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	125010	A. BUILDING _____ B. WING _____	09/30/2022

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LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

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F 000	INITIAL COMMENTS A re-certification survey was conducted by the Office of Health Care Assurance (OHCA) on 09/27/2022 - 09/30/2022. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. ACTS #9721 was investigated and not substantiated. Survey Dates: 08/30/2022 - 09/02/2022 Survey Census: 99 Sample Size: 20	F 000		
F 551 SS=D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of	F 551		

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

Electronically Signed

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F 551	Continued From page 1 the resident to the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law. §483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.	F 551		

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F 551	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the resident's wishes and preferences were considered in the exercise of the rights of the representative for one of two residents sampled. Findings include: On 09/28/22 at 12:32 PM, conducted a review of Resident (R)99's Electronic Health Record (EHR) in the conference room. R99 was admitted to the facility on 07/15/22 and expired on 08/27/22. R99 was admitted with diagnosis that includes Dementia and Alzheimer's. R99's Minimum Data Set (MDS) with an Assessment Reference Date 07/22/22, Section C. Cognitive Patterns documented R99's Brief Interview for Mental Status (BIMS) score was 3, indicating the resident has severe cognitive impairment. -Review of R99's Advance Health Care Directive (AHCD) form documented the resident designated Family Member (FM)1 as the primary Health-Care Power of Attorney (HCPOA) and if FM1 is not available, FM2 was designated as an alternative agent. R99 documented his/her wishes were: A) Yes, I do want my life prolonged as long as possible within the limits of generally accepted health-care standards that apply to my condition B) No, I do not want artificial nutrition and hydration C) Treatment to alleviate pain or discomfort should be provided to me even if it hastens my death.	F 551		

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-Review of R99's Physician Order for Life-Sustaining Treatment (POLST) documented FM1 completed the POLST prior to R99's admission to the facility. FM1 chose POLST treatment options that differed from R99's wishes documented in his/her AHCD regarding prolonging R99's life and administration of artificial nutrition and hydration. POLST treatments were documented as:

A) Do Not Attempt Resuscitation (DNAR) for Cardiopulmonary Resuscitation (CPR)
B) Comfort Measures Only to relieve pain and suffering
C) Long-Term artificial nutrition by tube

-Review of the Physician's Notes (07/18/22, 7/20/22, 08/01/22, 08/15/22, and 08/22/22) confirmed there was no documentation that the physician reviewed R99's AHCD, identified the discrepancy between the AHCD and POLST, a discussion with FM1 regarding R99's wishes/preferences or the discrepancy between the AHCD and POLST.

-Review of R99's Comprehensive Care Plan (CCP), created by Social Worker (SW)1 on 07/20/22, documented, "I have laid out my wishes on how I want to be treated in case I become seriously ill, unable to speak/unable to make my own decisions in my advance health care directive and POLST". Goals on the CCP was documented as R99's wishes will be followed by facility staff. Interventions included review of R99's AHCD, POLST, Living Will, and Code Status annually and as needed.

On 09/29/22 at 12:09 PM, conducted an interview with Social Worker (SW)1 and SW3 in the

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conference room. Inquired about the process for reviewing AHCD and POLST to ensure the resident's wishes/preferences are reviewed if there is a conflict between the AHCD and POLST. SW1 stated during the admission process, Patient Access Rep (PAR) documents if the resident has an AHCD and/or POLST. Social work will review the AHCD and POLST and if there is a discrepancy between the documents, it will be discussed with the resident if the resident is capable of making such decisions or with the HCPOA if someone is designated, and the discussion should be documented in the resident's chart.

On 09/30/22 at 09:25 AM, conducted a concurrent record review and interview with Nurse Manager (NM)5 in his/her office. NM5 confirmed the resident was DNAR, comfort measures only, and would receive artificial nutrition after reviewing R99's POLST. NM5 reviewed R99's AHCD then stated that he/she was unaware that R99's wishes were to prolong his/her life as long as possible, did not was artificial nutrition or hydration, and confirmed R99's AHCD and POLST were conflicting. NM5 stated when a resident is admitted, the AHCD and POLST are reviewed by social worker staff and the physician. Reviewed R99's AHCD that identified FM2 as the second HCPOA when FM1 was unavailable. Inquired if there were any instances when the facility attempted to get in touch with FM1 and could not. NM5 confirmed there were times when the facility attempted to get in touch with FM1 but could not due to FM1's work schedule (FM1 worked nights and slept during the day). Inquired if an attempt was made to contact FM2 when FM1 could not be reached. NM5 stated FM1 informed the facility that there

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was conflict in the family and instructed the facility not to contact FM2, so FM2 was not contacted when FM1 was unavailable.

On 09/30/22 at 10:47 AM, conducted concurrent record review of R99's EHR and interview with Social Worker (SW)1 in SW1's office. Reviewed R99's AHCD and POLST. SW1 confirmed there was a discrepancy between R99's AHCD and the POLST and stated the facility should honor the wishes of the resident documented on the AHCD. SW1 reviewed the entirety of R99's EHR, then stated social services did not review R99's AHCD and that the discrepancy between the resident's AHCD and POLST was not identified. Reviewed R99's CCP and inquired if the POLST or AHCD should have been followed due to the conflicting directives. SW1 stated the resident's AHCD should have been addressed because that was the resident's wishes when she had the capacity to make those decisions. Reviewed a progress note on 08/14/22 at 2:15 PM, that documented the HCPOA left the decision up to the resident to go to an acute facility when the physician recommended further care. Inquired if R99 had the capacity to make healthcare decisions. SW1 stated due to the resident's BIMS score (3, severe cognitive impairment), diagnosis of Alzheimer's and Dementia, and the implementation of the HCPOA, R99 was not able to make healthcare decisions and the resident's AHCD should have been reviewed because those are the resident's wishes when the R99 could make those healthcare decisions. SW1 could not provide documentation that R99's wishes on the AHCD was reviewed by the facility or with FM1.

On 09/30/22 at 3:27 PM, conducted an interview with the Nursing Home Administrator (NHA).

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F 551	Continued From page 6 NHA stated normally the ACHD and the POLST align, and both should be reviewed when the resident is admitted by social work and the physician when the physician orders the resident's code status. On 09/30/22 at 3:58 PM, conducted a telephone interview with the Quality Manager (QM). This surveyor informed QM of the discrepancy between R99's AHCD and POLST, interviews conducted, and reviews of R99's EHR with previously mentioned staff. QM stated the POLST should have been verified against the AHCD and the discrepancy should have been documented in the progress notes or in the CCP. Furthermore, the AHCD and POLST from the other facility should have been reviewed when the physician ordered the DNR (Do Not Resuscitate) in the EHR. Then, a discussion would have been done by the physician with the healthcare POA about this discrepancy which should have been documented. Requested for QM to review R99's medical records (to include hard charts and EHR) for any form of documentation that the facility was aware of the discrepancy between R99's AHCD and POLST and the discrepancy was reviewed with FM1 to ensure R99's wishes were taken into consideration. On 09/30/22 at 4:14 PM, QM called the conference room and informed this surveyor that R99's records and EHR were reviewed. QM confirmed there were no documentation by the physician that R99's AHCD directive was reviewed or that the physician discussed the AHCD with FM1 prior to ordering the DNR status to ensure the resident's wishes and preferences were considered.	F 551		

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F 551	Continued From page 7 On 09/30/22 at 4:30 PM, review of the facility's policy and procedure, Advance Directives (effective 01/01/09) documented "if there is an existing advance directive document, the social worker will review the document with the individual and the family at timed of admission and annually thereafter." Review of the facility's policy and procedure for Provider Orders for Life-Sustaining Treatment (POLST) (effective date: 06/23/16) documented, "in the event of a conflict concerning a POLST, a referral may be made to Ethics Committee for consultation" and "if the patient has an existing advance directive, the physician/APRN should ensure the content is consistent with those indicated while completing the POLST. In the event where the patient's choices have changed, the physician/APRN should encourage the patient to update his/her advance directive and inform nursing or social services staff."	F 551		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or	F 552		

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F 552	Continued From page 8 professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews, and facility policy review, the facility failed to ensure staff consistently informed a resident of care and services to be provided in a language the resident understood, to promote the resident's right to be fully informed of his/her total health status, for 1 (Resident #14) of 3 sampled residents reviewed for communication. Findings included: Review of a facility policy titled, "Communication with Persons with Limited English Proficiency," dated 11/01/2010, revealed, "Language assistance will be provided through use of competent bilingual staff, staff interpreters, contacts, or formal arrangements with local organizations providing interpretation or translations services, or technology and telephonic interpretation services. All staff will be provided notice of this policy and procedure, and staff that may have direct contact with LEP [limited English proficiency] individuals will be trained in effective communication techniques, including effective use of an interpreter." The policy also indicated, "3. Family members or friends of the LEP will not be used as interpreters unless specifically requested by that individual and after the LEP person has understood that an offer of an interpreter at no charge to the person has been made by the facility. a. Such an offer and the response will be documented in the person's chart."	F 552		

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F 552	Continued From page 9 Review of an "Admission Record" revealed the facility admitted Resident #14 on 06/17/2022 with diagnoses that included Alzheimer's disease, anxiety disorder, and insomnia. Review of an admission Minimum Data Set (MDS), dated 06/24/2022, revealed Resident #14 scored zero on a Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. The MDS indicated the resident had clear speech, was sometimes understood, and sometimes understood others. Review of a "CAA [Care Area Assessment] Worksheet," dated 09/24/2022, revealed Resident #14 had a decreased ability to make him/herself understood and/or to understand others. The worksheet noted there was a risk for frustration and isolation if the resident was unable to make him/herself understood or to fully understand information. Review of a care plan, dated as initiated on 06/21/2022, revealed Resident #14 was at risk of communication difficulty exacerbated by Dementia and minimal English. The goal was for the resident to be able to communicate his/her needs via an interpreter and visual communication board. A planned intervention was for staff to utilize a communication chart and/or use interpreter help as needed. During an observation on 09/29/2022 at 11:00 AM, Resident #14 was attempting to stand up; two staff members attempted to assist but were unable to determine what Resident #14 wanted.	F 552		

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Resident #14 became agitated. Licensed Practical Nurse (LPN) #1 stated staff had to guess what Resident #14 wanted, since they could not understand the resident.

During an observation on 09/30/2022 at 9:00 AM, Nurse Manager (NM) #5 spoke to Resident #14 in English, asking the resident to remove his/her belt and attempting to explain to the resident that NM #5 was checking the alarm on the belt to ensure it worked.

During an interview on 09/29/2022 at 10:01 AM, Certified Nursing Assistant (CNA) #1 stated that sometimes Resident #14 shouted because staff could not understand him/her. CNA #1 stated staff tried their best with gestures, and if they needed help, there was a Registered Nurse (RN) who spoke the resident's language. CNA #1 stated that when the RN was not working, staff just did the best they could.

During an interview on 09/29/2022 at 10:52 AM, LPN #1 stated Resident 14 was alert but did not speak English. LPN #1 stated since she did not speak the resident's language, it was tough to communicate, and she used gestures. LPN #1 stated there was a situation where Resident #14 was agitated while staff were attempting to bathe the resident. LPN #1 stated they were unable to communicate with Resident #14 in his/her language, and LPN #1 thought that was why Resident #14 became agitated.

During an interview on 09/29/2022 at 12:53 AM, Social Worker (SW) #1 stated the facility had the phone number for a language interpreter line and picture boards in various languages. SW #1 stated she gave the staff the information and that

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Resident #14 had a communication board.

During an interview at 09/29/2022 at 1:37 PM, NM #5 stated there were iPads available in the facility to assist with translation. Additionally, there was translator, and a staff member was sometimes utilized to translate for the resident. NM #5 stated she had called Resident #14's family member to interpret at times. NM #5 stated staff should have been aware of the translation options.

During an interview on 09/29/2022 at 3:22 PM, CNA #2 stated it was hard to take care of Resident #14 because the resident did not speak English. CNA #2 stated he used body language to figure out what Resident #14 was talking about. CNA #2 stated Resident #14 would speak to him, and he did not know what the resident was saying.

During an interview on 09/30/2022 at 9:11 AM, Unit Clerk #1 stated Resident #14 got frustrated when he/she could not express him/herself, because staff did not understand what the resident was saying.

During an interview with the Administrator and Director of Nursing (DON) on 09/30/2022 at 2:43 PM, the Administrator stated the facility had communication boards and a language line

interpreter that could be called. The Administrator stated staff were educated on this at the annual education fair. The DON stated Resident #14 did not speak English. The DON stated there was a phone interpretation service, pictures that could be pointed to, and machines that could be put in place. The DON stated staff was educated at the

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F 552	Continued From page 12 annual education fair, and there were signs on the desks with information as well.	F 552		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other	F 565		

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(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 565	Continued From page 13 residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interviews, document review, and facility policy review, the facility failed to promptly respond to requests and grievances from the Resident Council and maintain records to demonstrate the response. The failed practice had the potential to affect all residents. Findings included: Review of a facility policy titled, "Resident Rights and Responsibilities," dated 01/01/2009, revealed, "The facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings. When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility." Review of an undated facility document titled, "Resident Council Tool Kit" revealed, "The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. The facility must demonstrate their response and rationale for such response. However, this does not mean the facility must implement every request of the resident or family group." The document also indicated, "d. All grievances raised during the meeting should be recorded in the minutes. e. Responses to grievances should be received in a timely manner as indicated in the	F 565		

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facility's grievance policy. f. Responses should be specific and should be reflected in subsequent minutes."

Review of an "Agenda Resident Council Meeting," dated 01/26/2022, revealed the residents wanted a suggestion box to enable them to provide comments and feedback.

Review of a "March Resident Council Satisfaction Survey" revealed the residents requested and/or reported the following:

- In response to a question regarding the type of activities the residents desired, the residents indicated they would like to have a movie party, live music, a book club, a consistent exercise schedule, and more artwork projects, like painting by numbers.

- In response to a question regarding whether residents were satisfied with the meals provided by the facility, the residents indicated the flavors of the food were not good; the food always tasted the same; they serve the same five meals and mix my vegetables with my food. The residents' suggestions for the food they would like to see on the menu included pizza, chili, more fresh fruit options, tacos/ soft burritos.

- In response to a question regarding whether residents felt their calls for assistance were answered in a timely manner, the residents' comments indicated night shift canceled the call

light, then returned later without helping; staff always stated they were short-staffed; had to wait a long time, then staff would use the intercom to ask if the resident needed help; it "takes a long

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time in the mornings."

- In response to a question regarding whether the residents would like to provide suggestions to improve their care, the responses included that the facility always seemed "shorthanded, mostly in the evenings and night shift. Additionally, there was a suggestion for more opportunities to shower.

Review of an "Agenda Resident Council Meeting," dated 05/25/2022, revealed the residents shared interests in having more opportunities to socialize via Zoom; that residents would like to have a suggestion box for comments and feedback; that the Director of Nursing attend the next meeting; that church services be resumed via the Activities Department; and that a movie be shown in the Young 1 activity room.

A review of "Resident Council Meeting Minutes," dated 07/27/2022, revealed the residents shared an interest in understanding the Emergency Preparedness Plan due to the recent events of high surf along the southern coast and hurricane season.

Review of the July 2022 "Resident Council Satisfaction Survey Results" revealed that in response to a question regarding whether the residents would like to provide suggestions to improve their care, 70% of the responses were "yes." However, the residents' suggestions were not documented.

Review of "Resident Council Meeting Minutes," dated 09/21/2022, revealed the residents requested to have the Emergency Services

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Preparedness Team provide them with the plan to be implemented in the event of a natural disaster.

During an interview on 09/29/2022 at 12:05 PM, Social Worker (SW) #1 stated residents were asked questions about whether their needs were being fulfilled and if they had any concerns they wanted to discuss. SW #1 stated that at every other meeting, a survey was completed, which should have been recorded in the minutes. SW #1 stated SW #2 would have the information on this.

During an interview on 09/29/2022 at 12:27 PM, SW #2 stated that when a concern was brought up in the meetings, the department responsible for the concern would be notified. SW #2 stated the only concern brought up in the September 2022 meeting was that the residents wanted the meetings to be held in person. SW #2 stated dietary was a special guest at the meeting in January 2022, as the residents had a lot of concerns for dietary.

During an interview on 09/29/2022 at 1:12 PM, SW #2 stated there had not been any grievances from the council in the last six months, and there were no dietary concerns.

During an interview on 09/30/2022 at 10:05 AM, Resident #51 and Resident #64 stated they did not know how to file a grievance.

During an interview on 09/30/2022 at 10:19 AM, Resident #51 stated he/she brought up concerns in the council meeting when dietary attended, and other residents brought up dietary concerns in the meeting as well. Resident #51 stated the dietary concerns were not resolved.

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F 565	Continued From page 17 Resident #51 stated he/she thought having a suggestion box was important, but the council never received a response on that request. Resident #51 stated the council never received a response to the requests for information on emergency preparedness, and a lot of residents were "nervous about the big waves." During an interview on 09/30/2022 at 10:40 AM, Resident #51 stated he/she brought up a suggestion about mail delivery during a Resident Council meeting and never received any response. During an interview on 09/30/2022 at 1:09 PM, SW #1 stated there were dietary concerns brought up in the Resident Council meetings. SW #1 stated the surveys that showed the resident concerns were not saved, but they probably did have concerns during the Resident Council meeting about dietary, and that was why dietary attended a meeting. SW #1 stated resident concerns were written in residents' individual records, and the concerns were not written down during the Resident Council meetings. SW #1 stated the concerns should have been documented in the meeting minutes. SW #1 stated that Resident #51 had brought up the suggestion of having a suggestion box, and there was no documentation of follow-up on that request. When asked about the concern of the night shift cancelling call lights, SW #1 stated that concern was sent to the nursing department. SW #1 could not say whether any follow-up was completed on that issue. When asked about the resident who requested more opportunities to shower, SW #1 stated that issue was followed up on; however, when asked if there was	F 565		

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F 565	Continued From page 18 documentation of the follow-up, SW #1 did not know which resident wanted more opportunities to shower. SW #1 indicated she did not know what the residents' suggestions were when 70% of residents responded they wanted to provide suggestions to improve their care. During an interview on 09/30/2022 at 1:58 PM, SW #1 stated the Resident Council format had been changed; it should have included the actions taken. SW #1 stated she did not know what the follow-up was to any of the council's concerns. During an interview on 09/30/2022 at 2:11 PM, the Director of Nursing (DON) stated there had never been a nursing concern brought up in Resident Council meetings. The DON denied any knowledge of the concern brought up in the March 2022 meeting about call light response and was unaware that a resident stated he/she wanted more opportunities to shower. During an interview on 09/30/2022 at 3:06 PM, the Administrator stated if residents had concerns, an interdisciplinary team (IDT) meeting would be held to discuss the concerns with the related department. The Administrator stated the grievance log was only used if a complaint could not be resolved, but there should have been a complaint log. The Administrator stated whatever was expressed in the council meeting should have been written in the minutes, and the results should have been reported at the next meeting. The Administrator stated Social Services had a responsibility to follow up on the concerns.	F 565		
F 577 SS=E	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11)	F 577		

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F 577	Continued From page 19 §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility 1) failed to provide Resident (R)54 the correct contact information for agencies acting as client advocates, and 2) failed to post the correct contact information for the Office of the Ombudsman on three (3) of four (4) units. This deficiency has the potential to affect residents' and residents representatives' right to contact these agencies. Findings include:	F 577		

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F 577	Continued From page 20 1) On 09/27/22 at 10:54 AM, conducted an interview with Resident (R)54 in the resident's room. R54 stated he/she want to make several complaints to the Office of Health Care Assurance (OHCA) and the Ombudsman regarding the facility but was not given the correct phone numbers. R54 stated he/she told the staff multiple times the phone numbers that were provided was wrong and dismissed his/her initial complaints. Eventually, R54 was able to get in touch with a social worker and reported the phone number for OHCA was not working. R54 stated when the social worker returned, the phone number for OHCA and the Oahu Long-Term Care Ombudsman had been changed. On 09/30/22 at 08:00 AM, conducted a review of R54's Electronic Health Record (EHR). Review of the resident's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/28/22 documented R54's Brief Interview for Mental Status (BIMS) score was 15, indicating the resident is cognitively intact. On 09/29/22 at 09:45 AM, R54 provided two (2) Leahi Hospital Welcome Handbooks to this surveyor that he/she had received from social work staff. In the first handbook (updated 10/21/21), R54 documented the email address for the Oahu LTC Ombudsman was outdated and the phone number for OHCA was incorrect: Oahu Long-Term Care Ombudsman Ombudsman (OMB)2 Phone: 808-797-8055 Email: ltc.ombudsman4oahu@gmail.com	F 577		

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F 577	Continued From page 21 Department of Health Office of Health Care Assurance Skilled Nursing Facility (808)692-7240 The second handbook (updated 10/21/22, correction date was not changed) that R54 received documented the phone number listed for OMB2 was changed to OMB1's phone number, OMB2's email was updated to the correct information, and OHCA's phone number was corrected. Oahu Long-Term Care Ombudsman OMB2 Phone: 808-586-7268 Email: jomel.duldulao@doh.hawaii.gov Department of Health Office of Health Care Assurance Skilled Nursing Facility (808)692-7420 On 09/29/22 at 12:38 PM, conducted an interview with Social Worker (SW)1 and SW3 in the conference room regarding the Welcome Handbook that was provided to R54. SW1 and SW3 confirmed the OHCA phone number provided in the first Welcome Handbook was not correct and the revision date on the second handbook given was not changed to reflect the date the information was updated. OMB2 was contacted via email by the surveyor at ltc.ombudsman4oahu@gmail.com. OMB2 replied and stated the email address was changed in March 2022 to jomel.duldulao@doh.hawaii.gov. 2) On 09/30/22 at 4:00 PM, Surveyor (SV)1 conducted observations on all units and reviewed contact information provided for advocate	F 577		

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F 577	Continued From page 22 agencies. On the unit's information board, a form titled, "Notice Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility (LTC)" were posted on three (3) of four (4) units. The notice documented the phone number for the Office of the Ombudsman as (808) 587-0770. On 10/06/22 at 09:35 AM, this surveyor called the phone number and was informed that the phone number was for the Ombudsman for the State of Hawaii's Executive Office and does not have jurisdiction over LTC facilities. The employee stated that they have received calls from family members of residents in LTC facilities and they are unable to assist them with their complaints.	F 577		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives	F 578		

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and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on record review, interviews, and facility policy review, the facility failed to ensure a resident's code status was addressed in the current physician's orders in the electronic medical record to facilitate staff's ability to honor the resident/responsible party's wishes for 1 (Resident #27) of 1 sampled resident whose request for "do not resuscitate (DNR)" status was reviewed.

Findings included:

Review of a policy titled, "Provider Orders for Life-Sustaining Treatment (POLST)," dated 06/23/2016, revealed a "Code Status Order Form," which indicated, "This order must be completed and signed by the attending physician and filed in the patient's/resident's chart at all times." The form also indicated, "Note to

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F 578	Continued From page 24 Physicians: The current code status must be documented in physician's orders and physician's progress notes with details." Review of an "Admission Record" revealed Resident #27 had diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting unspecified side, impulse disorder, and hypothyroidism. The "Advance Directive" section of the "Admission Record" was blank. Review of a quarterly Minimum Data Set (MDS), dated 07/05/2022, revealed the resident scored 15 on a Brief Interview for Mental Status (BIMS), indicating the resident was cognitively intact. Review of a care plan, dated as initiated 06/28/2022, revealed Resident #27 had "laid out" his/her wishes in an advance healthcare directive, in the event the resident became seriously ill, unable to speak, and/or unable to make his/her own decisions. A planned intervention was to follow the resident's advance directive, POLST, and code status, which was indicated to be "DNAR [do not attempt resuscitation]." Review of a "Provider Orders for Life-Sustaining Treatment (POLST)" form, dated as signed by the resident's responsible party (RP) on 10/14/2020, revealed the resident's code status was, "Do Not Attempt Resuscitation/DNAR Allow Natural Death." Review of an "Order Summary Report," printed 09/29/2022, revealed Resident #27's current physician's orders did not include an order for code status.	F 578		

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F 578	Continued From page 25 During an interview on 09/29/2022 at 10:17 AM, Nurse Manager (NM) #5 stated that once a POLST was signed, the nurses should carry it out, and there should be a physician's order for full code or DNR in the resident's orders. NM #5 stated that Resident #27's code status was changed to DNR in 2020. NM #5 was unable to locate an order for code status in the electronic medical record. During an interview on 09/29/2022 at 10:09 AM, Registered Nurse (RN) #3 stated a resident's code status could be found in the resident's profile in the electronic medical record and in the physician's orders. The RN stated every resident should have a code status order. During an interview on 09/30/2022 at 2:58 PM, the Director of Nursing stated a physician's order should have been entered for the resident's POLST and that this was always "one of the main orders." During an interview on 09/30/2022 at 3:30 PM, the Administrator stated the POLST should have been put under the orders in the electronic medical record, so the code status would show in the chart.	F 578		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:	F 604		

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F 604	Continued From page 26 §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews, and facility policy review, the facility failed to ensure an assessment was completed to determine if a chair alarm and seat belt were medically necessary, safe, and appropriate for 1 (Resident #14) of 1 sampled resident reviewed for restraints. Findings included: Review of a facility policy titled, "Physical	F 604		

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F 604	Continued From page 27 Restraints and Devices," dated 03/06/2008, revealed the following: - "Definitions: A physical restraint is any manual method or physical or mechanical device, material, or equipment that is attached or adjacent to the resident's body that the resident cannot easily remove by him/herself and restricts the resident from freedom of movement or normal access to his/her own body." - Procedure: A. Responsibilities: 1. The Nursing staff shall: a. Determine through documented assessment that the device is needed to improve the resident's well being [sic], is medically necessary, and its benefits outweigh potential harmful effects. b. Select a restraint to be used only after other less restrictive measures have been found to be ineffective to protect the resident from harm." - B. Assessment/Care Planning: 1. A THREE-DAY ASSESSMENT PERIOD shall be implemented upon admission or use of new device that may be considered a physical restraint to determine if the resident requires the device to ensure resident's safety, increase function and/or to complete a medical treatment. 2. During the THREE-DAY ASSESSMENT PERIOD: a. The Nurse shall observe and assess the resident for risk for falls or injury. b. The observations and assessment must be documented in the Interdisciplinary Progress Notes (IPN) every shift. c. Documentation to include medical condition, functional ability, medications, cognitive status and psychological impact related to use of the device/restraint. d. The nurse will utilize alternatives for restraint use and document interventions tried."	F 604		

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- "5. After less restrictive devices or alternatives have been tried and found ineffective in protecting the resident from harm, the Nurse will: a. Complete the Restraint Assessment/RAP Review form on the computer for each device. Print a copy, sign and file in chart. b. Determine if the device is a restraint or not on page 2 of the form.

Review of an "Admission Record" revealed the facility admitted Resident #14 on 06/17/2022 with diagnoses that included Alzheimer's disease, anxiety disorder, and insomnia.

Review of an admission Minimum Data Set (MDS), dated 06/24/2022, revealed Resident #14 scored zero on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. The MDS indicated the resident required extensive assistance for transfer, was totally dependent for locomotion, and used a wheelchair for mobility. According to the MDS, the resident used a bed and chair alarm daily and used no restraints.

Review of a care plan, dated as initiated 06/17/2022 and revised 08/05/2022, revealed Resident #14 was at high risk for falls related to incontinence, vision/hearing problems, antihypertensive medication, and psychoactive medication. Interventions included a Posey alarm with splitter while in bed, so the call light was activated if the resident tried to get up unassisted; and a wheelchair Posey alarm with a speaker, to remind the resident to sit and wait for help, to be on at all times when the resident was in the wheelchair.

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Review of a "Progress Note," dated 07/05/2022 at 1:54 PM revealed the resident kept insisting on going home and trying to get out of the wheelchair and "going down to floor." The nurse noted that she called the resident's family member and left a message. Review of a "Progress Note," dated 07/05/2022 at 2:33 PM, revealed the nurse obtained verbal permission from the resident's family member to apply a seat belt when the resident was sitting in the wheelchair.

During an observation on 09/29/2022 at 10:15 AM, Resident #14 was sitting in a wheelchair with a Velcro waist belt applied.

During an observation on 09/29/2022 at 2:04 PM, Nurse Manager (NM) #5 asked Resident #14 if he/she could remove the Velcro belt. The resident was confused and stated he/she did not want to take it off and that it belonged to him/her.

During an observation on 09/30/2022 at 9:00 AM, NM #5 asked Resident #14 to remove the belt and the resident was able to remove it. The alarm did not sound. NM #5 stated it was supposed to have a recording that remined the resident, "The nurse is here to help." NM #5 stated the alarm was not activated when Resident #14 removed the belt.

During an interview on 09/29/2022 at 10:01 AM, Certified Nursing Assistant (CNA) #1 stated Resident #14 had a seatbelt when in the wheelchair. CNA #1 stated Resident #14 had it because he/she would try to stand up, and it stopped the resident from standing. CNA #1 stated Resident #14 knew how to open the belt and that it was a reminder.

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F 604	Continued From page 30 During an interview on 09/29/2022 at 1:22 PM, Licensed Practical Nurse (LPN) #1 was not sure when the Velcro belt was put in place or whether other interventions were tried before implementing the belt, but stated that Resident #14 knew how to turn off the alarm. During an interview on 09/29/2022 at 1:43 PM, NM #5 stated was not sure if there was a documented evaluation done to determine if the Velcro belt was a restraint for Resident #14. During an interview on 09/30/2022 at 3:26 PM, the Director of Nursing (DON) stated that when a resident had a device put in place that could potentially be a restraint, the resident would be assessed for the need for the device. The DON stated there was a paper assessment that was included in the facility policy. The DON stated he/she would have to read the policy to know if an assessment should have been done for Resident #14's potential restraint. During an interview on 09/30/2022 at 3:26 PM, NM #5 stated no assessment was done for Resident #14's Velcro belt. During an interview on 09/30/2022 at 3:26 PM, the Administrator stated the facility had an assessment to determine if a resident needed a device, assess whether the resident could remove it, and indicate the goal of the device. The Administrator stated the facility needed to do the assessment to rule out a device being considered a restraint.	F 604		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		

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F 609	Continued From page 31 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her 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 allegations of staff-to-resident abuse were immediately reported to the Administrator for 1 (Resident #14) of 1 sampled resident reviewed for abuse. Findings included:	F 609		

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F 609	Continued From page 32 Review of a facility policy titled, "Prevention of Resident Abuse, Neglect, Involuntary Seclusion and Misappropriation of Property," dated 11/03/2021, revealed, "All employees are required to report alleged complaints and/or violations involving abuse, neglect, involuntary seclusion, injury of unknown origin and misappropriation of property immediately to the Administrator and Director of Nursing (DON) of the facility. Such complaints and violations shall be reported to the State agencies within specified timelines according to law." Review of an "Admission Record" revealed the facility admitted Resident #14 on 06/17/2022 with diagnoses that included Alzheimer's disease, anxiety disorder, and insomnia. Review of an admission Minimum Data Set (MDS), dated 06/24/2022, revealed Resident #14 scored zero on a Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. Review of a "Progress Note," dated 07/15/2022, revealed the resident was being assisted in the bathroom by a Certified Nursing Assistant (CNA). The CNA was attempting to change the resident's soiled pants, and the resident got agitated and angry, accusing the CNA of hitting him/her. The note indicated the resident grabbed and pinched the CNA. Review of a "Progress Note," dated 09/03/2022, revealed two staff gave Resident #14 a shower. The resident accused the staff of taking his/her clothes off and pinching and hitting the resident. The note indicated, "Actually, resident was hitting and pinching staff."	F 609		

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F 609	Continued From page 33 During an interview on 09/29/2022 at 8:20 AM, the DON stated there had been no allegations of abuse reported in the past six months. During an interview on 09/29/2022 at 10:52 AM, Licensed Practical Nurse (LPN) #1, who was one of the staff involved in the 09/03/2022 shower for Resident #14, stated if there was an allegation of abuse, it was to be reported to the charge nurse, social worker, and DON. The LPN indicated on the day of the incident in the shower, the resident's allegation was reported to the charge nurse. During an interview on 09/29/2022 at 11:07 AM, Nurse Manager #5 stated Resident #14's behaviors included pinching and hitting. NM #5 stated the accused staff members reported that Resident #14 was the one doing the hitting, and NM #5 did not report the allegation because Resident #14 was the one who hit staff. NM #5 stated staff received annual training on abuse prevention and reporting. NM #5 stated staff needed to tell the supervisor about an allegation of abuse. NM #5 stated that if a resident complained that someone hurt them, pinched them, or punched them, it was expected that this would be reported. NM #5 stated a report of abuse was received, she would make sure the resident was safe, notify the DON and the Administrator, and remove the alleged perpetrator from resident care. During an interview on 09/29/2022 at 2:19 PM, the DON stated if a resident reported that a staff member hit or pinched them, it would be immediately investigated. The DON stated if a	F 609		

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F 609	Continued From page 34 resident had a history of accusatory behaviors, every time they made an allegation, it would be thoroughly investigated. The DON stated Resident #14's abuse allegations were not reported. During an interview on 09/30/2022 at 1:39 PM, Registered Nurse (RN) #3 stated if a resident reported that someone hit or pinched them, it should be reported right away, and the accused person would be removed from the resident area. During an interview on 09/30/2022 at 2:36 PM, NM #5 stated when Resident #14 stated two staff members were pinching him/her, the staff members reported that the resident had been pinching them. During an interview on 09/30/2022 at 3:15 PM, the Administrator stated there should have been an event report if a resident alleged that a staff member hit or pinched them, and it had to be investigated right away to rule out abuse. The Administrator stated the staff had to be separated and sent home until abuse was ruled out. The Administrator stated an allegation of abuse should be reported for a resident who was confused. The Administrator denied being aware of Resident #14's allegations and was not sure if they were reported and investigated.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation 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	F 610		

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F 610	Continued From page 35 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 investigate allegations of abuse and implement protective measures to prevent further potential abuse for 1 (Resident #14) of 1 sampled resident reviewed for abuse. Specifically, when Resident #14 alleged staff-to-resident abuse on two separate occasions, staff's failure to report the allegations to the Administrator resulted in failure to initiate investigations and protective measures for Resident #14. Findings included: Review of a facility policy titled, "Prevention of Resident Abuse, Neglect, Involuntary Seclusion and Misappropriation of Property," dated 11/03/2021, revealed, "All employees are required to report alleged complaints and/or violations involving abuse, neglect, involuntary seclusion, injury of unknown origin and misappropriation of property immediately to the Administrator and Director of Nursing (DON) of the facility. Such complaints and violations shall be reported to the	F 610		

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State agencies within specified timelines according to law. Each incident will be thoroughly investigated and actions taken to prevent potential abuse while the investigation is in progress." The policy also indicated, "When any event occurs involving the health, welfare or safety of residents, including reports of suspected abuse, the following steps shall be taken by staff: 1. Immediately remove the resident to an appropriate environment necessary to protect the resident's safety. If the alleged perpetrator is a: a. Resident: Separate the residents so they do not have access to each other or until circumstances of the reported incident can be assessed and determined. B. Employee: Notify the employee of the allegation and immediately relieve the employee from duty and any contact with the resident and other residents. The employee is removed from direct resident care until the complaint or allegation is investigated."

Review of an "Admission Record" revealed the facility admitted Resident #14 on 06/17/2022 with diagnoses that included Alzheimer's disease, anxiety disorder, and insomnia.

Review of an admission Minimum Data Set (MDS), dated 06/24/2022, revealed Resident #14 scored zero on a Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment.

Review of a "Progress Note," dated 07/15/2022, revealed the resident was being assisted in the bathroom by a Certified Nursing Assistant (CNA). The CNA was attempting to change the

resident's soiled pants, and the resident got agitated and angry, accusing the CNA of hitting him/her. The note indicated the resident grabbed

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and pinched the CNA.

Review of a "Progress Note," dated 09/03/2022, revealed two staff gave Resident #14 a shower. The resident accused the staff of taking his/her clothes off and pinching and hitting the resident. The note indicated, "Actually, resident was hitting and pinching staff."

During an interview on 09/29/2022 at 8:20 AM, the DON stated there had been no allegations of abuse reported in the past six months.

During an interview on 09/29/2022 at 10:52 AM, Licensed Practical Nurse (LPN) #1, who was one of the staff involved in the 09/03/2022 shower for Resident #14, stated that if there was an allegation of abuse, it was to be reported to the charge nurse, social worker, and DON, and they must investigate. On the day of the 09/03/2022 incident, LPN #1 stated the allegation was reported to the charge nurse. LPN #1 denied being removed from duty that day.

During an interview on 09/29/2022 at 11:07 AM, Nurse Manager (NM) #5 stated staff received annual training on abuse prevention and reporting. The NM stated for allegations of abuse, staff needed to stop the abuse, protect the resident, oust the person that was being accused, and tell the supervisor. NM #5 stated if a resident complained that somebody hurt them, pinched them, or punched them, it was expected that this would be reported. NM #5 stated she would make sure the resident was safe, notify the DON and the Administrator (NHA), and remove the alleged perpetrator from patient care. Regarding Resident #14's allegations, NM #5 stated Resident #14's behaviors included pinching and

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hitting. NM #5 stated the allegations were not investigated or reported. NM #5 stated the accused staff members stated that Resident #14 was the one who was doing the hitting, and the allegation was not reported because Resident #14 was the one who hit staff.

During an interview on 09/29/2022 at 2:19 PM, the DON stated if a resident reported that a staff member hit or pinched them, it would be immediately investigated. The DON stated if a resident had a history of accusatory behaviors, every time they made an allegation, it would be thoroughly investigated. The DON stated Resident #14's abuse allegations were not reported.

During an interview on 09/30/2022 at 1:39 PM, Registered Nurse (RN) #3 stated if a resident reported that someone hit or pinched them, it should be reported right away, and the accused person would be removed from the resident area.

During an interview on 09/30/2022 at 2:36 PM, NM #5 stated when Resident #14 stated two staff members were pinching him/her, the staff members reported that the resident had been pinching them.

During an interview on 09/30/2022 at 3:15 PM, the Administrator stated there should have been an event report if a resident alleged that a staff member hit or pinched them, and it had to be investigated right away to rule out abuse. The Administrator stated the staff had to be separated and sent home until abuse was ruled out. The Administrator stated an allegation of abuse should

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F 610	Continued From page 39 be reported for a resident who was confused. The Administrator denied being aware of Resident #14's allegations and was not sure if they were reported and investigated.	F 610		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to ensure post-fall care was provided in accordance with accepted standards of nursing practice, as evidenced by failure to consistently conducted neurological (neuro) checks after a fall for 1 (Resident #79) of 3 sampled residents reviewed for accidents. Findings included: Review of a facility policy titled, "Post Fall Monitoring," dated 06/09/2016, revealed, "Nursing staff will assess a patient/resident for injury following a fall event; and continue to monitor for a minimum of 72 hours or as long as necessary to ensure his/her condition is stabilized." The policy also indicated when a fall occurred, the steps staff were to take included the following: - "2. Nursing - Certified Nurses [sic]	F 684		

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F 684	Continued From page 40 Aides/Licensed staff: a. Notify staff including charge/head nurse to assess and assist with resident's care. b. Assist resident back to bed only after evaluated by licensed nurse. c. Initiate post fall monitoring - vital signs, pain score, neuro checks, and orthostatic blood pressure." - 4. Subsequent shifts a. Continue monitoring resident's condition for the next 3 days and document status in the medical record and in Daily Nursing Report. B. Vital signs, including pain score, (and neuro checks if there is any possibility that resident may have struck head) as follows: Every 15 min. [minutes] for first hour; if stable then Every 30 min x [times] 2; if stable then every hour x 2; if stable then Every 4 hours x 5; if stable then Every 8 hours x 2 days." Review of an "Admission Record" revealed the facility admitted Resident #79 on 08/11/2022 with diagnoses including Parkinson's disease, dementia, and adjustment disorder with mixed anxiety and depressed mood. Review of an admission Minimum Data Set (MDS), dated 08/18/2022, revealed Resident #79 scored 12 on a Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. The MDS indicated the resident required extensive assistance with bed mobility, and that walking and locomotion did not occur during the assessment period. According to the MDS, the resident did not have any falls in the past two to six months prior to admission. Review of an "Event Report Form," dated 09/06/2022 at 2:45 PM, revealed Resident #79 had an unattended fall from bed and was found on the floor. No injuries were notified. According	F 684		

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F 684	Continued From page 41 to the form, hospice, the supervisor, the physician, and the resident's family were all notified. The form indicated neuro checks were initiated. Review of "Neurological Check List/Post Fall Monitoring" form in the electronic medical record indicated neuro checks were completed on 09/06/2022 at 10:40 PM. The next documented neuro checks were almost eight hours later, on 09/07/2022 at 6:02 AM. Further neuro checks were documented on 09/07/2022 at 6:30 AM, 10:34 AM, 2:30 PM, and 10:25 PM.; 09/08/2022 at 6:37 AM, 2:30 PM, and 7:58 PM; and 09/09/2022 at 7:36 AM and 1:44 PM. During an interview on 09/30/2022 at 8:46 AM, Registered Nurse (RN) #1 stated when a resident had an unwitnessed fall, neurological checks were completed every 15 minutes for the first hour after the fall, then every 30 minutes for two hours. The RN stated the neuro checks would automatically "come up" in the electronic medical record when it was time for the next check to be completed. During an interview on 09/20/2022 at 2:18 PM, the Director of Nursing (DON) stated when a resident had an unwitnessed fall, staff were to follow the facility's neurological check policy. During an interview on 09/30/2022 at 3:13 PM, the Administrator stated neuro checks had to be done for unwitnessed falls because there was no way to tell if a resident had hit their head. The Administrator indicated the frequency of the neuro checks was included in the facility's policy.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices	F 689		

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F 689	Continued From page 42 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to properly assess and treat the mobility issues and provide for the dementia care needs of one resident (R)77 out of a sample of one, that could have potentially prevented R77's fall. This deficient practice has rendered harm to R77 who sustained a pelvic fracture that cannot be surgically corrected, with subsequent pain, decreased mobility, decreased appetite, and overall decreased quality of life. This has the potential to affect all residents with dementia and mobility issues in the facility who need timely rehabilitation (PT/OT) screening and individualized dementia care. Finding includes: On 09/27/22 at 09:48 AM, an initial observation of R77 was made. R77 laid in bed on his back with a blue blanket covering him up to his neck. R77's bed was on the floor, up against the wall, with a floor mat alongside the left of the mattress (facing into the room). R77's room was dark. Subsequent observations of R77 at 11:00 AM, and 12:03 PM, revealed R77 laid in the same position on his bed in his darkened room. State agency (SA) initiated conversation by asking him if he was cold and he	F 689		

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stated, "No," and closed his eyes.

On 09/28/22 at 06:50 AM, observed R77 lying on his back sleeping. A follow up observation was made at 09:44 AM and R77 was found lying in the same position with his eyes closed. No response was made by R77 when he was greeted.

On 09/28/22 at 08:37 AM, an initial record review (RR) of R77's EHR revealed in the "Progress Notes," no "Nurse Note" documented on 09/27/22 regarding R77's status. A "Nurse Note" documented on 09/28/22 at 04:52 AM stated, "...Slept good no behavior." A "Fall Note" was documented by Registered Nurse (RN)9 on 06/13/22 at 07:37 AM which stated that R77 was walking back and forth without an assistive device in the hallway of a nursing unit in the early morning of the night shift. RN9 held his hand assisting him with walking, when he firmly grasped RN9's hand, pulling RN9 towards him, let go of his grip from RN9, lost his balance, and fell onto his buttocks. R77 hit his head on a wheel of a cart on his way down to the floor.

On 09/29/22 at 07:13 AM, R77 was observed to be lying on his back on his bed, sleeping. A subsequent observation at 08:03 AM, found R77 lying in the same position with music playing in his room. At 10:27 AM, R77's room was quiet, and he laid in the same position on his bed with his eyes closed and did not respond to any greeting.

On 09/29/22 at 12:14 PM, R77's electronic health record (EHR) was reviewed. R77's medical diagnosis screen revealed that R77 is a 70 year old resident admitted on 05/11/22 for heart disease, post COVID-19 condition, diabetes,

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depression, restlessness and agitation, and anxiety. R77's primary physician documented in R77's admission note sent to the facility on 05/12/22 at 1:20 PM, the following: " ...Unsteady, muscle weakness, high risk for fallsPoor [sic] memory and safety awareness ..." and " ...certify that patient meets criteria and needs to continue care at the [facility] nursing home at the ICF [intermediate care facility] level of care for PT [physical therapy]/OT [occupational therapy] rehab [rehabilitation]..." Reviewed R77's admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 05/17/22. Under "Section C Cognitive Patterns," R77's Brief Interview for Mental Status (BIMS) score was three, rating his cognition as severely impaired. "Section G Functional Status," R77 needed "3. Extensive Assistance - resident involved in activity, staff provide weight-bearing support" with "2. One person physical assist" with walking. Mobility devices used by R77 were identified as a walker and wheelchair. "Fall Risk Assessment 2" documentation of 05/11/22 at 2:00 PM, scored R77 with a fall risk score of "6," which directs the facility to "initiate Fall protocol I."

On 09/29/22 at 12:30 PM, the facility's "Fall Prevention" policy and procedure (P&P) was reviewed. It stated, " ...B. All residents will be considered at risk for falls and standard care protocol (Protocol I) shall include the following: ...4. Reinforce use of assistive devises [sic], if used, and keep within reach ... 7. Consider rehabilitation screen, if appropriate, and maintenance exercise to maintain strength, ambulation and function." Continued RR of R77's EHR revealed in " ...Interdisciplinary Team Conference [IDT] Notes - V4" of 05/17/22 at 1:30 PM stated for the Social Worker summary:

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"Resident is transitioning to new environment, and will often need frequent reminders due to poor safety awareness. Resident is confused and has difficulty remembering why resident is at [facility]. When resident was first admitted resident was alert, and engaged in conversation well. As resident has been at [facility] for a couple of days getting used to environment, resident's affect is flat, and is restless and makes frequent attempts to get out of chair. Resident does well when other persons are around, and will need close supervision ..." No PT nor OT summary notes were documented in the IDT conference notes. The "Orders" screen showed "PT/OT eval. [evaluation]" was ordered on 06/17/22. There was no documentation by the rehabilitation department (PT/OT) until 06/17/22 at 3:12 PM which stated the following: " ...Per 6/13/22 x-ray, acute fracture of left acetabulum [sudden break in the left hip socket]; Per 6/15/22, left inferior ramus fracture [broken lower pelvic bone] ...Rolling left and right with 2 person max assist due to pain. Lower body dressing extensive to total assist." Review of "Orthopaedic [sic] Surgery" consult note dated 06/17/22 revealed R77's pelvic fracture was "...a non-surgical type fracture of the pelvis..."

On 09/29/22 at 1:54 PM, the Director of Nursing (DON) was queried if R77 was ever assigned care to be provided to him by one caregiver (one to one) due to his behaviors and she stated that he was never provided care solely by one caregiver but was always kept in the line of sight of staff.

Continued RR of R77's EHR revealed in " ... Interdisciplinary Team Conference Notes - V4" of 09/06/22 at 2:00 PM under the "...E. Dietary

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F 689	Continued From page 46 Summary...m. Problems/Needs: ...Resident w/ [with] decline in ADLs [activities in daily living], including feeding; requires mostly extensive assist per records; previously fed self after set-up. Resident w/ decline after fall 6/13/22, harder to sit up with head up, needing more assist w/ meals per records ...," and " ...F. Recreation Summary...A significant change assessment is warranted at this time, due to a decline in ambulation, transfer, locomotion on/off unit, and incontinence." "Bladder [urine] Elimination" task flowsheet from 06/01/22 to 09/28/22 was reviewed. In the month of June 2022, before R77's fall on 06/13/22, R77 had six episodes of incontinence and 46 episodes of continence. After his fall, R77 had 45 episodes of incontinence and six episodes of continence from 06/14/22 to 06/30/22. In July 2022, R77 had 79 episodes of incontinence and six episodes of continence. The month of August 2022 showed R77 being mostly incontinent with one episode of continence and in September 2022 until 09/28/22, R77 was totally incontinent of urine. A "Weight Change Note" documented on 07/05/22 at 3:32 PM stated, " ...Resident had weight loss of 16.8 lbs [pounds] (-9.82%) since last month." The "(Rehab) ADL - Walk in Corridor" task flowsheet showed that R77 ambulated 185 feet with the use of a walker from 08/15/22 to 08/25/22. In the month of September 2022, R77 only ambulated on 09/27/22 for 20 feet with a walker. Both involved "LIMITED ASSISTANCE - Resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight bearing assistance." On 09/30/22 at 10:02 AM, Nurse Manager (NM)7 was interviewed. NM7 stated that after R77's admission into the facility he was restless and	F 689		

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was always moving - sliding to the floor from his wheelchair, lying on the floor, walking in the hallways, he often refused to use his wheelchair and walker. R77 loved surfing and liked to watch sports. R77 spent 20 days on the unit she managed, and he became familiar with the staff. NM7 stated that R77 was transferred to another nursing unit after finishing his quarantine for 20 days. R77 "was stable" before he was transferred to the other nursing unit. NM7 stated that R77's dementia "rapidly" progressed. R77 was transferred back to her unit after his fall on 06/13/22 due to the smaller census of residents and the capability to provide more one to one supervision. NM7 described R77 now as being "more moody" and partially attributes his decline to the pain he is experiencing after his fall. NM7 stated that all ICF residents should receive a PT/OT screen on admission.

On 09/30/22 at 11:19 AM, interviewed NM4 in her office concurrently with RN9 on NM4's cell phone. R77 was transferred to NM4's unit on 06/09/22, had his fall on 06/13/22, and transferred back to NM7's unit on 06/14/22. NM4 stated that RN9 would call the nursing supervisor if RN9 needed help with R77. RN9 stated that R77 was more agitated than usual on her shift before his fall and that the nursing supervisor was unable to assist with R77 because she was busy doing another task. NM4 stated that she does notice that residents with changed environments become more restless after the change and that a slower transition is needed to help accommodate them and their needs.

Reviewed R77's care plan with last care plan review on 09/20/22. R77's problems of refusing to utilize his walker and wheelchair for mobility, his

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F 689	Continued From page 48 unsteadiness, muscle weakness and "rapidly" progressing dementia, were not addressed. Reviewed facility's policy and procedure, "Evaluation & Therapy for Inpatient/Residents," effective date 08/30/06, "...II. Policy All patient/residents who have received a physician's order for evaluation or who have been identified through the initial screening assessment as candidates for therapy will be scheduled for an evaluation." Reviewed the Dementia Care policy, identified by the DON as "Major neurocognitive disorder (dementia), identifying and managing resident safety risks, long-term care" revised on 02/18/22. It stated, "Introduction ...A resident with major neurocognitive disorder living in a long-term care facility typically has difficulty adapting to the unfamiliar environment. Daily interactions with multiple staff members can cause stress, further compromising the resident's safety and welfare ..." and " ...Managing behavior ...Observe the resident's behavior to identify triggers that lead to agitation. Behavior is a way in which residents with major neurocognitive disorder communicate their needs and desires ..." and "...Preventing falls...Collaborate with a physical therapist, if needed, to determine whether the resident may benefit from strengthening exercises, use of an assistive device, or safe seating training ..."	F 689		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law	F 755		

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F 755	Continued From page 49 permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure an account of all controlled drugs was maintained and periodically reconciled for two (2) of eight (8) medication carts sampled. As a result of this deficiency, there is the potential for diversion of controlled drugs. Findings include: 1) On 09/29/22 at 08:43 AM, conducted a review of the controlled drug binder located on a	F 755		

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medication cart with Nursing Staff (NS)41 in the unit hallway. Review of the audit sheet documented for 09/29/22 day to evening shift count, NS41 had pre-signed the off-going (day shift) nurse count. Inquired with NS41 the process for reconciling controlled drugs between shifts. NS41 stated the off-going nurse, and the on-coming nurse should conduct a count of all controlled drugs (in the locked drawer in the medication cart) together, then sign the audit sheet confirming the controlled drugs count is accurate. NS41 confirmed he/she should not have signed the controlled drug count sheet in advance.

On 09/29/22 at 09:00 AM, conducted an interview with Nurse Manager (NM)4 in the unit nursing station regarding the observation of the pre-signed controlled drug audit sheet. NM4 confirmed NS41 should not have pre-signed the off-going count and should have signed the audit sheet with the on-coming (evening) nurse to ensure the count for controlled medications are accurate and free from diversion.

2) On 09/29/22 at 08:52 AM, conducted a review of the controlled drug binder located on a medication cart with NS42 in the unit hallway. Review of the audit sheet for 09/29/22 off-going (night shift, 09/28/22) nurse and on-coming (day shift, 09/29/22) nurse documented NS42 did not sign the audit sheet in the presence of the second nurse at the time the count was conducted. Inquired with NS42 regarding the missing signature. NS42 proceeded to sign the sheet and confirmed he/she should have signed it at the time of the count in the presence of the other nursing staff.

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F 755	Continued From page 51 On 09/29/22 at 09:01 AM, conducted an interview with NM4 in the unit nursing station regarding this surveyor's observations of the unsigned controlled drug audit form for the morning count (night shift to day shift) on 09/29/22. NM4 confirmed nursing staff should sign the controlled drug audit form after counting the controlled drugs and confirming the information on the audit form is accurate and free from diversion. On 09/29/22 at 10:23 AM, the Director of Nursing (DON) came to the conference room and provided the facility's policy and procedure for Medication Administration: Controlled Substances documented the facility's procedure "7. At each shift change, a physical inventory of controlled medications, as defined by state regulations, is conducted by two licensed clinicians and is documented on an audit record." At 10:30 AM, the DON provide a second policy and procedure for Medication Storage: Controlled Medication Storage that documented the facility's procedure "6. At each change or when keys are surrendered, a physical inventory of all Schedule II, including refrigerated items, is conducted by two licensed nurses or per state regulation and is documented on the controlled substances accountability record or verification of controlled substances count report...".	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		

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F 761	Continued From page 52 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policies, the facility 1) failed to label a non-prescription medication bottle for Resident (R)58 with his name, and 2) failed to discard a discontinued non-prescription medication from one (1) of the eight (8) medication carts sampled. As a result of this deficiency, residents are put at risk for potential harm if improperly labeled medications or medications discontinued by their health provider are administered. Findings include: On 09/29/22 at 08:14 AM, a concurrent observation and interview was conducted with Nurse Manager (NM) 3. A bottle labeled "Kava Supplement" was observed with NM3 in a	F 761		

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F 761	Continued From page 53 medication cart located on the unit. NM3 confirmed that the bottle did not have any resident name written on it. NM3 stated that this medication was for R58, and that the medication had been discontinued. NM3 took the medication from the cart and then proceeded to discard it. On 09/29/22 at 08:20 AM, a concurrent record review of R58's medical record and interview was conducted with NM3. NM3 reviewed and confirmed that R58 had an order for "Kava (Piper Methysticum) capsule. Give 250 mg by mouth two times a day for dietary supplement. Family to bring supply ...Discontinued on 08/19/22." NM3 stated that when a medication is discontinued it is supposed to be discarded immediately from the medication cart. On 09/29/22 at 4:00 PM, a review of facility policy "3.7 Medications and Medication Labels" dated 05/16 stated, "5. Non-prescription medications not labeled by the pharmacy are kept in the manufacturer's original container. Nursing care personnel may write the resident's name on the container or label as long as the required information is not covered, if applicable by state regulations." On 09/29/22 at 4:05 PM, a review of facility policy "5.1 Discontinued Medications" dated 10/07 stated, "1. If a prescriber discontinues a medication, the medication container is removed from the medication cart immediately."	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		

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F 812	Continued From page 54 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to 1) ensure perishable food was labeled/dated to keep track of when it should be discarded, 2) food in the freezer was covered to prevent cross-contamination and/or freezer burn, and 3) perishable drinks were kept at adequate temperatures to avoid soiling and/or the growth of harmful pathogens. As a result of this deficiency, residents are at risk for harm from potential food-borne illnesses. Findings include: 1) On 09/27/22 at 08:50 AM, during the initial inspection of the kitchen with Dietary Staff (DS)1, in a walk-in refrigerator, observed carton of Egg Beaters (egg substitute) to be opened, unlabeled, with no manufacturer "Use by" date. Inquired with DS1 if the carton of Egg Beaters should have been labeled. DS1 confirmed it should have	F 812		

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been labeled with the date it was opened and the date it should be discarded, but it was not. DS1 discarded the carton of Egg Beaters.

On 09/29/22 at 08:25 AM, in the conference room, reviewed the facility's policy and procedure for "Food Labeling" that documented, "FNS [Food Nutrition Services] Staff will note the "date opened" on containers of food ingredients used in food production sections. Food items must be used within the recommended shelf life of the product."

2) On 09/27/22 at 08:51 AM, during the inspection of a freezer with DS1, observed two (2) trays of frozen fish fillets that were not covered, appeared to be freezer burnt, and the freezer fan was blowing directly onto the fish fillets. Inquired with DS1 regarding storing food in the freezer. DS1 confirmed the fish fillets appeared to have freezer burn and should have been covered while in the freezer but was not.

3) On 09/29/22 at 10:55 AM, conducted a second observation of kitchen for food preparation and tray service in the facility's kitchen. Observed DS5 prepping nourishment for 09/30/22 in one corner of the kitchen. Observed a tray with 23 cartons of Sysco Imperial shakes (chocolate, vanilla, and strawberry) on the bottom of a food cart. Requested to inspect the shakes with DS5. Surveyor observed that the tray that the shakes were on had a layer of water on it, and if the tray was not kept level, a considerable amount of water would spill off. When this surveyor lifted a shake from the tray, water dripped off from the shake. The carton was lukewarm to the touch. Inquired with DS5 about the water on the tray. DS5 initially did not reply to this surveyor and

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F 812	Continued From page 56 proceeded to walk away with the tray. Requested for DS5 to bring the tray back then confirmed with DS5 that the condensation was from the shake cartons. Requested for DS5 to leave the tray of shakes on the cart, to ensure the shakes were not mixed in with the resident supply while this surveyor located DS1. When this surveyor returned with DS1, the tray of shakes were missing and DS5 stated he/she placed the tray in the refrigerator. Inquired with DS1 regarding the temperature of the shakes. DS1 confirmed the shakes were warm and not safe for residents to consume. DS1 stated according to the manufacturer directions, the shakes should be kept frozen, then defrosted in the refrigerator and never defrosted on a tray at room temperature. On 09/29/22 at 11:04 AM, DS4 further confirmed the shakes should be frozen then stored in the refrigerator to defrost. 4) On 09/30/22 at 10:40 AM, observed DS8 ringing the buzzer for a unit with a tray of juices and one carton of strawberry Sysco Imperial shake. Requested to feel the shake carton and it was lukewarm. Inquired with DS8 if the shake carton was cold enough to ensure it was safe for a resident to drink. DS8 did not reply and gave the tray to unit staff. This surveyor informed the unit staff to check with DS1 to ensure the shake was safe to consume. Staff placed the shake in the unit refrigerator, and it is unknown if staff contacted DS1 for further inquiry by staff.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is	F 842		

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resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical

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F 842	Continued From page 58 record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to accurately document a rehabilitation maintenance program order for Resident (R) 4. This deficient practice has the potential to adversely affect the level of mobility for all residents who are ordered a rehabilitation maintenance program. Findings include: On 09/29/22 at 10:32 AM, a review of R4's medical record indicated a physician's order dated 06/14/19 which stated, "PT (physical therapy) evaluation completed. Skilled PT not	F 842		

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F 842	Continued From page 59 indicated, continue with rehab maintenance program 5x/week." A review of R4's care plan stated, "Problem: Decreased Range of Motion ...Interventions 7) Rehab will provide maintenance program 2-3x/wk ...initiated 06/13/19." On 09/29/22 at 11:11 AM, a concurrent interview and record review was done with Physical Therapist (PT) 1. PT1 reviewed R4's PT order and stated that the order was inaccurate and that R4 receives a rehabilitation maintenance program two to three times a week instead of five times a week. PT1 reviewed R4's care plan and stated that the order should have been revised to match R4's care plan for receiving a rehabilitation maintenance program two to three times a week.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		

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F 880	Continued From page 60 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 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.	F 880		

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F 880	Continued From page 61 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 reviews, and reviews of facility policies and procedures, the facility 1) failed to ensure infection control practices were implemented during wound care for Resident (R) 39, 2) failed to properly don personal protective equipment (PPE) before entering an isolation room to care for one resident (R) 149 out of a sample of eight residents, and 3) failed to properly discard opened tube feeding formula and its attached tube feeding line after being administered for Resident (R) 26. These deficient practices encourages the development and transmission of communicable diseases and infections and has the potential to affect all residents and staff in the facility. Findings include: 1) On 09/27/22 at 11:48 AM, conducted an observation of Nurse Manager (NM) 4 changing R39's dressing for a stage 4 pressure ulcer to the right buttocks with assistance from Nurse Educator (NE)1 in the resident's room. While cleaning around the wound, NM4 attempted to wipe a thick white paste that was pooled in the resident's buttock's crease. The white paste was not easily cleaned and required NM4 to re-wipe the area. NM4 re-wiped the area approximately six times with the same soiled pad.	F 880		

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F 880	Continued From page 62 On 09/27/22 at 12:09 PM, conducted an interview with NE1 in the hallway outside the resident's room. NE1 stated he/she was also the wound nurse in addition to providing staff education. Informed NE1 of the observation of reusing a soiled wipe to clean an area. NE1 confirmed NM4 should have used a new pad to clean the white paste from the resident's buttock crease to prevent the potential contamination of the stage 4 pressure ulcer due to the likelihood the contents of the paste could contain feces. On 09/28/22 at 3:36 PM, conducted a record review of R39's Electronic Health Record (EHR) in the conference room. Review of the physician's orders and the Electronic Medication Administration Record (EMAR) documented R39 was ordered and received intravenous antibiotics (Vancomycin 1 gram every 24 hours) for Methicillin-resistant Staphylococcus Aureus (MRSA). 2) On 09/27/22 at 09:10 AM, Nurse Manager (NM)7 was queried as to the resident isolation guidelines of the unit. NM7 stated that newly admitted residents who are vaccinated against COVID-19 are quarantined for seven days and residents who are not vaccinated for COVID-19 are quarantined for ten days. On 09/27/22 at 09:24 AM, a concurrent observation and interview was done with Registered Nurse (RN)8. RN8 was queried as to the PPE requirements for the isolation rooms in the unit. RN8 stated that the "blue zone rooms," indicating where they were located and its signage, required only a face shield and face mask. However, if aerosolizing procedures	F 880		

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(medical procedures involving the respiratory tract) were to be done with the resident, then a gown is required. RN8 further stated that the "yellow zone rooms" required full PPE to be worn, prior to entry and during caring of the resident. RN8 indicated the locations of the rooms, signage, and the PPE carts adjacent to them. R149's room was identified as a "yellow zone room."

On 09/28/22 at 06:45 AM, an observation was made of two staff members (SM) entering R149's room. SM1 and SM2 wore only face masks and face shields as they were moving R149's bed with R149 lying in it. Signs were posted outside of the room indicating how to appropriately don and doff PPEs and a cart to store PPE was located to the right of the doorframe of R149's room.

An immediate query was made with SM1 after the observation was made. SM1 stated that gown and gloves needed to be donned prior to entering R149's room and worn while caring for R149.

On 09/28/22 at 08:30 AM, the facility's "COVID-19 PERSONAL PROTECTIVE EQUIPMENT (PPE)" policy and procedure with effective date of 09/14/22 was reviewed. Under "...II. POLICY...b. Yellow Status Residents - Required PPE (Fit Tested N95/Equivalent [face mask], Face Shield, Gown and Gloves)...2) Donning N95/equivalent, Faceshield, gowns and gloves - do so outside of rooms..."

3) On 09/27/22 at 10:32 AM, a concurrent observation and interview was done with Nursing Staff (NS) 16 in R26's room. Observed with NS16 a ready-to-feed tube feeding formula container attached to a tube feeding line which

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was hanging on a pole in R26's room. The tube feeding line was not attached to R26 and the formula container was almost empty. The label on the formula container stated R26's name, room number, and tube feeding orders. The date 09/25/22 and the time 8:02 AM was handwritten on the label. The date 09/25/22 was written on a separate label attached to the tube feeding line. NS16 stated that R26's tube feeding formula container and tube feeding line was hung on 09/15/22 at 08:02 AM. NS16 stated that the tube feeding formula container and the tube feeding line should be discarded since it was past 24 hours from the time when it was hung. NS16 stated that she had forgotten to discard R26's tube feeding formula container and tube feeding line. NS16 then discarded the tube feeding formula container and tube feeding line in the trash can.

On 09/27/23 at 12:00 PM, R26's medical record was reviewed and indicated an enteral feed order that stated, "Glucerna 1.2 Cal. RTH [ready-to-hang] 240 ml TID [three times a day] per GT [gastrostomy tube] via pump at 240 ml/hour. Hold TF [tube feeding] if resident eats more than 75% of meal. Four times a day flush GT with 200 ml water after TF. Glucerna 1.2 Cal 240 ml per pump at midnight. Flush TF 200 ml at 0600."

On 09/28/22 at 2:26 PM, a concurrent record review and interview was done with Nurse Manager (NM) 3. NM3 reviewed R26's electronic medical record and confirmed that R26 required tube feedings. NM3 stated that ready-to-hang formula should be discarded after 48 hours upon opening but the facility discards ready-to-hang formula 24 hours after opening.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING _____ B. WING _____	09/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 65 On 09/29/22 at 09:06 AM, facility's policy and procedures "Enteral tube feedings; naso-gastric, gastrostomy and jejunostomy" dated 06/15/11 was reviewed and stated " V. Procedure. J. Prevent contamination of formula by the following: 2. Store formula properly. b. discard opened ready to use formula after 48 hours".	F 880		