STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125003	A. BUILDING _____ B. WING _____	06/06/2024

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on June 6, 2024. The facility was found not to be in substantial compliance with 42 CFR 483, Subpart B. A facility reported incident from Aspen Complaints/Incidents Tracking System (ACTS # 10953) was also investigated and no deficient practices were identified. Survey Dates: 06/03/24 to 06/06/24 Survey Census: 89 Sample Size: 19	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		7/19/24

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

Electronically Signed | 06/20/2024

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F 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to assure two residents (Resident (R) 27 and R46) were treated with dignity and respect and provided care in an environment that enhances their quality of life. This deficient practice has a negative effect on maintaining and enhancing both resident's self-esteem and self-worth and has the potential to cause psychosocial harm. Findings include: 1) On 06/03/24 at 11:33 AM, an interview was conducted with R27 in her room. R27 stated that the only concern she had with the facility was the long wait to get assistance from the staff. R27 said sometimes she waits for up to three hours to be changed when her incontinent pads are wet.	F 550	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: 1)By 6/24/24 all staff on the unit where R27 resides were provided education regarding dignity and the expectation to promptly address call lights. 2)On 6/5/24 staff on duty reeducation of dignity and respect was provided to the staff member that performed the deficient practice for R46 HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND	

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F 550	Continued From page 2 R27 stated that there was an instance in the morning when she wanted to use the toilet, so she called for assistance using her call light. By the time someone came to assist her, she had already soiled her incontinence pads and the evening shift staff had to clean her as they were making change-of-shift rounds. On 06/05/24 at 01:51 PM, review of medical records for R27 was conducted. R27 is an 82-year-old resident first admitted to the facility on 03/07/18. Review of current care plan with a review date of 03/01/24 stated R27 has, "Functional mobility and self-care deficits r/t (related to) lower extremity weakness, morbid obesity, and osteoarthritis." Interventions included, "TOILETING: Sit to stand lift assistance for commode transfers. I use briefs for B/B (bowel and bladder) incontinence . . . It is important to me to be assisted from bed to commode and then to the w/c (wheelchair). . ." On 06/06/24 at 09:19 AM, a follow up interview was conducted with R27 in her room. Asked R27 if the long wait for assistance to go to the toilet still happens. R27 said it still does and said, "I recently had to go in the bed. I'd rather go in the toilet, but I couldn't wait." When asked if she ever brought her concern to the nursing supervisor, R27 said, "I did bring it to their attention but not much you can do if the staff are busy." 2) Observation was conducted on 06/03/24 at 12:27 PM on the third-floor dining room. Hospital Aide (HA) 1 was heard stating, "Who is the feeder?" as she entered the dining room. One of the other staff members directed HA1 to R46. R46 was sitting in his wheelchair waiting for a staff member to assist him with eating his lunch.	F 550	WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected by the deficient practice. 1)By 7/19/24 all nursing staff were provided education regarding dignity and the expectation to promptly address call lights. 2)By 7/19/24 all nursing staff provided education on residents□ rights and dignity. WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Upon hire and annually, all clinical staff will receive additional education on dignified communication. Unit ambassadors will complete weekly audits of resident and staff interactions to ensure communication is dignified and appropriate. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: Education records will be audited monthly to ensure all new hires have received the education. Results of the audits will be reviewed at the QAPI meetings. Weekly, the Administrator will receive the ambassador audits. Ongoing validation by the Administrator.	

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F 550	Continued From page 3 Interview was conducted with HA1 on 06/03/24 at 12:30 PM. HA1 was asked if it was proper to call the facility residents "feeders." HA1 apologized and stated that she should have said, "who needs assistance?" instead. A review of the facility document titled, "Resident Rights," was conducted. The facility document noted, "Dignity-The facility will treat you with dignity and respect in full recognition of your individuality."	F 550		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657		7/21/24

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F 657	Continued From page 4 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to promote the participation for one of the sampled residents (R) 9 and her representative for the development and review of the resident's care plan. This failed practice has the potential to affect all the residents in the facility. Findings Include: R9 is a 90-year-old female admitted on 08/08/13. Interview was conducted with R9 in her room on 06/04/24 at 08:33 AM. R9 stated that she has not attended a care conference meeting for months. She does recall having meetings in the past but does not recall having one this past year. R9 also added that if a notification was sent to her son, he would have been present at the conference. Record review was done of R9's medical records. Documentation was found on a care conference meeting that was held on 02/22/24. A list of the staff present for the meeting was noted in the document. No documentation was found on the presence of the resident or the resident's representative. On 06/05/24 at 09:24 AM Minimum Data Set Coordinator (MDSC) 1 assisted in searching for documentation that should have been sent out to R9's representative. MDSC1 stated that the normal process would be the social worker	F 657	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 6/21/24, R9□s representative was notified of the next IDT care plan meeting for R1 HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected by this deficient practice. By 7/21/24 all resident records will be reviewed to ensure that the resident and/or the resident□s representative was invited to the last IDT care plan meeting for the resident. Any records found to be deficient, the resident and/or the resident□s representative will be immediately contacted to invite them to the next IDT care planning meeting for the resident. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR:	

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F 657	Continued From page 5 notifying the representative of the conference date and time. MDSC1 also added that the social worker will document on the resident's record of the representative's response to the invitation. MDSC1 was unable to find documentation that R9's representative was notified of the care conference held on 02/22/24. On 06/05/24 at 11:58 AM Director of Nursing (DON) confirmed that documentation could not be found that R9's representative was given notification of the care conference held on 02/22/24. A review was conducted of the facility document titled, "Kula Hospital IDT Process." The document noted, "Social Service to invite residents on the schedule for IDT Care Plan Conference. Please document resident's response if they accept or refuse invitation."	F 657	At each weekly IDT meeting, Social Services will communicate to the IDT that the residents and/or their representatives for the following week□s meeting have been invited to participate in the care plan meeting. This notification will be documented in the Social Services notes. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: On a weekly basis, Social Services will provide to the Director of Nursing and the Administrator an accounting of all invitations communicated to residents and/or their representatives to attend the care plan meeting for the upcoming week. Ongoing validation by the Administrator.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 686		7/19/24

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F 686	Continued From page 6 by: Based on observations, record review and interviews, the facility failed to ensure interventions to prevent or improve pressure ulcers or injuries were implemented for one of the three residents (Resident (R) 50) sampled. Staff did not ensure R50's left heel was offloaded and documented in the medical record every shift. This deficient practice has the potential to affect all residents that are dependent on staff for repositioning in bed. Findings include: On 06/03/24 at 11:05 AM, observed R50 in bed while Registered Nurse (RN) 2 was providing care. R50 had contractures to both lower extremities and was using an air mattress. RN2 stated that R50 still had a wound to his left heel but the pressure ulcer on his coccyx was already healed. On 06/05/24 at 08:30 AM, observed R50 lying in bed with head elevated and turned slightly to his right side. At 10:05 AM, review of medical records for R50 conducted. R50 was admitted to the facility on 04/20/23. Diagnosis included osteomyelitis (inflammation of the bone caused by infection) to left foot and colon cancer. Further review revealed that a significant change assessment was completed on 07/24/23 due to the development of a left heel pressure injury. On 11/16/23, progress notes stated the left heel pressure injury was resolved, however it reopened on 12/04/24. Interventions in the care plan also stated to check and reposition the resident at least every two hours and to make sure feet/heels are floated at all times. Asked RN2 where the staff documented to ensure R50	F 686	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: R50□s care plan was reviewed and updated by the IDT on 6/20/24 to ensure accuracy of interventions. By 6/21/24, all nursing staff on the affected unit were retrained on the importance of accurate and thorough documentation. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected by this deficient practice. By 7/19/24 all nursing staff will complete retraining on the importance of accurate and thorough documentation for all resident records. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Unit manager and Charge Nurses will audit nursing documentation twice a week to ensure compliance with thorough and accurate documentation. Any missing documentation will be addressed with the staff member immediately for correction. HOW THE CORRECTIVE ACTION WILL	

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F 686	Continued From page 7 is being turned every two hours and left foot is floated. RN2 said the every-two hours turning should be in the daily logs completed by the hospital aides and the floating of the feet/heels should be in the Treatment Administration Record (TAR). Reviewed TAR that was in the medical record for March, April, and May 2024 with RN2 and Nursing Supervisor (NS) 1. For March and April 2024, only the day shift staff were completing the log with three and nine missed entries respectively. For May 2024, night shift, day shift and evening shift staff completed the logs but had a total of 30 missed entries. NS1 confirmed that the expectation from the staff was to complete the log every shift to document that they were floating R50's feet/heel. NS1 stated, "Staff should document it if they did it."	F 686	BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: On a weekly basis, the Unit Manager will provide to the Director of Nursing and the Administrator an accounting of all documentation discrepancies and corrective action taken. Results of the audits will be reviewed at the QAPI meetings to ensure the corrective action is sustained. Ongoing validation by the Administrator.	
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to secure storage rooms located on the second and fourth floors where hazardous chemicals were kept. As a result of this deficient practice, the residents of the facility were placed at risk for accident hazards. 1) On 06/05/24 at 01:06 PM, observed the door to	F 689	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 6/5/24, all utility rooms were locked and the cleaning supplies found removed from the clean utility room.	7/19/24

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F 689	Continued From page 8 the clean utility room on the second floor was not locked. On the wall outside the clean utility room door was a small keypad lock container. Asked Registered Nurse (RN) 1 what was being kept in the room. RN3 said they keep some of the enteral feeding supplies and nourishments for the residents in the room. Inspected contents of the cabinets with RN3. An opened container of liquid bleach and liquid dish soap were found in one of the cabinets. RN3 notified Nurse Supervisor (NS) 1 who checked the small keypad lock container outside the clean utility room. NS1 said they usually keep the keys to the door in there, but no keys were found when she opened it. NS1 confirmed that the door to the clean utility room was supposed to be locked since they also had hazardous chemicals in there. On 06/06/24 at 10:30 AM, an interview was conducted with the Director of Nursing (DON) in the second-floor conference room. DON confirmed that all hazardous chemicals need to be stored in a locked cabinet or room. 2) During an observation on 06/03/24 at 11:15 AM, the Soiled Utility Room located on 4th floor nursing unit was not locked/secured and there was no staff in the immediate vicinity to prevent unauthorized entry to the room. The room contained a bottle of cleaning solution with a label that said, "Caution, eye irritant, harmful if swallowed ..." On 06/03/24 at 11:20 AM, Charge Nurse (CN) 4, acknowledged that the Soiled Utility room should have been locked/secured and stated that they would immediately have it secured.	F 689	HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected by this deficient practice. On 6/5/24, all utility rooms on all units were verified as locked. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: By 7/19/24, education provided to all staff regarding the need to keep utility rooms locked at all times. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: The unit manager or designee will perform a daily audit to ensure that the utility rooms are locked. Results of the audits will be reviewed at the QAPI meetings to ensure the corrective action is sustained. Ongoing validation by the Administrator at the monthly QAPI meeting.	
F 726 SS=D	Competent Nursing Staff	F 726		7/19/24

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F 726	Continued From page 9 CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services 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)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure nurse competency in medication administration as evidenced by Registered Nurse (RN)5 administering a laxative/stool softener to Resident	F 726	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:	

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F 726	Continued From page 10 (R)36 despite documentation of a large loose bowel movement that morning. In addition, medications were not documented as administered in a timely manner. This deficient practice places residents at risk for avoidable declines in health status and has the potential to affect all residents at the facility receiving staff-administered medications. Findings include: On 06/05/24 at 08:08 AM, medication pass observations were done with Registered Nurse (RN)5 as she prepared and administered medications for Resident (R)36. RN5 prepared a total of thirteen oral medications for R36, one of which was "Stimulant Laxative Plus [with stool softener]." The medications were administered at 08:15 AM. Review of R36's medical record revealed the following physician order from 10/03/23: "Stimulant Laxative Plus Tablet, one tablet orally twice a day, *HOLD FOR LOOSE STOOL." On 06/05/24 at 08:18 AM, in front of the third-floor medication cart, asked RN5 when was R36's last bowel movement (BM). RN5 responded that she did not know. RN5 then proceeded to lead Surveyor to a large spreadsheet on the bathroom door in the employee break room listing the BMs of all the residents on the floor. Under the "5" column (for 06/05/24) and "N" row (for the shift that just got off that morning) for R36, was an "L6." RN5 explained that meant before the night shift finished that morning, R36 had a large watery BM. Review of the documentation legend on the bottom of the spreadsheet revealed the following: "Type 6 Watery, no solid pieces	F 726	On 6/5/24, the licensed staff member was reeducated on medication administration preparation to include information that should be obtained and reviewed prior to medication administration (including the importance of reviewing and adhering to physician ordered parameters). Education also provided regarding documenting medication administration promptly after giving medication. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected by the deficient practice. By 7/19/24 all licensed nurses will receive retraining on medication administration preparation to include information that should be obtained and reviewed prior to medication administration (including the importance of reviewing and adhering to physician ordered parameters). Education will also be provided regarding documenting medication administration promptly after giving medication. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: By 7/19/24, daily assignment communication will be revised to included pertinent bowel status information and licensed nursing staff will include a verbal	

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F 726	Continued From page 11 (entirely liquid)." Asked RN5 if she checked the spreadsheet prior to giving medications. Initially, RN5 answered that she checks the spreadsheet daily before she passes medications. When asked why she administered a laxative to R36 when she had been documented as having a large, watery BM that morning, RN5 responded that she made a mistake, she does NOT check the spreadsheet before giving medications. RN5 stated that the Certified Nurse Aides (CNAs) are "supposed to report it [BMs]," but she received no report and so she gave the stimulant laxative plus. On 06/05/24 at 08:29 AM, an interview was done with Charge Nurse (CN)1 at the third-floor nurses' station. When asked what the process is for documenting and reporting off BMs, CN1 stated that the CNAs should let the nurse know immediately if there are loose BMs, then they should document it in the "ADL [activities of daily living] book," and on the "Master List [spreadsheet on the bathroom door]." When asked what the expectation is as far as who should be looking at the spreadsheet and when, CN1 agreed that the nurses should be checking the spreadsheet before giving any laxative medications. Review of the Medication Administration policy, last revised 07/2021, revealed the following: "Medications are administered as prescribed." On 06/05/24 at 08:39 AM, while RN5 was off administering medications to a different resident, a reconciliation review of R36's Medication Administration Record (MAR) with the medication pass observations was done. During the review,	F 726	report of that status at shift hand-offs for all residents. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: Charge Nurses and Nursing Supervisors will audit shift hand-off weekly to ensure that licensed nurses are communicating pertinent bowel status information. The Charge Nurses will perform weekly mid-shift audits to ensure that medications are being documented promptly after giving. Audits will be provided to the Director of Nursing and the Administrator. Ongoing validation by the Administrator.	

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F 726	Continued From page 12 noted that none of the thirteen medications given to R36 that morning had been documented as administered yet. In addition, the Stimulant Laxative Plus was also not signed off as administered the previous morning either. At 08:41 AM, an interview was done with RN5 in front of the medication cart. When asked when she signs off on the MAR that medications were administered, RN5 reported that after she has given all medications due to all the residents, then she goes back to their MARs and signs off on all of them at the same time. RN5 acknowledged that she did not sign off on the Stimulant Laxative Plus the previous day, stating, "I missed it." RN5 confirmed that she did administer the medication but forgot to document that. On 06/05/24 at 08:43 AM, interviewed CN1 at the nurses' station again. When asked about the process of signing off on the MAR, CN1 stated that nurses should be documenting medications as administered on the MAR immediately after administration. If held or refused, nurses should document an empty circle in the space where they would normally put their initials. Then they would document the reason the medication was held or refused on the back of the MAR. Review of the Medication Administration Record policy, last revised 07/2023, revealed the following: "All medications administered to the patient shall be recorded on the Medication Administration Record promptly after they are given."	F 726		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON	F 727		6/19/24

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F 727	Continued From page 13 CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide a Director of Nursing (DON) on a full-time basis. The same staff member covers the long-term care (LTC), the Critical Access Hospital (CAH), and the Intermediate Care Facility for the Intellectually Disabled (ICF/IID) facilities as the DON. Findings include: On 06/03/24 at 11:04 AM, an entrance interview for the Critical Access Hospital (CAH) recertification was done in the first-floor conference room with the DON and the Administrator. The DON confirmed that she was employed full-time, and was the DON for the CAH, the LTC facility, and the ICF/IID facility, each with their own facility-specific certification and licensing requirements. The DON and Administrator confirmed that they did not have a waiver for a full-time DON.	F 727	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No residents were identified in the 2567 report as being affected by the deficient practice. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected by the deficient practice. On 6/19/24, the organization leadership approved the restructuring of reporting structure to dedicate a full-time Director of Nursing (DON) to the Long-Term Care	

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F 727	Continued From page 14 A review of the Office of Health Care Assurance (OHCA) Licensed Beds and Location form noted that as of 06/03/24, there were 9 beds (4 occupied) in the CAH, 105 beds (89 occupied) in the LTC facility, and 9 beds (all occupied) in the ICF/IID facility.	F 727	(LTC) Facility. The management staff under the Critical Access Hospital (CAH) and the Intermediate Care Facility for the Intellectually Disabled (ICF/IID) licenses will no longer report to the DON for LTC. Instead, they will report directly to the Hospital Administrator with nursing administrative support from the Chief Nurse Executive. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The facility□s organizational structure has been restructured to reflect that the DON is only responsible for the Long-Term Care Facility at Kula Hospital. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: The Administrator will ensure that the DON for LTC only has oversight and responsibilities for the LTC Facility.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757		6/7/24

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F 757	Continued From page 15 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure adequate monitoring was done for one resident (Resident (R) 27) sampled for anticoagulant (medication to treat and prevent blood clots) use. The facility was not documenting if R27 was being monitored for signs and symptoms of bleeding. As a result of this deficient practice, R27 was put at risk for avoidable adverse health complications related to her health condition and the use of anticoagulants. This has the potential to affect all residents in the facility taking anticoagulants. Findings include: R27 is an 82-year-old resident first admitted to the facility on 03/07/18. Diagnosis included but not limited to atrial fibrillation (irregular heart rhythm that can lead to blood clots increasing the risk of stroke). Record review revealed that R27 was on Apixaban (anticoagulant) 5 mg (milligrams) twice a day. Interventions noted in plan of care dated 01/16/24 stated, ". . .	F 757	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 6/5/24, the Medication Administration Record (MAR) for R27 was updated to include a reminder for the nurse to evaluate the resident for any signs or symptoms of bleeding prior to administration of the anticoagulant medication. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents receiving anticoagulant medications have the potential to be affected by this deficient practice. By 6/7/24, a review of all residents MARs	

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F 757	Continued From page 16 Assess/record/report signs of bleeding problems to MD (medical doctor) . . . Please monitor me for possible side effects on Eliquis (Apixaban) TX (treatment) (see attached) . . ." The document that was attached to the plan of care was titled "Patient Education" and stated. ". . . side effects . . . Signs of bleeding like throwing up or coughing up blood; vomit that looks like coffee grounds; blood in the urine; black, red, or tarry stools; bleeding from the gums; abnormal vaginal bleeding; bruises without a cause or that get bigger; or bleeding you can not stop. . ." Documentation of staff monitoring for the signs and symptoms of bleeding was not found in the in R27's chart. On 06/05/24 at 01:51 PM, a concurrent interview and record review was conducted with Registered Nurse (RN) 2 and Nurse Supervisor (NS) 1 at the second-floor nurses' station. Asked RN2 how often do they monitor R27 for signs and symptoms of bleeding. RN2 responded, "Every shift." When asked where do the staff document it, RN2 said, "It should be in the MAR (medication administration record)." RN2 opened R27's chart and looked in the section where the MARs were kept but was not able to locate documentation of monitoring. NS1 said to also look in the progress notes but when RN2 checked, no documentation was found. NS1 added that they will get an order for the monitoring of signs and symptoms of bleeding so it will be transcribed onto the MAR, that way it will remind the nurses to document it when it is done. On 06/06/24 at 10:30 AM, an interview was conducted with the Director of Nursing (DON) in the second-floor conference room. DON confirmed that the monitoring for signs and	F 757	was conducted to identify those taking anticoagulant medications. A reminder was added to the MAR for those taking anticoagulant medications to prompt the nurse to evaluate the resident for signs or symptoms of bleeding prior to administering the medication. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: A reminder was added to the MAR□s for those residents taking anticoagulant medications to prompt the nurse to evaluate the resident for signs or symptoms of bleeding prior to administering the medication. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: Monthly MAR audits will be done by the Nursing Manager or designee to ensure all residents MAR□s with anticoagulant medications have the prompt for the nurse to evaluate the resident for signs and symptoms of bleeding prior to administration of the medication. Audit results will be provided to the Director of Nursing and the Administrator. Ongoing validation by the Administrator.	

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F 757	Continued From page 17 symptoms of bleeding for R27 should have been documented in the MAR every shift.	F 757		
F 812 SS=F	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, interview, and record review, the facility failed to store food in accordance with professional standards for food service safety. Residents (R) risk serious complications from foodborne illness as a result of their compromised health status. Unsafe and/or unsanitary food storage/handling practices represent a potential source of pathogen exposure for all residents at the facility who consume food or drink prepared at the facility. Findings include:	F 812	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No residents were identified in the 2567 report as being affected by the deficient practice. 1)The frozen beef patties were immediately discarded on 6/3/24. 2)Refrigerated storage of raw meats was evaluated 6/3/24 and rearrangement of	7/19/24

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F 812	Continued From page 18 1) On 06/03/24 at 10:00 AM, while conducting an initial tour of the kitchen with the Food Service Manager (FSM), observed a standing freezer next to the ice machine containing a small metal pan of approximately ten (10) poorly covered beef patties. The metal pan had been covered with plastic wrap that was not sticking to the pan, labeled "Beef 5/13/24," and the beef patties within were visibly freezer burned (discolored in appearance and covered in ice crystals). The FSM acknowledged the patties were not stored properly, explaining that they should have been either individually bagged in plastic bags, or individually wrapped in plastic wrap. The FSM confirmed that the patties were intended for resident consumption, but since the improper storage compromised the integrity and quality of the patties, the FSM removed them from the freezer for disposal. 2) On 06/03/24 at 10:22 AM, observations were done with the FSM in the walk-in refrigerator. On the bottom shelf normally reserved for raw meats, observed a large metal pan of "sweet yams" dated "6/2/24." Directly next to the sweet yams was a large metal pan of raw meat that was completely thawed. Both metal pans were loosely covered with plastic wrap. On the shelf directly above the sweet yams was a small metal pan of pureed sausage. When asked about the sweet yams, the FSM stated he "would like to see only meats on the bottom [shelf], but I'm OK with it because it's only ... sausage above it." Review of the facility's Food Storage policy, last revised 07/2023, revealed the following: "Raw meats will be stored separately, and when	F 812	designated shelving for raw meats was completed 6/4/24. 3)The unlabeled and expired food was immediately discarded on 6/4/24 4)The green tea was immediately discarded 6/3/24 HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected by the deficient practice. 1)All freezers were evaluated on 6/3/24 to ensure frozen foods were wrapped properly. 2)Refrigerated storage of raw meats was evaluated on 6/3/24 and rearrangement of refrigerators to allow for dedicated shelving for refrigerated raw meat to ensure they are stored separately. Completed on 6/4/24. 3)On 6/4/24, all resident food refrigerator/freezers evaluated to ensure there was not food that was not dated or expired. 4)On 6/3/24, all nourishment areas were checked to ensure there was no other outdated tea. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: 1)All foods will be wrapped securely for freezing. By 7/11/24 all Cooks will receive	

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F 812	Continued From page 19 thawing in drip proof containers, and stored in a manner to prevent cross contamination, below fruits, vegetables, and ready to eat foods." On 06/05/24 at 01:40 PM, an interview was done with the FSM in the first-floor Conference Room. The FSM stated that the yams were taken straight from the can, placed in the metal pan, and refrigerated. The FSM continued explaining that the yams would be reheated before serving, so were OK to be stored next to a pan of raw meat since they were both in non-drip pans. After further discussion, the FSM acknowledged that the yams were fully cooked straight out of the can, did not require reheating to be safely consumed, and therefore met the definition of a ready to eat food. 3) Observation was conducted on the third-floor nutrition room on 06/04/24 at 09:04 AM. The fridge contained a strawberry banana flavored yogurt labeled, "best by 05/23/24." The freezer contained an English muffin breakfast sandwich, removed from the box, without an expiration date. The freezer also contained a pineapple coconut ice cream labeled, "best by 05/31/24." Lastly, observation was made of an opened package of pizza rolls labeled, "Best if used by 09/26/23." An interview was conducted with Charge Nurse (CN) 1 on the third-floor nutrition room on 06/04/24 at 09:12 AM. CN1 stated that the nursing staff usually checks the fridge/freezer for expired food items. CN1 agreed that the four food items observed in the fridge/freezer should have been discarded because they were either unlabeled with an expiration date or were already past the expiration date. A review of the facility's document titled, "Food	F 812	training on securely wrapping foods for freezing. Daily, Lead AM & PM Cooks will audit frozen foods for proper wrapping. 2)Refrigerators have dedicated shelving for refrigerated raw meat to ensure it is stored separately. By 7/11/24, all Cooks will receive training on designated shelving for raw meats. Daily, the Lead AM & PM Cooks will audit refrigeration meat shelf. 3)Daily, the night shift nurse for each unit will check refrigeration and freezer food from family to ensure it is labeled and dated. By 7/19/24 all nursing staff will be provided education on labeling and dating foods brought by family prior to freezer or refrigerator storage. 4)The green tea bags were marked with a best by date. To ensure quality, this date will also serve as a use by date as to when they will be discarded. By 7/11/24, all Kitchen Helpers will receive additional training on discarding expired items while restocking nourishment. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: 1)Chef Manager will audit weekly that frozen foods are properly wrapped. Results of the audits will be reviewed at the QAPI meetings to ensure the corrective action is sustained. Ongoing validation by the Administrator at the monthly QAPI meeting. 2)Chef Manager will audit weekly that refrigerated raw meats are stored	

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F 812	Continued From page 20 Brought to Residents by Family and Visitors," dated 11/2017 was conducted. The document noted, "All foods brought into the facility will be checked by a staff member and labeled and dated ...Nursing will monitor the resident's room, unit pantry, and refrigeration units for expiration dates." 4) Observation of the 4th floor small kitchen room on 06/03/24 at 11:30 AM, six packets of tea bags had "use by 5/18/24" labeled. During staff interview on 06/03/24 at 11:35 AM, the Dietitian acknowledged that the six tea bags previously mentioned were expired and should have been discarded. Dietitian stated that they would immediately remove the expired items.	F 812	separately. Results of the audits will be reviewed at the QAPI meetings to ensure the corrective action is sustained. Ongoing validation by the Administrator at the monthly QAPI meeting. 3)Charge RN or designee for each unit will audit weekly that there are no outdated or unlabeled foods brought in by family. Results of the audits will be reviewed at the QAPI meetings to ensure the corrective action is sustained. Ongoing validation by the Administrator at the monthly QAPI meeting. 4)Chef Manager will audit weekly the nourishments for expired items. Results of the audits will be reviewed at the QAPI meetings to ensure the corrective action is sustained. Ongoing validation by the Administrator at the monthly QAPI meeting.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		7/19/24

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F 880	Continued From page 21	F 880		

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

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

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the

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F 880	Continued From page 22 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, interviews and record review, the facility failed to ensure the staff followed the proper use gloves and performed hand hygiene procedures during wound dressing change for Resident (R) 50. This deficient practice placed the residents at risk for the potential spread of infectious and communicable diseases. Findings include: On 06/04/24 at 02:52 PM, conducted an observation of Registered Nurse (RN) 3 changing the dressing of R50's left foot wound. RN3 gathered supplies from the treatment cart and placed them on R50's bedside table. RN3 then performed hand hygiene and donned a gown and gloves by the door before proceeding with the dressing change. After removing the old dressing to R50's left foot wound, RN3 discarded the old dressing and removed her gloves. Observed another pair of gloves were under the gloves RN3 just removed. RN3 then cleaned the wound with a gauze soaked with normal saline, dried it with a clean gauze and applied an ointment as ordered. RN3 then removed her gloves and donned a new pair without performing hand hygiene and applied	F 880	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 6/6/24, education was provided to the staff member found performing the deficient hand hygiene practice during wound care for R50 HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents with wounds have the potential to be affected by the deficient practice. By 7/19/24, all nurses were provided education on the procedure for wound care that includes proper hand hygiene while performing the wound care. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT	

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F 880	Continued From page 23 a new dressing. After repositioning R50 in his bed, RN3 removed gown and gloves and washed her hands in the sink with soap and water. Asked RN3 if she was initially wearing two pairs of gloves on each hand when she removed the dressing. RN3 confirmed that she had two gloves on each hand. On 06/06/24 at 10:30 AM, an interview was conducted with the Infection Preventionist (IP) and Director of Nursing (DON) in the second-floor conference room. Asked IP if the facility allowed staff to wear two gloves on each hand when performing tasks like dressing changes. IP confirmed that the staff are supposed to just wear one glove in each hand and to also perform hand hygiene between glove changes. Asked IP and DON for the facility policy on dressing changes and hand hygiene, IP said they have one for hand hygiene but not for dressing change. IP said he will provide a copy of the guidelines the facility uses for dressing changes and the policy for hand hygiene. Review of document provided titled "Wound Dressing Application" stated, ". . . Perform hand hygiene. . . put on gloves . . . Remove the old dressing . . . Discard the soiled dressing . . . Remove and discard your soiled gloves . . . Perform hand hygiene . . . Put on new gloves . . . Clean the wound . . . Remove and discard your soiled gloves . . . Perform hand hygiene . . . Put on new gloves . . . Pat the surrounding skin dry . . . Apply topical wound treatment . . . Apply the prescribed primary dressing. . ."	F 880	PRACTICE WILL NOT RECUR: Upon hire and annually, each licensed nurse will be required to complete wound care and infection control education. The initial training will include a hands-on demonstration/competency of a dressing change and the appropriate infection control actions to be taken prior to the licensed staff being allowed to perform wound care independently after hire. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: The staff development supervisor will ensure completion of initial and annual education and report results to Director of Nursing and Administrator. Ongoing validation by the Administrator	
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2)	F 908		6/10/24

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F 908	Continued From page 24 §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and review of equipment service manual, the facility failed to follow routine maintenance cleaning of the cabinet filter, based on the manufacturer's recommendation. This deficient practice put one Resident (R) 8 at risk for the development and transmission of communicable diseases and infections. Findings include: During resident observation on 06/03/24 at 11:45 AM, R8 was receiving oxygen via a Perfecto2 V Oxygen Concentrator. The cabinet filter of that oxygen concentrator appeared to have lint and/or dirt on the cabinet filter. During staff query on 06/05/23 at 01:50 PM, Director of Nursing (DON) said that they clean the cabinet filter once a month. Informed DON that according to the service manual, for this equipment, the recommendation for cleaning is at least once a week. DON acknowledged and revealed that there was a previous change in oxygen concentrator equipment. Review of the Service manual for the Perfecto2 V Oxygen Concentrator, Section 6 - Preventive Maintenance read the following: Cleaning the cabinet filter. There is one cabinet filter located on the back of the cabinet. 1. Remove the filter and clean at least once a week depending on environmental conditions. Note: Environmental conditions that may require more frequent	F 908	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 6/6/24 the filter for the affected oxygen concentrator for R8 was immediately cleaned. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents receiving oxygen via an oxygen concentrator have the potential to be affected. By 6/10/24 the filters on all oxygen concentrators were cleaned WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: On 6/10/24, the practice of cleaning filters for oxygen concentrators was changed from monthly to weekly (per manufacturer recommendations) and continues to be tracked and documented via the treatment administration record. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE	

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F 908	Continued From page 25 cleaning of the filters include but are not limited to; high dust, air pollutants, etc. 2. Clean the cabinet filter with a vacuum cleaner or wash in warm soapy water and rinse thoroughly. 3. Dry the filter thoroughly before reinstallation.	F 908	DEFICIENT PRACTICE WILL NOT RECUR: The unit charge nurses will inspect all concentrators filters and documentation weekly for evidence of cleaning being completed. The audit will be provided to the Director of Nursing and Administrator. Ongoing validation by the Administrator.	