STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125062	A. BUILDING ______ B. WING ______	09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE KUPUNA HERITAGE HOME, LLC	**4297A OMAO ROAD KOLOA, HI 96756**

(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 09/19/23-09/22/23. 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 43 residents at the time of entrance.	F 000		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in	F 676		11/1/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/11/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 676	Continued From page 1 accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to provide the necessary care and services to ensure that one out of one sampled residents (Resident (R) 37) abilities in activities of daily living do not diminish. This failed practice has the potential to cause a decline in R37's mobility. Findings Include: R37 is a 76-year-old female admitted to the facility on 01/03/23. R37 has a medical history that includes but not limited to Parkinson's disease. Interview was conducted with R37 on 09/20/23 at 11:51 AM in her room. R37 verbalized wanting to ambulate more often with a walker. R37 also added that she hasn't walked all week.	F 676	1. Resident 37's care plan was updated for ambulation with nursing. Resident 37 is being ambulated with nursing regularly and as she desires. 2. Facility residents have the potential to be affected by the alleged practice. 3. Current facility residents were reviewed by nursing and the interdisciplinary team to determine if therapy referrals to nursing had been received and acted on as needed. Referrals from therapy to nursing will be reviewed in the morning clinical meeting and followed up on as needed. Therapy and nursing were in-serviced regarding communicating referrals/recommendations by the SDC/designee. In-services will be ongoing	

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F 676	Continued From page 2 Interview was conducted on 09/22/23 at 08:57 AM in the nursing administration office. State surveyor requested from the Director of Nursing (DON) R37's ambulation records. DON stated that R37 would not have any ambulation records because she was not cleared to ambulate with nursing staff. Interview was conducted with Physical Therapist (PT) in the rehabilitation room on 09/22/23 at 09:09 AM. PT confirmed that R37 was cleared to ambulate with nursing staff on 06/07/23 and staff should be attempting to help her ambulate. Interview was conducted with DON on 09/22/23 at 10:24 AM in the classroom. DON stated that the usual practice after PT discharges a resident from their services is to create a care plan. The care plan then triggers treatment. Certified Nurse's Assistant (CNA) will be triggered to perform the activity with the resident and CNAs will be able to chart into the records. Unfortunately, R37 did not have a care plan created for ambulation activity after she was discharged from rehabilitation services. A review of the Electronic Health Record (EHR) indicated that PT had discharged R37 on 06/06/23. In the discharge summary it stated, "Patient will safely ambulate on level surfaces 100 feet using two-wheeled walker with Supervision or Touching Assistance with continuous steps to prepare for walk to dine for meals." EHR also indicated, "Patient has met goals set and nursing has been educated on walking program ...Discharge Instructions: see care plan."	F 676	as needed. 4. DON/Supervisor/designee will audit for compliance with follow up on therapy referrals/recommendations through resident interviews on resident rounds, review of the clinical meeting and medical record audits weekly for a minimum of 12 weeks and/or until compliance is achieved. The results of these audits will be brought to the monthly QAPI meeting by the DON for review and recommendations for a minimum of 3 months and/or until compliance is achieved.	

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F 676	Continued From page 3 A review of the EHR indicated that R37 only ambulated eight times in the last month. EHR also indicated the lack of a care plan for R37's ambulation activity.	F 676		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff, the facility failed to collaborate with the hospice provider for the development and implementation of the coordinated plan of care for one of one resident selected for hospice review. This is evidenced by the failure to include the hospice provider in the development of a plan of care and no consistent documentation of the hospice providers communication with the facility. Findings include: Resident (R)9 was admitted to the facility on 09/24/18. Diagnoses include but not limited to unspecified dementia, unspecified severity, without behavioral disturbance; psychotic disturbance, mood disturbance, and anxiety; generalized anxiety disorder; and adult failure to thrive. R9 is a hospice recipient (start date of 04/14/23).	F 684	1. Resident #9's hospice provider was contacted and a care plan meeting reviewing current care with hospice team was held. The Social Service Director was in-serviced by the Administrator regarding inviting the servicing hospices to upcoming care planning meetings and following up to ensure their attendance. 2. Residents receiving hospice services have the potential to be affected by the alleged practice. 3. The hospice companies providing current residents care were notified regarding their attendance at care planning by letter and phone call by the Administrator/designee. Current hospice residents were reviewed by the IDT to	11/1/23

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F 684	Continued From page 4 Record review found no copy of the election of benefit for hospice with the resident's diagnosis to qualify for hospice and the services to be supplied by hospice provider. On 09/22/23 at 11:44 AM interviewed the facility's Director of Nursing (DON). Requested to review R9's election of hospice benefit. Inquired what services is hospice providing. DON reported their staff continue to round on the resident. DON recalled the resident does not receive hospice aide services and recalls R9 receives spiritual care. Further queried how often does the nurse and spiritual counselor come to visit R9. There were monthly notes by hospice, dated 05/02/23, 05/30/23, 06/27/23, 08/11/23, and 09/11/23. Also found progress notes in the electronic medical record (07/11/23, 07/18/23, 8/8/23, 08/11/23, 08/15/23, 08/22/23, and 09/05/23). DON stated hospice is making weekly visits. DON reported nurses are making entries in the progress notes to document their communication with the hospice provider. Reviewed the care plan with the DON. There was no documentation the hospice provider participated in the development of the care plan for 04/11/23 and 07/12/23. The care plan documents discipline responsible for R9's care as hospice; however, there is no documentation of the hospice providers participation in the care planning process. Review of the election of hospice benefits found physician orders for lorazepam 2 mg/mL; morphine PRN; morphine concentrate solution 100 mg/5mL twice a day for pain; call hospice for discomfort, symptom management, changes,	F 684	update their care plans with hospice as needed. The Social Service Director in-serviced the interdisciplinary team regarding the necessity of hospice companies' participation/involvement in care planning process. In-services will be ongoing as needed. The SSD will invite the hospice company representatives to care plan meetings for their clients and follow up to ensure their involvement in the care planning process. 4. The Social Service Director / designee will monitor compliance with hospice attendance/involvement with care planning through weekly medical record reviews for a minimum of 12 weeks and/or until compliance is achieved. The results of these audits will be brought to the monthly QAPI meeting by the SSD for review and recommendations for a minimum of 3 months and/or until compliance and achieved.	

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F 684	Continued From page 5 questions, concerns, fall; call hospice at time of death; call hospice if no urine output x12 hours; and call hospice prior to accessing hospice e-kit. There was no documentation of the services/durable medical equipment the hospice would provide. On 09/22/23 at 12:05 PM interview was done with the Social Services Designee (SSD). SSD reported she is aware a nurse and volunteer come to visit R9. Also, she thinks the Chaplain provides services. SSD shared that previously the hospice social worker would coordinate with their facility to participate in care plan meetings, however, this person left and presently there is no hospice person to participate in care plan meetings.	F 684		
F 689 SS=D	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 observation, record review, and interview, the facility did not assure adequate supervision was provided to mitigate the risk of an accident for 1 (Resident 39) of 4 residents in the sample. The facility failed to ensure staff were present to implement the care plan to prevent Resident (R)39 from unsafe wandering. R39 wandered into R36's room which resulted in	F 689	1. Resident 39 was uninjured. His care plan was updated as needed regarding his wandering and falls. Staff on the unit were in-serviced on having someone rounding the wings during meal pass times by the SDC/designee. In-services will be ongoing.	11/1/23

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F 689	Continued From page 6 finding R39 on the floor. This deficient practice has the potential to result in resident-to-resident altercations. Findings include: On 09/19/23 at 12:37 PM observed the call light for Room D2 was on. There were no staff members on the unit. Staff members were on the C unit distributing residents' lunch meal at the kitchenette. Observed Registered Nurse (RN)4 pushing a cart with lunch trays on it When she approached Room D2, RN4 was heard speaking to someone, she then left the food cart and rushed off. Upon entering the room, observed Resident (R)39 on the floor in R36's room. D2 is not R39's room. R39 was observed in a sitting position with his forward wheel walker upright in front of him. R39 was on the floor next to the partially drawn curtain close at the foot of the bed across of R36. R36 was observed standing at his bedside. RN4 returned to the room with her vitals cart. R39 was stating he needed help. RN4 informed R39 that she would come back as she needed help. RN4 left the room. Observed R39 telling R36 that if he could get over to his bed he can pull himself up. During this time, R39 kept making attempts to grab his walker. RN4 returned and called for assistance, "Mr. Strong." R39 kept telling the nurse he needed help. RN4 asked R39 how he landed on the floor, he replied he fell. She then asked if he hit his head. R39 started to become agitated, repetitively telling her he wanted to get up. RN4 kept responding "they are coming." The R39 yelled "I just need to get the fuck up." Staff members responded and was able to get R39 to stand. On 09/20/23 at 08:38 AM observed R39 lying in	F 689	2. Facility residents have the potential to be affected by the alleged practice. 3. The DON/designee in-serviced direct care staff regarding rounding on the wings during tray passes. In-services will be ongoing as needed. Charge nurses will ensure that there is a staff member rounding on the wings during meals. Supervisors, managers and leadership will assist with meals as needed. 4. The DON/designee will monitor compliance with staff presence/rounding on the wings during meal passes through audit rounds 3 x weekly for a minimum of 12 weeks and/or until compliance is achieved. The DON will bring the results of these audits to the monthly QAPI meeting for review and recommendations for a minimum of 3 months and until/or compliance is achieved.	

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F 689	Continued From page 7	F 689		

bed. Asked him about his fall and he did not remember he fell yesterday. He conversed about where he worked and how he earned a living. R39 was asked if he knows R36. R39 responded he doesn't know who that is.

On 09/20/23 at 08:59 AM interviewed R36. R36 reported he is not sure what R39 was doing in his room. R36 stated he does not know how R39 fell, he couldn't see him behind the curtain. R36 reported he activated the call light when R39 entered his room and fell. R36 stated he told R39 to get out of his room. Further queried whether R39 was a welcome visitor, R36 responded, he didn't care, if R39 did not bother him.

On 09/21/23 at 02:45 PM record review noted R39 was admitted to the facility on 06/08/23. Diagnoses include but not limited to unspecified dementia, unspecified severity, with other behavioral disturbance; orthostatic hypotension; syncope and collapse; and insomnia.

A review of the John Hopkins Fall Risk Assessment Tool dated 09/19/23 documents, R39 did not have a fall in the previous six months and was assessed at moderate fall risk.

Review of the quarterly Minimum Data Set with assessment reference date of 09/12/23 noted R39 had severe cognitive impairment. R39 was not coded as having behavioral symptoms (physical or verbal, rejection of care, or wandering. R39 was assessed as requiring supervision with set up for walking in room and corridor. He requires limited assistance with one-person physical assist for transfers (how resident moves between surfaces including to and from bed, chair, wheelchair, standing

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F 689	Continued From page 8 position). A review of R39's care plan documents R39 has cognitive communication deficits related to dementia and is hard to redirect and becomes aggressive. Start date of care plan was 06/19/23. Approaches include remove resident from other resident's rooms and unsafe situations; when resident begins to wander, provide comfort measures for basic needs (e.g., pain, hunger, toileting, too hot/cold, etc.); and when resident wanders, approach resident from the front, walk in step with resident first before redirecting. On 09/21/23 at 09:00 interview was conducted with Certified Nurse Aide (CNA)3. CNA3 reported R39 wanders into other residents' room but this is the first time he went into R36's room. CNA3 also reported she had heard that R39 was sitting in the activities area and started swearing. R36 shouted to R39 to shut up and this is when R39 entered R36's room. CNA3 reported R39 will ambulate with the use of his forward wheel walker on the unit. CNA3 stated when she observes R39 wandering on the unit, she will attempt to redirect him. Review of the nursing schedule for 06/19/23 for Units C and D was one Charge Nurse and two CNAs. There was a total of 21 residents on the unit. The ratio of direct care staff (CNAs) to residents was 1:10.5. During the time of the incident, the two CNAs and Charge Nurse were assisting with passing meal trays to the residents. (Refer F725)	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)	F 725		11/1/23

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F 725	Continued From page 9 §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to provide sufficient nursing staff to assure resident safety and to attain or maintain the highest practicable physical, mental, and psychosocial well being for four out of 15 sampled residents (Resident (R) 37, 22, 34, 36). The deficient practice has the potential to negatively effect all of the facility residents' physical, mental, and psychosocial wellbeing.	F 725	Facility is engaged in multiple recruiting and hiring efforts as well as utilizing agency and traveling nurses. The managers-on-duty and licensed nurses, as well as the IDT and UMs assist the floor staff in passing trays, answering lights, transporting residents, and other duties. The Administrator met with the resident council to share what the facility is doing	

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F 725

Continued From page 10

Findings Include:

1) Concurrent interview and observation were conducted on 09/22/23 at 08:14 AM in the dining room. R37 verbalized that she had requested for her assigned Certified Nurse's Aide (CNA) 1 to take her back to her room a while ago, but CNA1 was nowhere to be found. R37 stated that it is very frustrating. CNA1 was then observed returning to the dining area to take one of the residents, R26, to the bathroom. R37 verbally requested to be taken back to her room after R26. CNA1 replied, "okay."

On 09/22/23 at 08:28 AM, R37 was observed still waiting in the dining room.

On 09/22/23 at 08:34 AM, CNA1 was observed assisting R26 in the bathroom and ambulating him to his room.

On 09/22/23 at 08:36 AM CNA1 was observed assisting CNA2. CNA1 and CNA2 were both ambulating R31 because R31 needed two staff assistance during ambulation. During that time both CNAs were in unit A. Therefore, unit B did not have a CNA available for the residents.

On 09/22/23 at 08:43 AM CNA1 transported R37 to her room.

2) Interview was conducted with R22 in unit A on 09/22/23 at 11:57 AM. R22 was observed waiting for his lunch tray near a dining table. R22 verbalized that since he has been admitted into the facility three years ago, he always received his meals late. Breakfast is scheduled for 07:00 AM but receives his tray at 08:00 AM. Lunch is scheduled at 12:00 PM but he receives his tray at

F 725 (Provider's Plan of Correction)

to address staffing concerns.

1a. Resident 39 was reviewed for his wandering. His care plan was updated as needed. Staff were on the unit pulling meal trays; however, they were not on that wing at the time he wandered into R36's room. Staff on the unit were in-serviced on having someone remain on the wing and rounding during meal pass times by the SDC/designee. Supervisors, managers and leadership were in-serviced regarding assisting with tray pass and meals by the Administrator / DON. In-services will be ongoing. The Administrator met with R36 about R39's wandering. R36 was also offered counseling.
1b. The administrator met with R37 to discuss the delay in getting her back to her room. Staff involved with R37 were in-serviced by SDC/designee regarding addressing the resident requests in a timely manner. In-services will be ongoing as needed.
1c. The administrator met with R22 regarding the timeliness of his meals. Kitchen staff and direct care staff involved with his meal were in-serviced regarding the timeliness of meals and tray pass. In-services will be ongoing as needed.

1d. Resident 34 with tray sitting 1 hour did not get up to eat. Meal was discarded and resident received another meal later. Staff involved were in-serviced by the SDC/designee regarding getting up residents timely and appropriate method

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HALE KUPUNA HERITAGE HOME, LLC	4297A OMAO ROAD KOLOA, HI 96756

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01:00 PM. R22 added that it wouldn't be too bad if the delay was ten or fifteen minutes, but one hour is just too long because he gets very hungry. R22 believed that the lack of staff is the cause for the delay in the meal tray passing.

3) On 09/19/23 at 12:00 PM, dining service was observed in Makalapua unit. It was noted on 09/19/23 at 12:08 PM, in Room C3 all residents in their beds sleeping. At 12:11 PM, still waiting for lunch and residents in C3 still in room sleeping. It was noted that certified nurse's aide (CNA) 4 and CNA 5 were the only staff prepping the trays to receive the main meal. At 12:13 PM a visitor for C4 arrives to see resident. At 09/19/23 at 12:15 PM, spoons being placed on trays for prepping.

At 09/19/23 at 12:24 PM the two CNAs and kitchen worker prepare and complete food trays.
At 09/19/23 at 12:29 PM, no trays served yet.
At 09/19/23 at 12:30 PM first tray served.
At 09/19/23 at 12:31 PM two more trays are served.
At 12:45 PM, R145 received her food in isolation room and housekeeper passed tray to CNA after CNA gowned up.
At 12:55 PM tray arrived.
At 12:56 on 09/19/23, R34 was still in the room sleeping and surveyor did not see a tray offered or for the resident to get up to eat.

09/19/23 at 01:19 PM, an interview with Registered Nurse (RN)1 who was in C4 room - Asked if resident (R)34 eats and she stated that the CNAs are instructed to see if he wants to eat and if not put into the fridge. Explained that surveyor did not see any interaction with R34 and that the CNAs seemed very busy and passed him by and he did not get offered a tray. RN1 stated

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of tray pass. Mealtime was late from the kitchen. The meals were at appropriate temperatures when passed despite being late. Dietary Manager in-serviced dietary staff regarding timeliness of meals. In-services will be ongoing as needed.

2. Facility residents have the potential to be affected by these alleged practices.

3. The Administrator and DON in-serviced the IDT, managers, supervisors, scheduler and direct care staff regarding assisting with tray pass/meals, sufficient staffing and staff scheduling. In-services will be ongoing as needed. The administrator will meet with the resident council regularly to address staffing concerns and review hiring/recruitment efforts. In-services will be ongoing as needed. The nursing leadership and the Dietary Manager met to review tray organization and pass to better meet the needs of the residents, especially those needing assistance eating and/or at risk for weight loss. Tray pass was reorganized to better meet these needs.

4. Administrator/DON and scheduler will monitor staffing requirements and schedule for the upcoming week prior to the week and then daily in order to provide sufficient staff for a minimum of 12 weeks and/or until compliance is achieved.
DON/Supervisor/designee will audit for compliance with resident ADL requests through resident interviews on resident rounds, review of the 24 hour report and

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F 725	Continued From page 12 that she would check on it and did not get back to surveyor. Interview was done on 09/22/23 with CNA3 who stated that they were busy and got a late start. "We were trying to get the residents nice and clean for you all and before you know it, it was time to do lunch. We did the best we could with, and we put R34's tray up but did not get back in time to get him up. Interview with Administrator who confirmed that R34 did not get up and his tray was on the table. R34 was the last resident to get a tray after an hour's time and did not get up out of bed to eat. (Refer F802). 4)The facility did not assure there was sufficient staff on a unit to prevent Resident (R)39 from wandering into R36's room. This deficient practice has the potential to result in unsafe wandering/resident-to-resident altercations. (Refer F689)	F 725	medical record audits weekly for a minimum of 12 weeks and/or until compliance is achieved. The DON/designee will monitor compliance with staff presence/rounding on the wings during meal passes through audit rounds 3 x weekly for a minimum of 12 weeks and/or until compliance is achieved. The results of these audits will be brought by the administrator to the monthly QAPI meeting for review and recommendations for a minimum of three months and/or until compliance is achieved.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		11/1/23

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F 758	Continued From page 13 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to follow through on a gradual dose	F 758	1. Resident #16's medication was reviewed and dose reduction was	

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reduction (GDR) for one of five sampled residents (Resident (R) 16). This deficient practice has the potential to affect all residents on anti-psychotic medications and who need a gradual dose reduction and may be clinically contraindicated at a higher dose.

Findings include:

Unnecessary medications record review (RR) on 09/21/23 at 01:37 PM was done. RR for Trazodone 50 milligrams (mg) revealed a GDR attempt request by the pharmacist in June of 2023. A reminder was made on pharmacy drug regimen review dated September 2023 to ask physician to respond to a GDR attempt request for Trazodone from June 2023.

Interview was done on 09/22/23 at 08:41 AM with the Director of Nursing (DON) who stated that this was not done, and it was missed but we are taking care of it now.

RR on 09/22/23 at 10:00 AM revealed a new order for GDR of Trazodone 50 mg to decrease to 25 mg every night (qhs) on 09/21/23.

Policies for gradual dose reduction and tapering of medications and Medication Regimen Review were reviewed on 09/22/23 at 10:30 AM. Medication Regimen Review and Reporting 8.1, #7 states A record of consultant pharmacist's observations and recommendations is made available in an easily retrievable format to nurses, physicians, and the care planning team within 48 hours of MRR completion. #8 states "the nursing care center follows up on the recommendations to verify that appropriate action has been taken. Recommendations shall be acted upon within 30

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implemented by Medical Director. Resident 16's primary physician was in serviced regarding addressing pharmacy recommendations by the Medical Director. The regional nurse in serviced the DON regarding following up on pharmacy recommendations. In services will be ongoing as needed.

2. Facility residents have the potential to be affected by the alleged practice.

3. Residents followed by this primary physician were reviewed to ensure follow up on pharmacy recommendations. Adjustments and order changes were made as needed. Care plans were updated as needed. Charge nurses were in serviced regarding follow up on pharmacy recommendations by the SDC/DON/designee. In services will be ongoing as needed.

4. The DON/designee will monitor compliance through audits of pharmacy recommendations and medical records monthly for a minimum of 3 months or until compliance is achieved. The results of these audits will be brought to the monthly QAPI meeting by the DON for review and recommendations for a minimum of 3 months or until compliance is achieved.

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F 758	Continued From page 15 calendar days. Further RR for Ohana Pacific Health policy Gradual Dose Reduction and tapering of medications statement #2 states All medications shall be considered for possible tapering. Tapering that is applicable to antipsychotic medications shall be referred to as gradual dose reduction. #3 states residents who use antipsychotic drugs shall receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, to discontinue these drugs.	F 758		
F 812 SS=D	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 observation, document review, and interview with staff, the facility failed to: ensure	F 812	1. Food items thawing in the sink were discarded. Storage bins were emptied and	11/1/23

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potentially hazardous foods (raw chicken and fish) were thawed properly; food items were sanitarily stored; stored food items were uncovered/sealed; stored boxes of food direly on the floor; and food items were not labeled to assure they are discarded in accordance with the facility's policy and procedures.

Findings include:

On 09/19/23 at 09:50 AM a brief tour of the kitchen was conducted with Cook (C)1. Observed raw chicken in the sink. The chicken was in an opened plastic bag and covered with water. C1 reported the chicken is being thawed for cooking today. Inquired whether they run water while thawing food items. C1 did not respond.

Observation with Server of food storage bins found three bins stored under a shelf. The bins had a clear plastic cover that could be slid back to open the container. Observed, oatmeal stored in a brown bag that was not sealed at the top. Further observed the back portion of the lid (area where clear plastic cover slides over) was covered with brown/black substance. The Server stated this was probably dust. Another bin was observed with ants crawling on the outside of the container close to lid. There were several brown bags and plastic bags stored in this bin. The brown bags were folded over. Upon opening the lid, observed one ant crawling in the bin. The Server reported brown sugar was stored in this bin. The third bin stored rice; the rice was in a brown bag which was not sealed.

Observation of the refrigerator found a clear plastic container storing white shredded cheese.

F 812

cleaned. Items needing labeling were labeled. Left-overs were discarded. Brown sugar was discarded. Pest control was contacted and treated the ants in the kitchen. Kitchen and food storage areas were cleaned and sanitized. Staff involved were in serviced by the Dietary Manager/designee regarding defrosting of food, storage and labeling of food stuffs, cleanliness, and sanitation.

2. Facility residents have the potential to be affected by the alleged practice.

3. Dietary Manager/designee in serviced dietary staff regarding defrosting of food, storage and labeling of food stuffs, cleanliness, and sanitation. Dietary Manager/designee also in serviced staff regarding daily kitchen sanitation audits. In services will be ongoing as needed.

4. The Dietary Manager/designee will monitor compliance with food labeling, storage, and sanitation through kitchen rounds 3 x weekly for a minimum of 12 weeks and/or until compliance is achieved. The results of these audits will be brought to the monthly QAPI meeting by the RD for review and recommendations for a minimum of 3 months and/or until compliance is achieved.

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F 812	Continued From page 17 The container had a label with a date of 09/10/23. The Server reported food items are kept for a week in the refrigerator. Also observed a clear plastic container with individually wrapped sliced orange cheese. This container was labeled with date of 08/14/23. Server confirmed the cheese was supposed to be disposed of after a week. In the refrigerator observed a metal pan that was covered with plastic wrap. The Server reported this was kalua pork which was served last week. There was a container of layered brown and purplish creamy substance. The server reported this was peanut butter and jelly. There was no label of what the food item was and when it was prepared. Also found a small plastic container that was not labeled. The Server reported this was poi that they served last Friday with the kalua pork. Further observed a small carton of liquid whole egg in the refrigerator. The top of the carton was opened and there was no label of when the product was opened. The Server reported this was used this morning. Further queried whether the product should be closed. Server unable to answer. Also observed a metal rack with two shallow metal pans of cooked item with no label. The Server reported this was bread pudding, which was prepared yesterday, and they forgot to label it. Observation of the freezer found three stacks of boxes. The boxes at the bottom of the stacks were placed directly on the floor, sliced carrots, cut green beans, and chicken. The Server reported these items were just delivered and needed to be stored on the shelf. Second observation on 09/20/23 at 09:49 AM found the ants were still crawling on the brown	F 812		

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sugar bin and the top of the oatmeal bin was opened but still with a smattering of "dust". Observed signage on the walk-in refrigerator/freezer that read, "Do No Keep Leftovers...Only Evening Shift Keep Rice If Any Left". A second sign read "Label and Date All Items - Discard After 3 Days".

Also observed unwrapped frozen fish fillets in the sink submerged in water. There was no running water.

On 09/20/23 at 10:00 AM, interviewed the Registered Dietitian (RD). Inquired what is the facility's procedure for defrosting food items. The RD was agreeable to follow up.

On 09/20/23 at 10:01 AM concurrent observations were done with food service director (FSD). Observation found the frozen fish fillets piled in a metal pan with water running. The fillets on top were not submerged in water. Took the temperature of the fish and water, which was 32 degrees Fahrenheit. FSD stated she is not sure that the facility was not in compliance and usually thaw items in the refrigerator. Explained to her initially there was no running water and now there is so why the change? FSD replied that the fish should be full submerged in water and instructed C2 to get a bigger pan and explained staff did not run water as the sink would overflow. FSD stated this is not a food safety issue. Requested a copy of the facility's policy and procedure for thawing food items.

Observation of the three bins containing oatmeal, rice, and brown sugar. FSD stated she will make sure these bins are cleaned within the hour. FSD also observed the ants crawling on the brown

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F 812	Continued From page 19 sugar bin. On 09/20/23 at 10:54 AM, FSD provided copies of the facility's food storage policy and labeling and dating policy. FSD stated that the facility does not have a policy and procedure for thawing food, the closest was the procedure in the food storage policy, "4. Frozen foods are thawed at refrigeration temperatures of 40-degree F or below, under running water, or quick-thawed as part of the cooking process." FSD reported that she will be providing education to the staff regarding thawing frozen food items. Review of the policy and procedure, "Labeling and Dating Policy" documents the following: "3) Ensures that all foods are stored off the ground."	F 812		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective	F 867		11/1/23

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F 867	Continued From page 20 systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and	F 867		

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(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and

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F 867	Continued From page 22 assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review (RR) and interview, the facility failed to have written, in their policies and procedures, data collections systems, monitoring, adverse event monitoring, feedback from direct care staff and other residents and representatives, opportunities for improvement, established with the minimum qualifications that should be established. This deficient practice has the opportunity for minimum Quality Assurance and Performance (QAPI) measures to be missed. Findings include: Observation of the policy on 09/21/23 at 10:00 AM revealed an incomplete policy and procedure demonstrating information needed to guide quality assurance and performance improvement. A concurrent record review and interview was done on 09/22/23 at 10:43 AM with the administrator and the Director of Nursing (DON). The facility was able to show their Quality Assurance and Performance Improvement (QAPI) projects and improvement but could not	F 867	1. The QAPI policy was updated to incorporate the needed information and data sources. The regional nurse inserviced the Administrator and DON on the updated policy. 2. Facility residents have the potential to be affected by the alleged practice. 3. The Administrator/DON in-serviced the Interdisciplinary Team and QAPI committee members on the updated policy. In-services will be ongoing as needed. The QAPI committee will follow the updated policy in the monthly QAPI meeting. 4. The Administrator will monitor compliance with the updated policy through monthly review of QAPI information/data for a minimum of 3 months and/or until compliance is achieved. Results of these review audits will be brought to the monthly QAPI	

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	125062	A. BUILDING ______ B. WING ______	09/22/2023

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F 867	Continued From page 23 speak to their policy which lacked the information to describe and guide the details of a QAPI program. Administrator stated that she did not have the information needed in the policy and that the facility would be working on it.	F 867	meeting by the Administrator for review and recommendations for a minimum of 3 months or until compliance is achieved.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals 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		11/1/23

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F 880	Continued From page 24 (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 and interview with staff, the facility failed to ensure staff followed infection control procedures for a resident on contact precautions. This deficient practice has the	F 880	1. The Speech Therapist involved with R94 was in serviced regarding appropriate isolation precautions and hand washing by the SDC/designee. In services will be	

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F 880	Continued From page 25 potential to result in transmission of communicable infections. Findings include: On 09/19/23 at 11:05 AM observed Resident (R)94 had signage posted outside of her room regarding contact precautions. Overheard staff member in the resident's room. R94 requested water. The staff member removed personal protective equipment (PPE). Upon return staff member went to the cart housing PPE, placed water container on the cart, donned gown, removed a pair of gloves from the box, and don gloves. Staff member delivered the water and doffed all PPE in the resident's room. The staff member was overheard informing R94 that they will do a diet trial. The staff member hand sanitized with alcohol-based hand sanitizer (ABHS). As the staff member was leaving the unit, briefly interviewed the staff member. Staff member confirmed she is the Speech-Language Pathologist (SLP) and was assessing resident for diet texture. The staff member left the unit. Observed the PPE cart contained, gowns, gloves, and face mask. There was a signage placed with the contact precaution sign that was handwritten instructing to wash hands with soap and water. On 09/19/23 at 11:52 AM, Director of Nursing (DON) was interviewed. The DON reported R94 is on contact precautions for exhibiting signs and symptoms of norovirus. DON confirmed the posting of handwritten sign with instructions to wash hands with soap and water. Inquired where would staff go to wash their hands, she indicated they would go down the hall to the bathroom. Observation was shared with the DON, and she	F 880	ongoing as needed. 2. Facility residents on precautions have the potential to be affected by the alleged practice. 3. The DON/SDC/designee in serviced facility staff regarding appropriate isolation precautions and handwashing. In services will be ongoing as needed. The isolation carts' supply lists were reviewed and were updated as needed to include hand sanitizer. There are also multiple sources of hand sanitizers through resident care areas. 4. The DON/designee will monitor compliance through observation round audits weekly for a minimum of 12 weeks and/ or until compliance is achieved. The results of these audits will be brought to the monthly QAPI meeting by the DON for review and recommendations for a minimum of 3 months and/or until compliance is achieved.	

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F 880	Continued From page 26 acknowledged the handwritten sign wasn't very prominent. Also, queried whether the isolation cart should be supplied with ABHS for staff convenience. DON confirmed the isolation cart should be supplied with ABHS for staff use. Second observation found ABHS on the isolation cart and a typed signage with bold/large font regarding the need for handwashing with soap and water.	F 880		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview with staff, the facility did not assure the toilet and shower call light system was accessible for residents lying on the floor. This deficient practice has the potential to affect residents' ability to call for help if they fall to the floor. Findings include: On 09/21/23 at 08:50 AM interview and concurrent observation was made with Maintenance Associate (MA)1 on Unit D of both bathrooms, inquired if a resident falls to the ground, is the call light cord next to the toilet and in the shower long enough to pull for the resident	F 919	1. Call bell cords were replaced in the bathrooms by the Maintenance Director. 2. Facility residents have the potential to be affected by the alleged practice. 3. The Administrator in serviced the Maintenance Director regarding call bell cord accessibility. The SDC/designee in serviced the direct care staff regarding call bell cord accessibility and reporting cords not long enough to Maintenance. In services will be ongoing as needed. Call bell cords throughout the facility were reviewed by maintenance for appropriate	11/1/23

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F 919	Continued From page 27 to access. MA1 stated they try not to make the cord too long as they don't want it to get tangled. MA1 confirmed the cord may not be long enough. On 09/21/23 at 09:00 AM concurrent observation and interview was conducted with MA1 and MA2. Observation of the two residents' bathrooms on Unit C was done. The MAs confirmed the cord was not long enough for the toilets in both bathrooms for residents to access if on the ground. And the cord for the shower was not long enough for residents to access if on the ground. MA2 stated they will look into it and fix it today.	F 919	length and replaced as needed. 4. The Maintenance Director will monitor compliance with call bell cord accessibility through weekly facility rounds for a minimum of 12 weeks and/or until compliance is achieved. Results of these audits will be brought to the monthly QAPI meeting by the Maintenance Director for review and recommendations for a minimum of 3 months and/or until compliance is achieved.	
F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, the facility did not assure it had an effective pest control program. Observation of the kitchen found ants crawling on storage bin. Although the facility has a contract for pest control services, there were observations of ants crawling on the storage bin. This deficient practice has the potential to have food items contaminated resulting in food borne illnesses. Findings include: On 09/19/23 at 09:50 AM observed a storage bin with ants crawling outside of the bin and an ant in the bin. The Server reported, the bin contained brown sugar. Second observation on 09/20/23 at 09:49 AM found ants crawling on the bin. Third	F 925	1. Pest control was contacted and came in and treated the facility for the ants. 2. Facility residents have the potential to be affected by these alleged practices. 3. The Lead Maintenance arranged for pest control to come in more frequently than the monthly visit to ensure the ants were under control. The Dietary Manager in-serviced kitchen staff to notify the Lead Maintenance when they had pests in the kitchen. In-services will be ongoing. 4. The Dietary Manager/designee will monitor compliance with pest control	11/1/23

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F 925	Continued From page 28 observation on 09/20/23 at 10:00 AM found ants crawling on the bin. The food service director reported the facility receives monthly pest control services. A copy of the last invoice and pest control service was provided.	F 925	through kitchen and facility rounds 3 x weekly for a minimum of 12 weeks and/or until compliance is achieved. The results of these audits will be brought to the monthly QAPI meeting by the Administrator for review and recommendations for a minimum of 3 months and/or until compliance is achieved.	