STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. BUILDING _____ B. WING _____	05/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALAKAUA GARDENS	1723 KALAKAUA AVENUE HONOLULU, HI 96826

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F 000	INITIAL COMMENTS A re-certification survey was conducted by the Office of Health Care Assurance (OHCA) on 05/27/22. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. On 05/26/22 at 03:59 PM the State Agency (SA) notified the Director of Nursing of Actual Harm at F689, Free of Accidents. The facility failed to implement the use of a gait belt consistent with the facility's standard of practice and the resident's needs, goals, and care plan to prevent an avoidable fall resulted in sustaining a fracture to right rib. On 05/27/22 the SA found F689 Past Non-Compliance on 05/25/22 through observations, interviews and documentation provided from 05/22/22 to 05/26/22. The facility was notified during the exit conference. The SA also investigated the following Aspen Complaints/Incidents Tracking System (ACTS) #9477 and #9413 were substantiated ,and #9479, #9335 and #9077 were not substantiated. Survey Dates: 05/24/22 to 05/27/22 Survey Census: 49 Sample Size: 19	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in	F 550		7/15/22

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

Electronically Signed | 07/16/2022

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F 550	Continued From page 1 this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to ensure a Resident (R) 196 was treated with dignity and respect by a nursing staff	F 550	For R196, the DON sent CNA23 home after the incident was reported, and then terminated CNA23 on 3/18/22.	

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F 550	Continued From page 2 which resulted in R196 scared and distressed. Findings Include: R196 was admitted to the facility on 02/11/22 and discharged on 03/30/22. Review of R196's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/17/22 documented R196's Brief Interview Mental Status (BIMS) at 12 (moderate impaired cognition). Review of the Event Report completed by the facility on 03/24/22 , the facility reported on 03/18/22 R196 reported to Dietary Clerk (DC) 1 "...she was frightened" and R196 reported to Registered Nurse (RN) 7 "I am scared. She was too rough, I don't know what I did to deserve that." Review of DC1's written report documented while in R196's room, "The resident informed me that she felt unsafe and threatened by someone in the facility, and that she would like to call the police. She stated people working there were doing suspicious activities. The CNA [Certified Nursing Assistant (CNA) 23] came into the room to check on the resident, then returned and poured her drinks into the toilet. The resident stated that CNA was destroying the evidence. She [R196] confronted the CNA "...why are you treating me like this? I don't deserve how I am being treated." The CNA asked the resident what she did to her. The resident responded with an unclear answer. The CNA asked if the resident would like to go to the dining room. The resident responded that she would like to stay in her room ...the CNA insisted and pushed her in a wheelchair to the dining room, in a way that looked aggressive. The resident also expressed that the CNA was hurting her while being transferred to the dining room."	F 550	The Director of Activities conducts personal interviews and Resident Council Meetings to ascertain if there are any issues with residents and whether they feel their rights are being honored. The last meeting was held on 6/29/22. Resident Rights inservices were conducted on July 13 & 14, 2022 for clinical and non-clinical staff. The Director of Activities and/or designee will continue to conduct interviews with all new residents, monthly with current residents, and hold Resident Council meetings monthly, to ensure there are no deficient practices. Any issues raised is shared with the interdisciplinary team who is required to address and rectify any issues. Minutes of the meetings and/or interviews are documented. The results of the Director of Activities and/or designee will be reported to the Quarterly Quality Improvement Committee as well as the Governing Board. 7/29/22 and ongoing.	

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On 05/26/22 at 12:51 PM interview with Family Member (FM) 1 was done. FM1 stated R196 was not getting any sleep at the facility and her anxiety level was very high. FM1 could not recall the specific incident on 03/18/22 but spoke to R196 every day. FM1 stated R196 mentioned " ...there was one person, a woman, I remember she was really rough with her ...I called the Head Nurse to make sure she did not come in again."

On 05/26/22 at 12:58 PM interview with R196 was done. R196 stated she did not recall the incident on 03/18/22 but stated she remembered an incident when a staff member was treating her rough and was "...angry about something...she was throwing up her hands and pushing me aside in the room...I was scared" R196 further stated "I don't have the best memories."

On 05/26/22 at 01:52 PM interview with CNA23 as done. CNA23 stated the night before 03/18/22, on 03/17/22, CNA23 did her rounds at approximately 10:00 PM and went into R196's room, R196 was awake. CNA23 reportedly asked her "Why are you snooping around in the dark?" and R196 responded to CNA23 that she was not snooping and that she was a Christian. CNA23 reported the next day R196 expressed she was afraid of her to DC1. CNA23 stated she should have not used the word "snooping" and stated, "I used the wrong phrase."

On 05/27/22 at 11:31 AM interview with DC1 was done. DC1 stated she was in R196's room on 03/18/22 because she is responsible for asking residents' their food preferences. DC1 reported while asking R196 her food preferences R196 told her "...she didn't feel safe and she felt that

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F 550	Continued From page 4	F 550		

she was threatened by someone in the facility..." DC1 observed CNA23 come into R196's room grab orange juice from R196's table and dump it in the toilet without asking R196 if she was done. R196 reported to DC1 that CNA23 is destroying the evidence, R196 did not elaborate to DC1 what evidence CNA23 was trying to destroy. DC1 reported R196 then asked CNA23 why she was treating her that way and CNA23 inquired with R196 what she did to her. DC1 reported that CNA23 then asked R196 if she wanted to go to the dining room and R196 stated she wanted to stay in her room. DC1 reportedly observed CNA23 put socks on R196's feet and stated "...it looked like it was not gentle enough so... [R196]...said it was hurting her." DC1 then reportedly observed CNA23 ask R196 to scoot back in her wheelchair and before R196 could scoot back into her chair CNA23 began pushing R196 to the dining room even after R196 reported she did not want to go. DC1 reported that R196 "...seemed very scared."

On 05/27/22 at 12:44 PM interview with Director of Nursing (DON) was done. DON stated the facility sent CNA23 home after the incident was brought up and then terminated CNA23. DON reported during investigation the resident did not remember the situation but "...couldn't rule out the CNA had been a little rough putting her sock and shoes..." on the resident and "...did not give direction ...did not handle herself like she should ...we want to be kind or polite to our residents."

Review of "Hawaii Notice of Patient Rights" included in the facility's admission packet documents residents have the right to "Be treated with consideration, respect and in full recognition of their dignity and individuality..."

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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 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 interviews and record review the facility failed to inform Resident (R) 17 the duration and end date of isolation due to Transmission Based Precautions (TBP). Findings Include: R17 was admitted to the facility on 03/18/22. Review of R17's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/22/22 documented R17's Brief Interview Mental Status (BIMS) at a 15 (cognitively intact). On 05/24/22 at 01:06 PM interview with R17 stated she was on TBP and quarantining in her	F 552	Although there was prior no documentation in the chart, the resident was informed on 5/27/22 and she confirmed with the Unit Manager that she had previously been informed and was aware of the duration and end date of isolation. Staff were inserviced on May 30 and again on July 13 & 14, 2022 regarding informing residents and documenting when their quarantine begins and ends. The Director of Nurses and/or designee checked on 5/30/22 and found no other residents being affected by this defective	7/15/22

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F 552	Continued From page 6 room because she had close contact with a family member who tested positive for COVID-19. R17 stated she found out on 05/20/22 but did not know how long she will be in isolation or when it will end. On 05/25/22 at 03:53 PM review of R17's Electronic Medical Record (EMR) was done. On 05/20/22 the physician ordered seven days of droplet isolation due to possible exposure to COVID-19. On 05/20/22 a nursing note documented "Resident in 7 day droplet isolation due to a possible COVID exposure with family member. Resident tested negative on antigen Covid test ....DON [Director of Nursing] and MD [physician] aware ..." On 05/27/22 at 10:57 AM interview with Unit Manager (UM) was done. UM stated when a resident is in isolation nursing staff will inform the resident how long they will be in isolation for. UM stated R17 is alert and orientated and able to remember her appointment dates. UM confirmed there is no documentation in the EMR that R17 was informed of the duration and end date of her isolation.	F 552	practice. The Director of Nurses and/or designee will conduct a verbal audit of those residents in quarantine to ensure that that they have been informed when quarantine begins and ends. The results of the audits will be reported to the Quarterly Quality Improvement Committee as well as the Governing Board. 7/29/22 and ongoing	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	F 609		7/15/22

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F 609	Continued From page 7 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 review of the facility's policy and procedures and staff interview, the facility failed to immediately report allegation of abuse to the adult protective services (APS) in accordance with State Law for one of two facility reported incidents related to allegations of abuse. Findings Include: Cross Reference to F550 Resident Rights. The facility to ensure Resident (R) 196 was treated with dignity and respecy by a nursing staff which resulted in R196 scared and distressed. The facility submitted an Event Report to the State Agency regarding an allegation of abuse. On 03/18/22 at 05:05 PM, R196 reported to Dietary Clerk (DC) 1 she was scared and Certified Nursing Aide (CNA) 23 was hurting her.	F 609	This resident has been discharged. The Director of Nurses reviewed the cases reported to OCHA involving suspected abuse and/or neglect and found no further cases with this deficient practice. The Administrator and/or designee will insure that all OCHA reports involving suspected abuse and/or neglect is also reported to APS. The Director of Nurses and/or designee will audit all OCHA reports involving suspected abuse and/or neglect has also been reported to APS.	

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F 609	Continued From page 8 A review of the facility's "Incident Report" and "Event Report" submitted by the facility found this allegation was not reported to APS. A review of the facility's policy and procedure for abuse and neglect entitled "Facility Requirements for Reporting and Investigating Allegations" documents "Allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property will be reported to the State Survey Agency and other agencies in accordance with State Law." On 05/27/22 at 12:44 PM interviewed the Director of Nursing (DON). DON confirmed the facility was investigating allegation of abuse and a report was not made to APS regarding this allegation.	F 609	The results of the audits will be reported to the Quarterly Quality Improvement Committee as well as the Governing Board. 7/29/22 and ongoing	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders.	F 655		7/15/22

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F 655	Continued From page 9 (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a written plan of care to the Resident (R) 101 and the family representative. This deficient practice failed to ensure the continuity of care, and communication between facility staff and resident/ family members regarding care that is being provided to the resident. Findings Include:	F 655	The Director of Nurses and/or designee corrected the Care Plan. On 6/9/22, the resident and family participated in a Care Plan Meeting and was given a copy of this Care Plan. The Director of Nurses and/or designee audited the current residents Care Plans on 5/30/22. There were no other residents with this deficient practice.	

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F 655	Continued From page 10 During an interview with R101's family member (FM) on 05/25/22 at 02:12 PM, surveyor asked FM "have you been informed about R101's care plan or participated in the care plan meeting?" FM responded, "I don't know what the plan of care is, not yet, maybe it's because she was just admitted yesterday." On 05/25/22 at 02:46 PM, surveyor reviewed electronic medical record (EMR) for R101. Reviewed progress note dated on 05/23/22 documents "Social Services has assessed the resident's psychosocial needs and has created the initial care plan." No further documentation found in the EMR to indicate the written care plan was provided to the representative or her family. On 05/25/22 at 03:29 PM surveyor received the following documentation from the Director of Nursing (DON): Care plan; interdisciplinary team (IDT) care plan conference/ Welcome meeting form. No written documentation found to indicate that written care plan information was provided to the family. DON reported that she spoke to the Social Services Director (SSD) over the phone to verify there was no written information in the record. DON verified there was no written documentation that family was provided the care plan or treatment team information. Surveyor followed up with FM on 05/26/22 at 01:15 PM and asked him if he had received a written copy of the care plan. FM stated not yet, and looked at his wife who shook her head no.	F 655	The IDT staff were inserviced on May 30, and again on July 13 & 14, 2022 regarding formulation of individualized Care Plans to include interventions, the requirement to provide a written plan of care to the resident and family representative and to document when it was communicated. The Director of Nurses and/or designee will audit the Baseline Care Plans for documentation on when and who was provided a written plan of care for the resident, weekly x 4 weeks, monthly thereafter. The results of the audits will be reported to the Quarterly Quality Improvement Committee as well as the Governing Board. 7/29/22 and ongoing	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		7/15/22

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F 657	Continued From page 11 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, interview, record review, the facility failed to update one resident's care plan (Resident (R) 24) out of 19 sampled residents, to identify R24's bilateral lower extremity swelling and refusals to wear compression stockings to treat his swelling. This deficient practice has the potential to affect all residents in the facility who have a medical problem and refuse care to treat that problem. Finding includes:	F 657	Resident #24□s Care Plan was revised on 6/22/22 to include his refusal to wear compressions stockings to treat his swelling. The Director of Nurses and/or designee audited on 5/30/33, the other residents and did not find any with this deficient practice. The IDT staff were inserviced on May30th	

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F 657	Continued From page 12 On 05/24/22 multiple observations of R24 were done between 08:22 AM and 02:12 PM. At 08:22 AM, an initial observation revealed R24 sitting up in his wheelchair in his room watching television. He wears eyeglasses and is slightly hard of hearing. He wore non-skid socks on his feet. His legs were noted to be swollen and he did not wear any compression stockings nor were his legs elevated. At 09:33 AM, R24 was sitting up in his wheelchair in his room, legs not elevated, drinking juice, with a newspaper on his bedside table. No compression stockings on his legs were noted. At 10:25 AM, R24 was up in his wheelchair in the activity room. He was not elevating his legs nor wearing compression stockings on his lower extremities. At 11:58 AM, R24 was sitting in his wheelchair at a table in the dining room, both legs not elevated. No compression stockings were observed to be worn on his legs and feet. R24's legs were swollen mid-calf to his ankles and his skin was with brown discoloration. At 01:16 PM, R24 was sleeping sitting up in his wheelchair, both legs were not elevated nor was he wearing compression stockings. His television was on. On 05/25/22 at 03:35 PM, R24's electronic medical record (EMR) was reviewed. R24 is a 99 year old resident admitted to the facility on 03/31/22 for peripheral vascular disease (blood circulation disorder affecting the limbs). R24's care plan did not identify his bilateral leg edema (swelling) as a problem and his refusal of wearing compression stockings to treat his swelling. The "Order Summary Report" revealed "COMPRESSION STOCKING WHEN OUT OF BED, OFF AT NIGHT every day and night shift for DX [diagnosis] EDEMA BOTH LEG" was ordered	F 657	and July 13 & 14, 2022, regarding the need revised Care Plans to include the current practice and any refusal of treatment, any alternative methods offered. The Director of Nurses and/or designee will audit that the Care Plans that reflects the current practice and for documentation that includes any refusal of treatment, any alternative methods offered, weekly x 4 weeks, monthly thereafter. The results of the audits will be reported to the Quarterly Quality Improvement Committee as well as the Governing Board. 7/29/22 and ongoing	

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F 657	Continued From page 13 on 04/25/22. The order for the compression stockings on the "Treatment Administration Record" (TAR) for Tuesday, May 24, 2022, day shift was marked as administered. On 05/26/22 at 09:19 AM, R24 was interviewed, and he stated that he preferred not to wear the compression stockings because it was "humbug." R24 further stated that he elevates his legs sometimes while in bed and stated that his legs have been swollen "for a long time" due to having spinal surgery in the past. On 05/26/22 at 04:10 PM, the facility's policy for "Comprehensive Care Plans," 11/2017 was reviewed. Under "Guidelines: ...7. The care plan will be person-specific with measurable objectives, interventions and timeframes. It will address goals, preferences, needs and strengths of the resident. 8. Care plan will include: ...b. Services that would have been provided but the resident has refused ..."	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	F 686		7/15/22

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F 686	Continued From page 14 new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record reviews, the facility failed to ensure that one resident (Resident (R) 149) out of a sample of three residents, received the appropriate care for preventing a skin tear on R149's tail bone from turning into a pressure ulcer (bedsore). This deficient practice has the potential to affect all residents who have a skin wound on pressure points and are fully dependent on staff for care. Finding includes: On 05/24/22 between 08:22 AM and 02:07 PM, periodic observations of R149 in her room were done (08:22 AM, 09:33 AM, 10:25 AM, 11:28 AM, 12:02 PM, 12:26 PM, and 01:16 PM). At these times, R149 was noted to be lying in bed on her back, not turned to the right or left side. At 12:26 PM, R149 was sitting up high in bed on her back while Registered Nurse (RN) 5 assisted her with lunch. At 02:07 PM, R149 was not in her bed. R149 was not on a specialty mattress. On 05/24/22 at 01:46 PM, R149's electronic medical record (EMR) was reviewed. R149 is an 88 year old resident admitted on 05/13/22 from an acute care facility with the principal diagnosis of having bacteria in her blood originating from a urinary tract infection. A "NSG [Nursing] Skilled Progress Note" for R149's admission written on 05/13/22 at 8:53 PM identified under "11. Additional Key Categories ...2. Are there any skin/wound concerns at this time?" No was marked. A "Patient Referral" documentation sent to the facility by R149's physician on 05/17/22 at 07:24 PM was reviewed. R149 had a diagnosis	F 686	This resident has since been discharged. The Director of Nurses and/or designee audited the skin conditions of other residents to ensure that other residents were not at risk for pressure ulcers on 5/30/22. There were no other residents with this deficient practice. The staff were inserviced on May 30th and July 13, & 14, 2022 regarding turning and repositioning residents to prevent pressure ulcers. The Director of Nurses and/or designee will audit turning and repositioning documentation, as well as accuracy of wound documentation, weekly x 4 weeks, monthly thereafter. The results of the audits will be reported to the Quarterly Quality Improvement Committee as well as the Governing Board. 7/29/22 and ongoing	

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of "xerosis" (abnormally dry skin) that made R149 a "very high risk" for skin breakdown and pressure ulcers and would need close monitoring for these skin conditions. R149's admission "Minimum Data Set" (MDS) dated 05/19/22 revealed under "Section G Functional Status" that R149 needed "extensive assistance" for bed mobility (how a resident changes body position in bed) and needed "two+ (or more) persons" to physically assist R149 with bed mobility. A "Skin & Wound Evaluation V5.0" documented on 05/22/22 at 09:22 AM, revealed that R149 had a skin tear on her tail bone described as "Category 1: Flap - Flap type (partial thickness): Epidermis [top layer of skin] and dermis [thick layer of skin below the epidermis] are separated. Wound measurements documented as: "Area 2.6 cm2 (square centimeters), Length 2.4 cm (centimeters), Width 1.6 cm." No depth of the wound in centimeters was identified. R149's care plan was reviewed. R149's diagnosis of having xerosis placing her at high risk for skin breakdown was not identified. Documented for "Focus The resident has an ADL self-care performance deficit," the "Intervention" to assist with bed mobility was not updated to reflect that R149 needed two people to assist with turning her in bed. "Bed Mobility: The resident requires limited assistance by (1) staff to turn and repositioning in bed. Date Initiated: 05/13/22" was still documented on R149's care plan.

On 05/26/22 at 09:26 AM, Certified Nursing Aide (CNA) 19 was interviewed at the unit's nursing station. CNA19 stated that residents needing to be turned to prevent pressure sores are turned every two hours.

On 05/26/22 at 10:34 AM, a concurrent

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observation and interview with Unit Manager (UM) of R149's skin tear on her tail bone was done in R149's room. R149 was lying in bed and turned to her left side only with the assistance of the UM. UM stated that R149 had a previous wound on her tail bone that healed but recently developed a skin tear and, while currently observing R149's tail bone, stated that the skin tear had become bigger. UM stated that he will make a consult with the wound team that rounds at the facility and who will be at the facility tomorrow at 01:00 PM. At 02:29 PM, in a follow up conversation with the UM, UM stated that because of the skin wound's location on a pressure point (tail bone) that it could be turning into a pressure injury. UM will obtain an order for a paste to apply to the area and for an air mattress.

On 05/25/22 at 04:05 PM, reviewed the facility's policy on "Repositioning," revised May 2013. Under "General Guidelines: 1. Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief." "Interventions ...4. For residents with a Stage I [one] or above pressure ulcer, an every two hour (q2 hour) repositioning schedule is inadequate." Under "Steps in the Procedure Repositioning the Resident in Bed 1. Check the care plan ...to determine resident's specific positioning needs including special equipment, resident level of participation and the number of staff required to complete the procedure ...9. Use two people and a draw sheet to avoid shearing while turning or moving the resident up in bed ..."

On 05/31/22 at 03:30 PM, received "Wound Care SNF Consult Service Progress Note" with Date of Service: 05/27/22 for R149. Wound consult was

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F 686	Continued From page 17 obtained due to a new wound on R149's sacrum (tail bone) starting from an abrasion. The wound on R149's sacrum was measured as: Area 4.2 cm, Length 2.1 cm, Width 2.0 cm, Depth 0.2 cm. "Impression: 1. Ulcer of sacral region, with fat layer exposed."	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices 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, record review, and interviews with staff member, the facility failed to implement the use of a gait belt consistent with the facility's standard of practice and the resident's needs, goals, and care plan to prevent an avoidable fall for 1 out of 2 residents (Resident (R) 11) sampled that resulted in sustaining a fracture to right rib. Findings Include: Review of R11's Event Report regarding an incident 04/26/22, R11 had a witnessed fall and sustained fracture to his right rib. The report documents R11 standing with two therapists at the elevator with his walker and "...was attempting to place his face mask on. He fell forward and to the right hitting his right rib cage on the walker frame. The therapists caught him	F 689	Past noncompliance: no plan of correction required.	

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and lowered him to the floor."

R11 was admitted to the facility on 03/08/22 with diagnosis of difficulty in walking not elsewhere classified, displaced intertrochanteric fracture of right femur subsequent encounter for closed fracture with routine healing, encounter for other orthopedic aftercare, muscle weakness, other lack of coordination, and unspecified fall subsequent encounter.

Review of R11's "Initial History & Physical" dated 03/09/22, prior to admission to the facility, R11 was admitted to the hospital from 03/04/22 to 03/8/22 after losing balance at home and having a mechanical fall resulting in a displaced right femoral intertrochanteric fracture. The history and physical further documented R11 with history of chronic vertigo.

Review of R11's admission minimum Data Set (MDS) with an assessment reference date of 03/13/22, R11's Brief Interview Mental Status (BIMS) scored him at 12 (moderate impaired cognition). In Section G. Functional Status, under Transfers (how resident moves between surface including to and from bed, chair, wheelchair, standing position), R11 requires extensive assistance with one-person physical assist. Walk in Corridor, R11 requires one-person physical assist. Locomotion on unit, R11 requires total dependence with one-person physical assist. Locomotion off unit, R11 requires extensive assistance with one-person physical assist. Under Balance During Transitions and Walking, R11 scored a 2 (not steady, only able to stabilize with human assistance) for walking (with assistive device if used) and turning around and facing the opposite direction while walking.

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On 05/25/22 at 10:22 AM interview with R11 was done. R11 stated he has a history of vertigo and broke his right rib at the facility after attempting to put his mask on in front of the facility elevators. R11 stated he lost his balance and fell forward onto his walker while with two therapy staff. R11 stated "...they couldn't catch me."

On 05/26/22 at 12:40 PM interview with Occupational Therapist Assistant (OTA) 1 and Physical Therapist Assistant (PTA) 2 was done. OTA reported she was one of the therapists with R11 when the incident happened on 04/26/22. OTA stated she was following R11 with his wheelchair and Physical Therapist (PT) 3 was standing next to R11. OTA1 further stated R11 was using his walker and before he walked into the facility elevator, he attempted to put his mask on, lost his balance and fell forward on to his walker. OTA1 reported R11 did not have his gait belt on that day but would usually have use a gait belt in case he loses his balance.

On 05/26/22 at 04:41 PM interview with Director of Rehabilitation (DOR) was done. DOR confirmed R11 did not have a gait belt on when services was provided on 04/26/22 and stated there is "...no documentation that he didn't need to use the gait belt anymore." DOR further stated it was the therapist "...fault...didn't use safety device to prevent." DOR reported therapy services are contracted by the facility and it is their policy for all residents to wear gait belts.

Review of therapy's "Performance Corrective Action" for PT3 dated 04/27/22 documents the description of the incident "On 04-26-22, ...PT3] ...was working with a patient...who experienced a

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fall during a vertigo incident resulting in a rib fracture. At the time of the fall, the patient was not wearing a gait belt...policy states that all patients must wear a gait belt during therapy unless the patient refuses to wear one..."

On 05/26/22 at 03:39 PM interview with Director of Nursing (DON) and concurrent review of R11's Electronic Medical Record (EMR) was done. Concurrent review of R11's fall risk assessment dated 03/08/22 scored R11 at an 8. DON stated a score of 8 or higher in the fall risk assessment indicates R11 at a higher fall risk. Concurrent review of R11's diagnosis list and initial history and physical dated 03/09/22, DON confirmed the history and physical documented R11 with a history of chronic vertigo and it was not included in the facility diagnosis list. Inquired with DON if there is a reason for R11 not to use a gait belt when ambulating or during transfers with staff members, DON stated it is standard of practice for staff to use a gait belt anytime they are assisting the resident with ambulating or transfers.

Review of Advance Practice Nurse progress note with an encounter date of 04/27/22 documents "Patient with fall while working with therapy on 4/26/22. Nursing noted he fell down onto walker and noted to hit his right flank, ...He complained of pain so Xray [X-ray] was ordered. Xray results showed possible nondisplaced fracture involving right 7th rib...He admitted to increased pain with deep breath, coughing, and movement."

Review of physician progress note with an encounter date of 04/29/22 documents "Therapists says has some difficulty with sit to stand due to right rib pain but still participating.

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Patient says has pain in right rib with coughing and movements. Sometimes it hurts even with swallowing or when has to bear down to have BM [Bowel Movement]. BM was small yesterday he couldn't bear down as much."

On 05/27/22 the SA found the deficient practice Past Non-Compliance on 05/25/22 through observation , interviews and documentation provided from 05/24/22 to 05/26/22.

On 05/24/22 at 09:26 AM observed R8 using a gait belt while receiving therapy services.

On 05/24/22 at 09:35 AM observed R41 using a gait belt while receiving therapy services.

On 05/26/22 at 08:42 AM observed R40 using a gait belt while receiving therapy services.

On 05/26/22 at 04:41 PM interview with DOR was done. DOR stated after the incident a written performance corrective action was taken on PT3. DOR explained the performance corrective action included training PT3 and monitoring PT3 two weeks after the written performance corrective action was completed.

Review of the "Performance Corrective Action" dated 04/27/22 documents verbal counseling and verbal warning was done with PT3 for the incident on 04/26/22 due to policy procedure violation, gait belt use. A two week follow up action was documented on 05/10/22, PT3 "...has used gait belt with all patients."

On 05/27/22 at 12:54 PM interview with DON was done. DON stated, "The therapist was reeducated...and received disciplinary action."

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F 689	Continued From page 22 DON further stated that staff were in-serviced to use gait belts, the facility monitors for competency and monitors for gait belt use. Review of "In-Service Training Report" dated 04/27/22 documents training provided to all therapy providers "All staff at Kalakaua Gardens are to make sure that a patient is using a gait belt during therapy at all times UNLESS the patients chooses not to use one AND if so, it must be documented thoroughly" On 05/27/22 at 02:58 PM the facility provided documentation of monitoring gait belt use completed on 04/27/22, 04/28/22, 04/29/22, 05/02/22, 05/03/22, 05/04/22, 05/05/22, 05/06/22, 05/09/22, 05/10/22, 05/11/22, 05/18/22 and 05/25/22. The monitoring log included residents affected and therapy staff members providing the service.	F 689		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedures, the facility failed to properly administer three of nine medications that were observed, resulting in a medication error rate of 8% (three errors of 25 medications administered). Findings Include:	F 759	The agency staff was no longer allowed to work in the facility. The Director of Nurses and/or designee conducted observations on 5/30/22, during medication administration to ensure this practice did not reoccur.	7/15/22

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F 759	Continued From page 23 On 05/26/22 at 08:35 AM observed medication administration with Registered Nurse (RN) 14 on the fourth floor near rooms 401 to 403. RN14 prepared the following medications for Resident (R) 27: 1. Amlodipine 2.5 mg tabs 1-tab every day (QD). 2. Lisinopril 20mg 1-tab QD. 3. Med Pass 2.0 Observed RN14 crush Amlodipine and Lisinopril, mix them together with Med Pass 2.0 in a medication cup and give it to R27. When RN14 completed the medication administration, inquired if it is best practice to mix all of the crushed medications together and give them all to the resident at the same time, RN14 replied that it depends on the situation. Surveyor attempted to discuss further with RN14, however, RN14 moved her cart away from the surveyor and did not respond. On 05/26/22 at 09:15 AM interviewed Charge Nurse (CN) 11 about the medication administration observation with RN14. CN11 explained that although RN14 is an agency nurse she should know that crushed medications should not be given together in case the resident doesn't take all of it. On 05/26/22 at 01:45 PM interviewed Unit Manager (UM) and inquired if it is appropriate for nursing staff to mix crushed medications all together and give it to the resident at the same time, UM responded "no" and that it is not a good practice. Inquired if the agency staff are trained on the facility's medication policy and procedures prior to working in the facility, UM stated an initial competency assessment is done. UM further	F 759	The licensed staff were inserviced on 5/27/22 and again on July 13 & 14, 2022, regarding the medication requirements for crushed medications. The Director of Nurses and/or designee will continue to conduct observations during medication administration to ensure this practice does not occur, weekly x 4 weeks, monthly thereafter. The results of the audits will be reported to the Quarterly Quality Improvement Committee as well as the Governing Board. 7/29/22 and ongoing	

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F 759	Continued From page 24 stated the facility uses agencies with the same procedures as the facility and receive a report from the agency that staff are cleared with a pre-employment clearance. On 05/26/22 at 10:47 PM reviewed the facility's pharmacy services medication administration policy number 759 (08/2018). The policy documents "Crushed medications will not be combined to give multiple medications at once, whether administered orally or via a feeding tube."	F 759		
F 761 SS=E	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 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	F 761		7/15/22

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F 761	Continued From page 25 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedures, the facility failed to ensure two medication carts on two separate occasions were locked or attended. This deficient practice potentially increases the risk of injury for any resident, or visitor who can access the medication cart. Findings Include: 1) During a medication administration observation on 05/26/22 at 08:35 AM with Registered Nurse (RN) 14 on the fourth floor near rooms 401 to 403, surveyor observed RN14 walk away from her medication cart to go into Resident (R) 27's room. The medication cart was observed unlocked and unattended. After she returned, surveyor attempted to discuss that the cart was left unlocked and unattended with RN14, however, she quickly moved her cart away from the surveyor and did not respond. On 05/26/22 at 09:15 AM interviewed with Charge Nurse (CN) 11 about the medication cart being left unlocked and unattended by RN14 during the medication administration observation. CN11 explained that although RN14 is an agency nurse, she should know to always lock her cart before leaving to give medication. On 05/26/22 at 01:45 PM interview Unit Manager (UM) was done. Inquired if agency staff are trained on the facility's medication policy and procedures prior to working in the facility, UM stated an initial competency assessment is done.	F 761	The agency staff was not allowed to work in the facility again. RN12 was counseled on 5/27/22. The Director of Nurses and/or designee conducted an audit of medication carts and med rooms on May 27, 2022 to ensure this practice did not occur. The licensed staff were inserviced on 5/27 and again on July 13 & 14, 2022 regarding the requirements for locking medication carts and med room when not in active use. The Director of Nurses and/or designee will continue to conduct audits to ensure medication carts and medication rooms are secure when not in use, weekly x 4 weeks, monthly thereafter. The results of the audits will be reported to the Quarterly Quality Improvement Committee as well as the Governing Board. 7/29/22 and ongoing	

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F 761	Continued From page 26 UM further stated the facility uses agencies with the same procedures as the facility and receive a report from the agency that staff are cleared with a pre-employment clearance. On 05/26/22 at 11:08 AM reviewed the facility's policy and procedure "Pharmacy Services Labeling and Storage of Drugs and Biologicals", policy number 761 (11/2017). The policy documents "The facility stores drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. " 2) On 05/24/22 at 11:54 AM RN12 was observed assisting a resident to the dining room without locking the medication cart. RN12 confirmed the medication cart was unlocked and unattended and stated the medication cart should have been locked.	F 761		
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,	F 880		7/15/22

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F 880	Continued From page 27	F 880		

reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable 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

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F 880	Continued From page 28 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review, the facility failed to clean multi-use resident care items and provide medications to residents in a sanitary manner. Registered Nurse (RN) 9 failed to properly disinfect the blood pressure (BP) cuff and vital signs (VS) machine after using it on Resident (R) 96 and RN14 had personal snacks and a drink container on top of the medication administration cart during medication administration. These deficient practices potentially increases the risk of infection for residents in the unit. Findings Include: 1) During a medication administration observation with RN14 on 05/26/22 at 08:35 AM on the fourth floor near rooms 401 to 403, observed a zip lock bag full of trail mix (nuts and chocolate pieces) and a large drink container sitting on top of the medication cart. Inquired if it is ok to have personal snacks and beverage containers on top of the medication cart while administering medications, RN14 did not answer and moved the cart away to go to the next room. On 05/26/22 at 01:45 PM interviewed the Unit	F 880	The agency nurse was no longer allowed to work in the facility. The Director of Nurses and/or designee conducted visual observation audits on 5/30/22, and found the equipment is being wiped down after each use, prior to storage, and no personal items were found on the medication carts. The staff were inserviced on May 30, 2022. They were again inserviced on July 13 & 14, 2022, regarding not leaving personal items on the medication carts; Infection Control procedures regarding wiping down equipment after each use, prior to storage, and the Infection Prevention videos: Sparking Surfaces, Clean Hands, Keep COVID-19 Out! And Lessons. The Director of Nurses and/or designee will continue to conduct observation audits to ensure equipment is wiped down after each use prior to storage, weekly x 4 weeks, monthly thereafter.	

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F 880	Continued From page 29 Manager (UM) and explained the observation during medication administration. Inquired if it is appropriate for nursing staff to have personal snack items and beverage containers on top of the medication cart while administering medications, UM responded "no" it is not and explained that staff can keep personal snacks and beverages in their bag or in the break room. 2) On 05/25/22 at 08:33 AM, an observation of RN9 was made on the unit. RN9 took the blood pressure (BP) for R96 in her room with a vital signs (VS) machine prior to administering R96's BP medication. RN9 removed the multi-use BP cuff from R96's upper arm and placed it in the basket under the VS machine without disinfecting the BP cuff first. RN9 then placed the VS machine outside of the room . A "Disinfect after use" label was noted on the VS machine. A therapies staff ambulating a resident in the hallway outside of R96's room, removed an oxygen saturation finger clip off the same VS machine used for R96 to utilize on the resident ambulating because he complained of having difficulty breathing while walking. On 05/25/22 at 08:40 AM, RN9 was interviewed in the hallway. RN9 stated that he was supposed to disinfect the BP cuff and VS machine after using it for R96, but he got distracted. On 07/05/22 at 03:30 PM, the Centers for Disease Control and Prevention (CDC) "Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008," updated May 2019 was reviewed. "Failure to properly disinfect or sterilize equipment carries not only risk associated with breach of host barriers but also risk for	F 880	The results of the audits will be reported to the Quarterly Quality Improvement Committee as well as the Governing Board. 7/29/22 and ongoing	

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F 880	Continued From page 30 person-to-person transmission (e.g., hepatitis B virus) and transmission of environmental pathogens (e.g. Pseudomonas aeruginosa)."	F 880		