #1 about suspicions of abuse, any allegations made by the resident or family, any potential for harm, bruising, or new skin discolorations, but this was not written down. The DON stated he had also asked the licensed nurses about this, but the interviews were not written down. The DON indicated he asked the CNAs about the incident and that he would have to check the investigation summary to confirm whether he documented the CNA interviews. The DON was unable to recall which CNAs were interviewed during the investigation. The DON stated that when there was an injury of unknown origin, there should be a thorough investigation. The DON stated Resident #423's family was not interviewed during the investigation. During an interview on 09/23/2022 at 1:28 PM, the Administrator stated there should have been a root cause analysis done to rule out abuse. The Administrator also stated there should have been interviews with staff members and that usually he, the DON, and the nursing team would collaborate and review the schedule to determine who was involved in the resident's care.	F 610		
F 880 SS=F	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.	F 880		10/17/22

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F 880	Continued From page 14 §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 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	F 880		

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F 880	Continued From page 15 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, interviews, record review, and facility policy review, the facility failed to ensure infection control precautions were consistently implemented to prevent the potential spread of COVID-19 or other infectious illnesses to residents and staff. Specifically, the facility: - Failed to ensure staff correctly utilized, changed, and disposed of personal protective equipment (PPE) on 7 (Piikoi One, Piikoi Two, Lewalani Ground Unit, Lewalani One, Pensacola One, Pensacola Two, and Pensacola Three) of 8 units observed. - Failed to ensure a resident was notified of the need for transmission-based precautions for 1 (Resident #428) of 5 sampled residents reviewed for transmission-based precautions. Findings included:	F 880	Resident #423 was educated on isolation rationale and timeframe on 9/23/22. Resident no longer requires isolation Current residents have the potential to be affected by this practice. An audit was conducted on 9/22/22 to verify which bins would be less preferred, so staff can properly dispose of PPE with ease. DON/ADMIN/Unit Managers immediately surveyed the units and removed 21 flip-type bins. These were then replaced with covered (sealing) bins. Bins were placed near resident rooms and emptied timely to prevent overflowing. Current residents on isolation were re-educated on 10/14/22 on the rationale and timeframe of their isolation period.	

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F 880	Continued From page 16 1. Review of the Centers for Disease Control and Prevention (CDC) document titled, "Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities," dated June 2021, revealed "1. Multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to significant morbidity and mortality for residents and increased costs for the health care system. 2. Enhanced Barrier Precautions (EBP) is an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission of S. [Staphylococcus] aureus and MDROs. 3. EBP may be applied (when contact precautions do not otherwise apply) to residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status or infection or colonization with an MDRO. 4. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE with hand hygiene products at the point of care." Review of the CDC document titled, "Example of Safe Donning and Removal of Personal Protective Equipment (PPE) Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings," dated 2007, revealed, "Remove PPE at doorway before leaving patient room or in anteroom." Review of the CDC document titled, "Implementing Filtering Facepiece Respirator (FFR) Reuse, Including Reuse after Decontamination, When There Are Known Shortages of N95 Respirators," updated 10/19/2020, revealed, "Crisis Capacity Strategies" which included that with limited reuse, an N95	F 880	Flip-type bins will not be utilized until further notice. DON/designee will continue infection control spot checks to ensure that the correct infection control practices are being adhered to. Facility education was initiated on 9/26/22 pertaining to the doffing of PPE prior to room exit, notifying residents of isolation period(s) and emptying trash/soiled linen bins timely. Staff education was initiated on 10/11/22 on Sparkling Surfaces, Clean Hands, Keep COVID-19 Out!, CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: PPE Lessons, Reprocessing Reusable Resident Care Equipment, and Environmental Cleaning and Disinfection. .The facility has designated the Infection Preventionist/ designee to inform residents of new isolation status DON/designee will conduct facility rounds to validate that staff members are donning/doffing PPE appropriately, bin use remains as stated and that they are emptied timely: 1) 5 staff daily x 2 weeks, then 2) 10 staff weekly x 2 weeks, then 3) 5 staff per week x 2 months	

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F 880	Continued From page 17 mask could be donned for one patient contact, then doffed (removed) and stored before being used for another patient contact for a limited number of donnings; however, the document included a, "Situational update as of May 2021," which indicated, "The supply and availability of NIOSH [National Institute for Occupational Safety and Health]-approved respirators have increased significantly over the last several months. Healthcare facilities should not be using crisis capacity strategies at this time and should promptly resume conventional practices." Additionally, the update indicated, "Respirators that were previously used and decontaminated should not be stored." During an interview on 09/19/2022 at 1:13 PM, Registered Nurse (RN) #2 stated staff should change their gloves, gowns, face shields, and N95 masks between rooms where contact and/or droplet precautions were in place. She stated for the other rooms, staff should clean their face shield and change their N95 mask. 1.a) Observation on the Piikoi Two Unit on 09/19/2022 at 1:49 PM revealed Certified Nursing Assistant (CNA) #8 leaving Room 210, which had signage indicating it was a COVID-positive room. The CNA removed her face shield and N95 mask in the hallway outside the resident's room, then removed her contaminated gown and threw it away in the hallway trash can. The call light for Room 210 came on again at this time, so CNA #8 donned new PPE and went back into the room. At 1:54 PM, CNA #8 left Room 210, removed her gloves and gown in the hallway, left her N95 mask and face shield on, and entered Room 204 at 1:57 PM. Room 204 had signage indicating contact and droplet precautions were required;	F 880		

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F 880	Continued From page 18 the room housed three COVID-positive residents. Observation on 09/19/2022 at 2:13 PM revealed that CNA #8 donned gloves, removed a trash bag containing contaminated PPE from a small trash container, shook the bag to settle the contents, then tied the bag. CNA #8 emptied two additional trash cans which contained contaminated PPE and shook the bags to enable her to fit more trash in them. During an interview on 09/19/2022 at 2:24 PM, CNA #8 stated she was trained on donning and doffing PPE and to dispose of it in the hallway trash. CNA #8 stated she should have changed her mask and face shield after leaving Room 210. During an interview on 09/19/2022 at 2:45 PM, RN #2 stated she was taught to dispose of PPE in a trash can outside the resident's room. She stated since COVID-19 was airborne, she thought staff should dispose of the PPE in the room, just prior to leaving the room, to keep the hallway free from contamination. RN #2 stated PPE should be changed between each resident, so the CNA going from Room 210 to Room 204 should have changed her mask and face shield to protect the next person from contamination. RN #2 stated the hallway should be as clean as possible and having trash containers in the hall with contaminated PPE was not clean. She stated the hall was not an isolation area and should be clean. 1.b) Observation on Piikoi One Unit on 09/21/2022 from 12:08 PM to 1:22 PM revealed the following rooms with signage indicating enhanced precautions and PPE were required: - Room 102: The trash can was in the hallway	F 880		

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F 880	Continued From page 19 outside the door, with PPE gown strings hanging out of the top. - Room 106: The trash can was in the hallway with the lid open. - Room 108: The trash can was in the hallway with the lid open. The container was full of used PPE gowns. - Room 117: The trash can was in the hallway with the lid closed, but a PPE gown was hanging out of the top of the can. - Room 119: The trash can was in the hallway with the lid open. Blue PPE gowns were hanging over the top rim of the can. On 09/21/2022 at 2:25 PM, Room 116 was observed to have a trash can in the hallway with the lid open. A yellow PPE gown was hanging out of the top of the can. During an interview on 09/21/2022 at 1:02 PM, Licensed Practical Nurse (LPN) #2 stated she took her gowns off in the rooms and brought them out to the trash cans in the hallway. LPN #2 stated she thought the rooms had too much clutter, so the facility placed the trash cans in the hallway. 1.c) Observations on 09/22/2022 from 10:36 AM to 10:50 AM on the Lewalani Ground Unit, which was designated for persons under investigation (PUI) for COVID-19, revealed the following: - Room G01: Signage was posted for contact and droplet precautions. The trash can was in the hallway with the lid open. The can was full of contaminated PPE gowns. - Room G02: Signage was posted for contact and droplet precautions. On 09/22/2022 at 10:38 AM, an unidentified staff member removed a contaminated gown in the doorway of the room,	F 880		

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F 880	Continued From page 20 rolled up the gown, closed the door to the room, walked to the trash can approximately two feet away, and pushed down the gowns in the trash can with her bare hands. - Room G03: Signage was posted for contact and droplet precautions. The trash can was in the hallway, with straps from PPE gowns hanging out the top of the can. - Room G09: Signage was posted for contact and droplet precautions. One trash can was in the hallway between Rooms G09 and G10, approximately three feet away from the door to each room. The lid was open, and the can was overflowing with contaminated PPE gowns. During an interview on 09/22/2022 at 10:50 AM, RN #5 stated the Lewalani Ground Unit had two COVID-positive residents at this time, which were indicated with red signs on the door to their rooms. The other residents on this unit were on precautions due to potential exposure because a staff who had provided care to them tested positive. Observations on the Lewalani One Unit on 09/22/2022 from 11:32 AM to 11:48 AM revealed the following: - Room 101: Signage was posted for contact and droplet precautions. The door to the room was open. At 11:38 AM, an unidentified staff member left the room, removed the contaminated gown, rolled it up, and pushed it into a full trash can in the hallway. The trash can lid was left open. - Room 105: Signage was posted for enhanced precautions. A soiled linen can was in the hallway with gowns hanging out the top of the container. - Room 108: Signage was posted for enhanced precautions. Trash and soiled linen cans were outside the door to the room. Soiled linens were	F 880		

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F 880	Continued From page 21 visible in the soiled linen can, and the trash can was overflowing with contaminated PPE. During an interview on 09/22/2022 at 11:33 AM, RN #4 stated the resident in Room 101 was a new admission, and new admissions were presumed COVID-positive. RN #4 thought the door to Room 101 should be closed but did not close the door. Observation on 09/22/2022 at 11:38 AM revealed an unidentified staff member left Room 101, removed her gloves and gown, threw away the gloves, rolled up the gown, and stuffed it into an already full trash can. The trash can lid was left open. 1.d) Observation on the Pensacola One Unit on 09/22/2022 from 9:35 AM to 9:55 AM revealed all rooms had enhanced precautions signage posted. Further observation revealed the following: - Room 101: The trash can was in the hallway next to the door. The lid was open, and the can was almost full of contaminated PPE gowns. - Room 104: The trash can was in the hallway with the lid open. PPE gowns were visible in the can. - Room 110: The trash can was in the hallway with the lid ajar. - Room 111: The trash can was in the hallway next to the door to the room. The lid was open and PPE gowns were visible in the can. - Room 116: The trash can was in the hallway next to Room 115 with the lid open and PPE gowns visible. 1.e) Observation on the Pensacola Two Unit on 09/22/2022 from 9:16 AM to 9:32 AM revealed a	F 880		

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F 880	Continued From page 22 trash can in the hallway by the door to Room 203. The lid was open and soiled gloves were visible in the can. 1.f) Observation on the Pensacola Three Unit on 09/22/2022 from 9:00 AM to 9:13 AM revealed Room 315 had enhanced precautions signage posted. The trash can was in the hallway with the lid open. PPE gowns were visible in the can. During an interview on 09/22/2022 at 2:12 PM, the Infection Control Preventionist (ICP) stated the PUI Unit was where residents who were presumed to be COVID-positive were housed. The ICP stated the trash can lids should be closed. She indicated soiled items should be dropped into the trash cans rather than pushed, and PPE should not hang out of the cans. She stated the trash cans were placed by each door to save space in the residents' rooms. The ICP further stated staff should change gowns and gloves in the hallway and keep their mask and face shield on if they were only taking care of COVID-positive residents. During an interview on 09/22/2022 at 3:14 PM, the Director of Nursing (DON) stated the covers of the trash cans should be closed to prevent harmful microorganisms from circulating into the air. The DON stated contaminated PPE should be removed in the room or in the doorway for rooms with contact and/or droplet precautions. He stated the garbage bags with soiled PPE should not be shaken. During an interview on 09/23/2022 at 3:17 PM, the Administrator stated his expectation was that the trash cans be emptied routinely, not overflowing, and that staff use PPE when pushing	F 880		

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F 880	Continued From page 23 trash into the cans. 2. Review of a facility policy titled, "Infection Prevention and Control Program (IPCP)," revised 03/2021, revealed, "10. Visitors and residents will be informed and educated regarding ICCP as well as any outbreak situation which may affect them." The policy also indicated that when transmission-based precautions were implemented, "c. Resident, resident representative and visitors will be educated regarding the transmission-based precautions." Review of an "Admission Record" revealed the facility admitted Resident #428 on 09/02/2022 with diagnoses that included encounter for other orthopedic aftercare, asthma, bipolar disorder, and anxiety disorder. Review of an admission Minimum Data Set (MDS), dated 09/08/2022, revealed Resident #428 scored 15 on a Brief Interview for Mental Status (BIMS), indicating the resident was cognitively intact. Review of a care plan, dated as initiated on 09/06/2022, revealed Resident #428 was at risk for infection related to COVID-19. Interventions included: - Document and report signs/symptoms promptly. - Observe droplet isolation precautions as needed. During an interview on 09/20/2022 at 9:35 AM, Resident #428 stated he/she was not aware that he/she was on transmission-based precautions initially and wished someone had informed him/her. Resident #423 stated he/she was in the lobby, and an activity aide informed him/her of the precautions. Resident #423 stated he/she did not	F 880		

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F 880	Continued From page 24 know when the precautions were supposed to start or when they would end. During an interview on 09/21/2022 at 10:28 AM, Unit Director (UD) #1 stated residents were notified when they were on transmission-based precautions. UD #1 stated the nurse on the unit notified the residents of the length of time they would be on droplet precautions and would notify the resident the day they arrived at the facility. During an interview on 09/22/2022 at 2:48 PM, Registered Nurse (RN) #9 stated when residents were admitted to the facility or started on isolation precautions, staff would explain it to them. RN #9 stated she was not sure if residents were told how long they would be on droplet precautions. RN #9 stated Resident #428's current isolation precautions started on 09/14/2022. RN #9 stated she thought she told the resident the length of time he/she would be on droplet precautions but may not have mentioned it. RN #9 stated the Unit Director would explain to residents what was going on with their precautions. During an interview on 09/22/2022 at 3:02 PM, UD #1 stated she was not working when Resident #428's droplet precautions were initiated. UD #1 indicated she was not sure when the droplet precautions were started. During an interview on 09/22/2022 at 3:16 PM, Resident #423 stated he/she wanted to know when the precautions would be over. During an interview on 09/23/2022 at 8:58 AM, the Infection Control and Prevention Nurse (ICP) stated the nurse on the floor should tell the residents how long they would be on precautions.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	125011		09/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 25 She stated she was not sure if those conversations with the residents were documented anywhere. During an interview on 09/23/2022 at 10:45 AM, the Director of Nursing (DON) stated the licensed nurse should communicate with the residents regarding transmission-based precautions and it was preferred that the residents were told specific dates. During an interview on 09/23/2022 at 1:20 PM, the Administrator stated the nursing team would notify the residents of transmission-based precautions. The Administrator stated the ICP or the nursing team should let residents know the timeframe for the precautions.	F 880		