STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125013	A. BUILDING _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAUNALANI NURSING AND REHABILITATION CENTER	5113 MAUNALANI CIRCLE 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 000	INITIAL COMMENTS The Department of Health, Office of Health Care Assurance, conducted a recertification survey on 08/28/23-08/31/23. The facility was found not be in compliance with 42 CFR §483, Subpart B. The Office of Health Care Assurance will accept the federal Medicare recertification of this facility for state relicensing purposes and has exempted this facility from a relicensing inspection as authorized by Chapter 11-94.2, Hawaii Administrative Rules, §11-94.2-6(e). Refer to the federal Medicare recertification survey report to review the statement of deficiencies and the facility's plan of correction. The census was 84 residents at the time of entrance.	F 000		
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	F 578		9/24/23

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

Electronically Signed | 09/22/2023

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F 578	Continued From page 1 resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives 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 interview and record review, the facility failed to: 1. Honor one Resident (R)2's wishes to refuse treatment per the advanced healthcare directive for one resident of one in the sample. 2. Did not honor the medical decision to stop medication that potentially prolong's life when the medical decision maker asked the nursing staff not to give the medication that would lower her blood pressure (BP). 3. Follow up with R2 and her medical decision maker about considering comfort care as an option. The deficient practice violates the rights of the resident and her representative to make treatment decisions.	F 578	1. R2□s wishes were reassessed by the Social Worker, Nursing Manager and Physician. Plan of care was updated to align with R2□s wishes and advance directive. 2. Nursing Manager and Licensed Nurses completed a chart review for all residents to identify other potential residents whose wishes to refuse treatment were not honored. None were found. 3.Procedures for reporting have been updated for Licensed Nurses to inform Social Services when a resident refuses treatment. Nursing and Social Services	

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F 578	Continued From page 2 Findings include: Telephone interview with R2's Family member (FM)1 on 08/29/23 10:54 AM, who is the medical decision maker number one for R2. When asked if her aunt's choices are being honored by the facility stated. No, I don't think they are, they have been giving her a medication that she refuses to take, I can't remember what it is, but she has refused it a lot, and they do call me and ask if they can provide the medication and ask for my approval. It doesn't seem to matter if I tell them no, because I think they will give it to her anyway. When she could make her own decisions, she specifically told me she did not want to take that medication. I am not sure what it is, but she kept refusing it, then they gave her a medication patch instead. When the nurse called to talk to me, I did not agree for her to take it, because I know it is not her wishes. I think the nurse went to the manager and they overrode my decision and gave it to her anyway. When asked if they discussed hospice with her at the care plan meetings, she said hospice was only brought up to me one time, and the person told me its only for people who have cancer. Interview with the Social Worker (SW) on 08/31/23 at 09:03 AM regarding R2. Shared the discussion with FM1 who is R2's medical decision maker and the concern that R2 is having to take the blood pressure medication that she does not want to take, because she feels that it is prolonging her life with medication. Asked the SW if she is aware that FM1 has this concern and if it was ever brought up during R2's interdisciplinary team (IDT) meetings, or via telephone conversations. Asked SW if Hospice	F 578	will follow up with residents and/or representatives to reassess residents wishes and advance directive. Every quarter during care conference, the IDT will review resident s advance directive, goals of care, medications/treatments, and any refusals to ensure residents wishes are being honored. 4.Social Services will monitor quarterly that the plans of care are reviewed with resident and/or representative to ensure that it aligns with resident s wishes and advance directive.	

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F 578	Continued From page 3	F 578		

was a consideration for R2. The SW stated that hospice was discussed with FM1 by the former SW, and not documented. Surveyor asked for information either from the nursing staff or previous SW notes to indicate if Hospice was an option for the resident.

Reviewed "A guide to Advance Care Planning: Making Life Decisions. (Brochure by Kokua Mau, continuous care from the Executive Office on Aging. Department of Health on 08/31/23 at 09:21 AM. Page 6 What is Comfort Care? "The goal of comfort care is to give the best quality of life for the person and family during the time of illness, dying, and grieving.

08/31/23 11:02 AM Reviewed the electronic medical record (EMR).
Medical Diagnosis includes Vascular dementia, history of falling, repeated falls, abnormal weight loss, essential primary hypertension, and major depressive disorder.

Reviewed physician (MD) orders: R2 is taking the following medications that may prolongs life:
1. Catapres-TTS-2 Transdermal (on the skin) Patch (to lower BP) Weekly 0.2miligrams (MG)/24HR (Clonidine).
Apply 2 patch trans dermally one time a day every for Hypertension (high BP) remove old patch when placing new patch two times a day for Hypertension.
3. Nitro-Bid Ointment 2 % (Nitroglycerin) (that lowers BP).
Apply 2-inch trans dermally every 8 hours as needed (PRN).

Reviewed the following nursing notes regarding a refusal to take medication:

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F 578	Continued From page 4	F 578		

8/24/2023 15:43 Late Entry:
Subject: BP
Data: Record shows that resident with episodes of elevated BP despite on Clonidine patch mg/24 hr., 1 patch Q 7 days. MD notified and ordered to increase patch to 2 patches trans dermally every (Q) 7 days.

8/4/2023 20:09
Data: Resident refused eve shift medications despite encouragement, education and other staff help for taking eve medication. Resident states, I am not going to take any medications".

8/4/2023 15:14
Subject: Intermuscular (IM) Diazepam order
Data: MD extended diazepam injection 5mg IM q 12 hrs. PRN for agitation / combativeness / self-harm for 2 weeks.

7/26/2023 15:11
Subject: Behavior
Data: Resident asleep throughout shift. Attempted to administer routine medications; however, Resident refused three times, despite education. VS: 187/68, 55, 18 RR, 97.6F, 95% RA. PRN Nitro-paste administered at 1400 to right chest.

7/25/2023 22:02
Subject: Behavior
Data: Resident is pleasant this shift. However, refused to take her evening med and said "I took these today already. I am not taking any more meds. Take them away". Encourage multiple times and educated resident but unsuccessful. Resident had a good dinner, ambulated to bathroom. No other behavior noted.

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7/24/2023 10:06
Subject: Blood pressure
Data: This AM resident's BP was 195/82. MD in house in a notified of BP results. This nurse applied Nitro-bid paste PRN.

7/12/2023 03:01
Subject: BP med changes
Data: Started on clonidine patch, oral bp meds d/c-d. BP 146/64.

7/10/2023 10:32
Subject:
Data: POA was informed, and resident will be informed too.

7/10/2023 09:42
Subject: MD rounds
Data: MD updated this morning re: resident's refusal to take meds including BP meds.
New orders: DC Norvasc and Atenolol BP meds; Keep nitro paste as ordered.
TTS-2 Clonidine (Catapres) patch applied weekly.

6/15/2023 13:42
Subject: Refusal of medication/ behavior
Data: Resident refused despite encouragement. Resident states, "I don't like". Resident went toilet eats lunch then went back to bed. No acute distress noted. No suicidal behavior or episodes of unwanted behaviors this shift.

5/26/2023 10:01 Late Entry:
Subject: Intravenous fluids (IVF)
Data: Continues on IV. Last bag running to right wrist. Resident asks repeatedly when the IV will finish. Gets upset about IV. Asks to change the kerlix around IV site. During dressing change, resident lay on bed and cried that she wants to

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F 578	Continued From page 6 die already and to leave her alone. Refused meds in the morning. 5/24/2023 06:44 Subject: IVF Therapy Data: Resident is on IV fluids. Currently on liter #1. IV to right wrist patent, intact, and running without difficulty. 5/23/2023 19:47 Subject: New IV fluid therapy Data: ...Still with no oral (PO) intake for dinner. No fluids intake. Continued to offer fluids/meal, resident opened eyes then shook head "no" and fell back asleep. Continue IV therapy. 08/31/23 11:33 AM Reviewed care plan dated 08/18/23. I have a diagnosis (dx) of vascular dementia. I can be confused and exhibit delusional behavior at times. I will be able to make my basic needs known on a daily basis. I have the tendency to refuse all my medications. Try to come back at a different time. I may refuse to take my meds for the whole day. Please do provide encouragements and education. My family and physician are aware of this behavior.	F 578		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 697		9/24/23

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F 697	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to manage pain adequately for one of one resident (R) sampled for pain (R84). Specifically, the facility failed to ensure that R84's as needed (PRN) pain medication was kept in stock, failed to administer the PRN pain medication when asked for, failed to assess his pain level when needed, and failed to develop pain management goals with the Resident. As a result of this deficient practice, R84 was prevented from attaining or maintaining his highest practicable level of well-being. Findings include: Resident (R)84 is a 69-year-old male admitted on 08/14/23 for short-term rehab following surgical repair of a left lower leg fracture. On 08/30/23 at 07:57 AM, during an interview with Registered Nurse (RN)20 as she prepared medications for R84, RN20 stated the facility was having problems getting medications in from the pharmacy at times. As an example, RN20 reported that R84's as needed (PRN) pain medication, Oxycodone, was "out" and that she had called the pharmacy about it the day before. When asked what the facility normally does when a medication like that is out, RN20 replied "oh, we can get it from the e-kit [emergency kit], but we prefer to get it from the pharmacy." On 08/30/23 at 08:03 AM, as RN20 gave R84 his routine pain medication, Acetaminophen, R84 asked for his Oxycodone. RN20 told him that his Oxycodone was "out." RN20 was not observed asking R84 to rate his pain level at this time,	F 697	1. Licensed Nurse promptly addressed resident□s 8/10 pain by obtaining Oxycodone supply from the emergency kit and administering it as ordered for severe pain. Oxycodone was effective. Upon re-assessment, the pain rate decreased to 4/10. Licensed Nurse followed up with Pharmacy regarding delivery of PRN Oxycodone and it was delivered in the evening on 8/30/23. Resident was educated on non-pharmacological intervention such as elevating affected leg. Pain goal was discussed with resident and care plan was updated with tolerable pain level of 7/10. 2. Licensed Nurses checked the supplies in medication carts and re-ordered medications as necessary to ensure medication availability. Nurse Managers and Licensed Nurses completed a pain assessment, reassessed their individual pain management goals, and updated the care plan. 3. The medication order procedure has been updated for Licensed Nurse to peel the sticker off the blister pack and paste it onto the medication order log after re-ordering medications. Upon pharmacy delivery, evening and night shift Licensed Nurse will check off the medications that were delivered. If medication is not received in a timely manner, Licensed Nurse will follow up with the on-call Pharmacist. If medication is not forthcoming, Nurse will access the RxNow	

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F 697	Continued From page 8 despite giving him his routine pain medication and him asking for his PRN pain medication. RN20 was also not observed offering or implementing any non-pharmacological pain interventions such as elevating R84's visibly swollen left lower leg, which was hanging down as he sat in his wheelchair. In addition, it was noted that RN20 did not offer to obtain any Oxycodone from the e-kit prior to leaving the room. On 08/30/23 at 08:07 AM, an interview was done with R84 in his room. When asked about his pain, R84 stated he had "severe pain" in his left ankle, and rated it an "eight to nine" out of 10. R84 reported that the facility had been out of his Oxycodone "for about two days." When asked if the facility had tried to get some from another pharmacy, see if they had some in the emergency kit, or offered to have the doctor change the medication to something that was available, R84 replied, "no." R84 described his pain as "off and on throbbing," and stated "I need to elevate my foot, that helps a little with the throbbing and swelling." R84 reported that he was not satisfied with his pain management. When asked, R84 stated that he had only felt relief of the throbbing pain twice since he was admitted, and that both times it was after taking the Oxycodone. On 08/30/23 at 08:21 AM, during an interview with the Director of Nursing (DON) outside of the third floor elevator, the DON agreed that a pain assessment should have been done when R84 asked about his Oxycodone, and that she would follow-up on getting him his Oxycodone as soon as possible, or call the Doctor to change the order to a different medication if the Oxycodone was	F 697	machine or Emergency kit for the medication. Licensed Nurses were educated to assess pain level when resident has verbal or non-verbal signs and symptoms of pain. Non-pharmacological interventions for pain was added to the MAR to prompt Licensed Nurse to offer and document intervention and effectiveness of intervention that was offered. Licensed Nurses were educated on adding pain management goals in the resident□s pain care plan. 4. Nurse Manager to audit the medication order log daily to ensure medications are ordered and delivered. DON will serve as PIP (performance Improvement Project) Leader for pain management to ensure pain control is achieved for residents. Results will be tracked and reported to QAPI committee monthly.	

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not immediately available. The DON shared that she was "not happy" about the situation, and stated that staff had been "trained to manage pain better than this."

During a review of R84's electronic health record (EHR), the following physician order from 08/14/23 was noted:

"Oxycodone HCl [hydrochloride] Oral Tablet 5MG [milligrams] Give 1 tablet by mouth every 6 hours as needed for moderate to severe pain (4-10/10)."

A review of R84's Medication Administration Record (MAR) revealed the last time he had received the Oxycodone was at 07:30 PM the night before.

On 08/30/23 at 10:44 AM, during a review of R84's Comprehensive Care Plan (CP) for Pain, the following interventions were noted:

"Monitor pain level daily during care and as needed."

"Offer and administer pain medication (PRN) as ordered."

Further review of R84's CP for Pain noted no documentation of R84's pain management goals such as what pain level was acceptable or tolerable for him and/or what level of pain would he like to keep it below.

A review of the facility's Policy and Procedure for Pain Management noted the following:

"... Resident's pain will be alleviated or reduced to

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F 697	Continued From page 10 a level of comfort that is acceptable to the resident ..." "... G. Intervention if medication is out of stock or no supply: a. Check emergency kit (e-kit) for pain medication ... d. Offer non-pharmacological pain interventions."	F 697		
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 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:	F 761		9/24/23

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F 761	Continued From page 11 Based on observations, interview, and facility policy review, the facility failed to properly store medications in a manner that facilitates considerations of precautions and safe administration in one out of three medication carts sampled. This deficient practice has the potential to promote medication administration error to the residents in one unit in the facility. Findings include: Concurrent observation and interview were conducted on 08/30/23 at 10:28 AM on the third-floor hallway. An opened bottle of floor stock Acetaminophen was found in one of the facility's medication carts. The bottle of Acetaminophen did not have an expiration date. Licensed Practical Nurse (LPN)1 and Unit Manager (UM)1 both inspected the bottle for an expiration date. LPN1 and UM1 both could not locate an expiration date on the bottle. A review of the facility's policy titled, "Medication Storage," with a review date of 07/08/23 was conducted. The facility's policy indicated, "Medications will be discarded based on expiration date per facility protocol. If no open date or date of expiration is unknown, Licensed Nurse to discard medications per facility protocol."	F 761	1.The Acetaminophen bottle (1,000 tabs) that was unlabeled with the expiration date was immediately removed from the medication cart. 2. Nurse Managers checked all medication carts to ensure that there were no other house stock medications that did not have the expiration date and removed it from the cart. 3. The House stock supply of Acetaminophen was changed from 1,000-tabs bottle to 100-tabs bottle so that the content will be used up before the expiration date becomes rubbed-off.. 4. Nursing Manager will do a monthly audit of house stock medication to ensure house stock bottles are labeled with the expiration date sticker.	
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences;	F 806		9/24/23

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F 806	Continued From page 12 §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and facility policy review, the facility failed to provide accommodation for food preferences for one of 20 residents sampled, Resident (R)60. Findings include: R60 is a 91-year-old female admitted to the facility on 07/16/21. A review of R60's most recent Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 07/13/23 revealed that R60 was determined to have a Brief Interview for Mental Status (BIMS) score of 15, meaning she was found to be cognitively intact. Observation and interview were conducted on 08/29/23 at 07:42 AM in R60's room. R60 was up in bed having breakfast. R60's menu indicated, "give cornflakes with brown sugar every breakfast, 1/2 tuna sandwich only for breakfast, no boiled eggs, omelet is fine or scrambled egg is fine, no oatmeal or cream of wheat." What R60 received from the kitchen was Portuguese sausage, rice, banana, and cream of wheat. She did not receive any of her chosen menu items. R60 stated that she often gets the wrong items sent to her from the kitchen. She does not complain to the staff or have her food tray replaced because she does not want anyone getting upset with her. Interview was conducted with Kitchen Manager	F 806	1. R60□s menu was reviewed immediately by the Dining Services Manager. Menu alerts were created in PCC to trigger notices for Dietary staff to review documentation during meal prep and delivery. Dietary Manager reassessed menu options for R60. Dining Services Manager provided in-service for staff on R60□s individualized menu and educated staff on the importance of accuracy for meal preparations and resident preferences. 2. The Dining Services Manager completed a detailed menu preference assessment for all residents. The Dining Services Manager, Chefs, and Unit Manager re-evaluated the individual needs for preferences and options for all residents, updated reviewed all preference requests for all residents, in-serviced the staff, and audited the tray lines for accuracy. 3. Dietary team members, alongside nursing, will complete daily tray audits on rotating units and mealtimes. Staff were re-educated to review the residents□ individualized menus, preferences, likes and dislikes.	

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F 806	Continued From page 13 (KM) on 08/29/23 at 11:02 AM in the kitchen. KM stated she usually does rounds on the residents and asks them about their food preferences. She added that the residents' food preference is what the kitchen delivers. A review of the facility's policy titled, "Resident Food Preferences," revised July 2017 was conducted. The facility policy indicated, "Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team."	F 806	4. The Dining Services Manager developed and implemented meal preference and observation reports that will be monitored and will document the outcomes. Accuracy of meals will be monitored and tracked. Performance results will be reported monthly to the QAPI committee.	
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 - §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 facility policy review, the facility failed to store and	F 812	1. The Dining Services Manager immediately disposed of all items	9/24/23

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F 812	Continued From page 14	F 812		

handle food items under sanitary conditions. This failed practice could place all facility residents at risk for food-borne illness.

Findings include:

Observation was conducted on 08/28/23 at 08:27 AM in the kitchen. A large freezer contained cake, six English muffins, and four bagels. All mentioned food items were wrapped in plastic and did not have a label. On the prep table, a half full bottle of thickener was observed without a label.

Observation was conducted in the storage room on 08/28/23 at 08:40 AM. Six unopened boxes were placed directly on the floor. Large opened bags of penne pasta and macaroni noodles were wrapped in plastic with no labeled open dates. The freezer contained two large pork butt out of the box without dates, a package of edamame (soybeans) with an expiration date of 02/18/22, and unknown meat item in an unlabeled blue bag.

Interview was conducted with Kitchen Manager (KM) on 08/28/23 between the times of 08:27 AM and 08:40 AM in the kitchen and storage room. KM indicated that once a food item is opened it should be dated right away. She also added that items should not be placed directly on the floor.

A review of the facility's policy titled, "Refrigerators and Freezers," with a revised date of December 2014 was conducted. The policy documented, "All food shall be appropriately dated to ensure proper rotation by expiration dates..."Use by" dates will be completed with expiration dates on all prepared foods in refrigerators. Expiration dates on unopened food

unlabeled and expired found in all freezers, both in the kitchen and the storage room. The Dining Services Manager properly stored and labeled the items from the day□s delivery to the designated areas.

2. The Dining Services Manager conducted refresher training on proper food safety, food storage, and proper food handling, disposal, and assigned accountability to a designated dietary staff member. Consistent communication and coordination between staff members are emphasized to ensure all food items are properly monitored and labeled.

In-services were conducted on the importance of observing the 6 inches off the floor requirement when receiving food deliveries from vendors. The Dining Services Manager included inventory, proper receipt of delivery, and first in first out procedures as part of the cross-training for dietary staff members.

3. The Dining Services Manager review and update dietary policies. Daily audits on proper storage and labeling in the kitchen and dry storage areas will be assigned to cooks to meet our policy standards.

4. The Dining Services Manager developed and implemented observation reports that will be used to monitor and document compliance on food storage, labeling and proper distribution of food. Performance results will be reported

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F 812	Continued From page 15 will be observed and "use by" dates indicated once food is opened... Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates."	F 812	monthly to the QAPI committee.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		9/24/23

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F 880	Continued From page 16 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure appropriate protective and preventive measures for communicable diseases and infections. This is	F 880	1. The opened doors to airborne precautions rooms were closed. Nurse Aide caring for R61 immediately stopped resident care and donned appropriate	

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F 880	Continued From page 17 evidenced by the facility failing to ensure staff followed transmission-based precautions (TBP) (Transmission-Based Precautions are the second tier of basic infection control and are to be used when additional precautions are needed to prevent infection transmission) by wearing the proper personal protective equipment (PPE), as well as not keeping the room door closed for seven out of the seven rooms on Airborne Precautions (a type of TBP). These deficient practices have the potential to affect all residents in the facility, as well as all healthcare personnel, and visitors at the facility. Findings include: 1) Observation on 08/28/23 at 08:50 AM showed Resident (R)234 was on isolation; Airborne Precautions for COVID-19 (COVID) and that the room door was wide open which would allow the contaminated air to flow out of the room to the hallway. Record review showed R234 was admitted to the facility on 08/12/23. COVID was diagnosed on 08/16/23. Staff interview on 08/28/23 at 09:35 AM, Unit Manager (UM)2 said that the room door was kept halfway open because R234 was identified for fall risk and on fall precautions. UM2 also acknowledged that with the room door being wide open, the contaminated air was allowed to flow out of the room to the hallway. As a result of this deficiency, the facility put all other residents on that nursing unit at risk for contracting COVID. Review of facility policy on Infection Control - Precautions read the following: Policy; It is the	F 880	PPE before resuming care to the resident. 2. The doors for all residents on airborne precautions were closed and increased observation were done for those residents at fall risk. Infection Preventionist completed an audit for those residents on Enhanced Barrier Precautions to ensure appropriate use of PPE and provide education upon deficient practice. 3. Procedure was updated to close doors to airborne precautions and increased monitoring of residents that are fall risk. Procedure also updated to consider alternative interventions for those at higher risk for fall such as strategic room placement while resident is on airborne precautions with room doors closed. In-service staff on updated procedure. 4. Infection Preventionist and IP team members will complete a monthly audit on the closing of doors for residents on airborne precautions and use of appropriate PPE for those on Enhanced Barrier Precautions.	

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F 880	Continued From page 18 policy of this facility to use appropriate precautions to reduce the risk of transmission of pathogens from both recognized and unrecognized sources of infection. Verbal communication and appropriate signs to be posted regarding the type of precautions required. Types of Infection Control Precautions, Transmission Based Precautions, additional precautions used for residents with documented or suspected infection or colonization with highly transmissible or epidemiologically important pathogens for which additional precautions are needed to prevent transmission. There are 3 types; Contact Precaution, Enhanced Barrier Precaution, Droplet Precautions, Airborne Precautions. Airborne Precautions are intended to prevent transmission of infectious agents that remain infectious over long distances when suspended in the air. Disease particles are small and require special respiratory protection and room ventilation. Procedure ... Place resident in private room and keep door closed until the resident is transferred to another facility with an AII room (airborne infection isolation room) or to an acute care facility... On 08/29/23 at 07:30 AM, six of seven rooms that had Airborne TBP signs outside were observed with the doors left wide open. Upon interview with the Infection Preventionist (IP), it was confirmed that the doors were left wide open to these rooms. Guidelines from the Centers for Disease Control and Prevention (CDC) state that doors will be closed when Airborne TBP are in place, to prevent spread of airborne-transmitted communicable diseases such as COVID. Seven residents were positive for COVID in these rooms and included rooms 214, 216, 217, 218 and 219.	F 880		

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F 880	Continued From page 19 Further observations made on 08/29/23 included three wall-mounted fans outside of these open rooms, mounted high on the hallway walls to increase air circulation, were on. This observation was also confirmed with the IP. The wall-mounted hallway fans being on helps facilitate the spread of airborne microorganisms to other areas of the unit, putting all residents, visitors and staff at risk of the development and transmission of COVID. Two of the three wall-mounted hallway fans had an accumulation of dust particles visible on them, putting all residents, visitors and staff at risk of development and transmission of communicable diseases transmitted from the dust accumulation on these fans. During continued observations on 08/29/23, staff were seen outside of the opened Airborne TBP rooms wearing medical procedure masks. Staff were observed donning a higher grade N95 respirator only before entering the Airborne TBP rooms, and then removing it and placing a medical procedure mask on after leaving the room, leaving the doors open behind them. CDC guidelines state the highest available respirator should be used when being exposed to COVID and as part of Airborne TBP personal protective equipment (PPE). Use of medical procedure masks in the hallways outisde of the open rooms, and not the higher grade respirator available to them, puts the staff at risk of developing COVID and spreading it to non-infected residents, visitors, and staff in other parts of the facility. 2) On 08/28/23 at 10:00 AM, observations and a concurrent interview was done with Resident (R)61 at his bedside. Observed an	F 880		

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F 880	Continued From page 20 enhanced-barrier precautions sign posted on the wall near the head of his bed that instructed staff to "Wear gloves and a gown for the following High-Contact Resident Care Activities ... Providing Hygiene ..." When asked, R61 stated that he had not seen staff wearing a gown when changing his adult incontinence brief. Observations both inside and outside the room noted no personal protective equipment (PPE) cart with gowns for staff to don (put on) in the immediate vicinity. On 08/28/23 at 10:59 AM, observed Certified Nurse Aide (CNA)33 changing R61's adult incontinence brief wearing a procedure mask and gloves, but no gown. When asked about the gown, CNA33 apologized and stated she should be wearing one. CNA33 immediately covered R61 with a blanket, took off her gloves, performed hand hygiene, and walked out of the room and down the hall to grab a disposable gown to don. When she returned to the room and began donning her PPE, asked CNA33 about the unavailability of a PPE cart either inside or immediately outside the room. CNA33 replied that they "don't always have a PPE cart outside every door," and currently most of their PPE carts were on the second floor, but that PPE was still readily available in a centralized area on each unit. On 08/31/23 at 09:33 AM, during an interview with the Director of Nursing (DON) and the IP in the IP's office, both agreed that CNA33 should have been wearing a gown while she performed personal hygiene on R61.	F 880		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i)	F 921		9/24/23

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F 921	Continued From page 21 §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe, functional, and comfortable environment for residents, staff, and visitors, as evidenced by the unlevel and/or multiple floor panels that are lifting in the hallways and dining room(s) of the resident floors, and in the elevator. As a result of this deficient practice, residents, staff, and visitors are placed in an uncomfortable environment and are at risk for avoidable injuries. Findings include: On 08/28/23 at 09:30 AM, during a tour of the third floor makai wing, observed multiple areas of black tape on the floor panels along the hallway. When stepping in certain areas of the hallway, some floor panels were noted to give slightly when stepped on, causing an unlevel and unstable surface to walk on. On 08/29/23 at 10:39 AM, during an interview with Maintenance Staff (MS)1 near the third floor elevator, MS1 stated that the black tape on the floor is because the floor panels "are lifting." MS1 continued on to explain that the facility had tried to replace some of the floor panels, but they began lifting too. On 08/29/23 at 11:30 AM, during a tour of the 2nd and 3rd floors, mismatched floor panels with black tape, lifting floor panels, and/or an unlevel	F 921	1. We acknowledge the black tapes on the floor in the 3rd floor corridor. They were placed as a temporary remedy to floor panels that separated despite multiple attempts to correct the situation. Additional proposals for different flooring have been received and we will proceed with a new floor as soon as the contractor receives the materials and manpower for the job. Meanwhile, we continually monitor the condition of the floor to ensure it does not pose safety hazards. 2. The flooring on the other floors is smooth, clean and without any taping. 3. We anticipate having the black tape removed by November 15, 2023. 4. The CFO and Maintenance Staff will do daily rounds to ensure there is no safety hazard due to the black tapes on the floor and will follow-up with the contractor weekly to ensure completion of work on the floor by November 15, 2023.	

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F 921	Continued From page 22	F 921		

walking surface were observed all along the hallways, at the entrances or doorways to some of the resident rooms, outside and inside the elevator on both floors, and in one of the dining rooms.

On 08/31/23 at 08:38 AM, an interview was done with the Maintenance Manager (MM) in his office. When asked about the flooring on the resident floors, MM reported that the facility had replaced all of the flooring for the anniversary celebration, "probably three years ago," and soon after began having problems with the floor shifting. MM continued on to describe how the facility had tried to replace some of the floor panels, that's why they are mismatched, but the problem remained. When asked about the uneven walking surface in some areas, MM reported that it was not just the floor panels that needed to be replaced, but the substrate beneath the floor panels as well. MM reported that the floor panels had been a problem for well over a year and that administration was aware.

On 08/31/23 at 11:01 AM, an interview was done with the Chief Financial Officer (CFO) in the Administrator's office. When asked specifically how long the flooring on the resident floors had been a problem, the CFO responded that it had been an issue (in various stages) "since 2021." The CFO also reported that replacing the flooring (including the substrate beneath the flooring) was one part of a larger renovation project that was waiting for State permits.