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	125048	A. BUILDING _____ B. WING _____	02/28/2025

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ANN PEARL NURSING FACILITY	45-181 WAIKALUA ROAD KANEOHE, HI 96744

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F 000	INITIAL COMMENTS The State Survey Agency (SA) Office of Health Care Assurance (OHCA) conducted a recertification survey from 02/25/25 to 02/28/25. The facility was found not to be in substantial compliance with the requirements of §42 CFR 483, Subpart B for Long Term Facilities. Three Facility Reported Incidents (FRI) from the Aspen Complaints/Incidents Tracking System (ACTS) #11529, #11458, and #11445 were investigated and found to be in compliance. Census: 48 Sample Size: 14	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		

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

Electronically Signed

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 656	Continued From page 1 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a resident-centered trauma-informed care (TIC) care plan for one of one resident (Resident (R) 41) reviewed with a diagnosis of Post Traumatic Stress Disorder (PTSD). As a result of this deficient practice, the facility staff did not have sufficient information to meet the R41's needs. Findings include: Cross-reference to F699 TIC for R41. The facility failed to develop a TIC plan of care to address	F 656		

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F 656	Continued From page 2 the trauma triggers and specific needs of R41 with a diagnosis of PTSD.	F 656		
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. (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 record review and interview, the facility failed to revise the care plan for one of one sampled resident (Resident (R) 42) for elopement. This deficient practice has the	F 657		

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F 657	Continued From page 3 potential to place R42 at risk for future elopements. Findings include: R42 is a 72-year-old male, admitted to the facility on 06/20/24. R42 has medical diagnoses that include, but not limited to schizophrenia and dementia. A review of R42's Electronic Health Record (EHR) was conducted on 02/26/25. R42's EHR noted a progress note that on 10/11/24, R42 had walked out of the front door of the facility because he was needing money for cigarettes. A review of R42's current care plan noted that on 07/10/24, the facility had created a plan of care for R42's wandering and exit seeking behaviors. Since 07/10/24, there was no revision done for this plan of care. Interview was conducted with Director of Nursing (DON) on 02/27/25 at 10:22 AM in her office. DON confirmed that the facility would normally address the root cause of his elopement, which was seeking money for cigarettes, and update the resident's care plan. She added that a revision of R42's care plan should have been done after he walked out of the facility door on 10/11/24.	F 657		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range	F 688		

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F 688	Continued From page 4 of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure one of two residents (Resident (R)12) sampled for limited range of motion (ROM) received the appropriate treatment, equipment, and services to maintain and/or prevent a decline in ROM in her left hand and elbow, as evidenced by inconsistent application of orthotic devices and ROM exercises. As a result of this deficient practice, R12 was placed at risk of a decline in ROM and a loss of function. Findings include: R12 is a 76-year-old female admitted to the facility on 03/25/19 for long-term care. A review of R12's Minimum Data Set (MDS) Annual Assessment with an Assessment Reference Date (ARD) of 12/01/24 noted that her diagnoses include, but are not limited to, left-sided weakness and paralysis following a stroke, chronic pain, and heart failure. The Annual Assessment also documents R12 with a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating that she is cognitively intact.	F 688		

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F 688	Continued From page 5 On 02/25/25 at 09:16 AM, observations and interview were done with R12 at her bedside. Observed that R12 was not moving her left arm. When asked, R12 stated that she had a stroke in 2015 and has not been able to move her left arm too much since. No braces or splints were visible at the bedside at this time. On 02/25/25 at 01:07 PM, observations and interview were done with R12 at her bedside. Observed an elbow splint and wrist splint sitting on the nightstand behind her bed. R12 stated that they were for her left arm because of her stroke and resulting paralysis and weakness, and that facility staff helped her put them on every day. R12 confirmed that they had not been applied yet that day. Review of physician/provider orders revealed the following orders related to R12's splints: 01/10/25 Splint: Apply left elbow splint for 1-2.5 hours during day shift (06:00 AM - 02:00 PM), once a day. 01/10/25 Splint: Apply left palm protector splint with finger separators for 1-2.5 hours during day shift, once a day. 01/10/25 Splint: Apply left wrist, hand, finger, orthosis for 1 - 2.5 hours during evening shift (02:00 PM - 10:00 PM), once a day. On 02/26/25 at 08:00 AM, a review of R12's electronic health record (EHR) revealed that Point-of-Care (POC) responses for splints and passive range of motion (PROM), which is ROM that is achieved when an outside force (such as a	F 688		

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F 688	Continued From page 6 therapist) exclusively causes movement of a joint, did not reflect the application or offer of application of her splints or PROM, on any shift, since 02/23/25. On 02/26/25 at 09:05 AM, an interview was done with Certified Nurse Aide (CNA) 52, who was also the Restorative Nurse Aide (RNA), out in the activities area. When asked, CNA52 stated that she documents individual therapies as soon as possible but definitely gets all charting in by the end of day. For R12, CNA52 stated that she does PROM first, then applies her splints, daily after her morning medications (per resident preference). Further review of POC responses for RNA services in the last thirty (30) days revealed PROM was done, and splints were documented as applied, for half that number of days. On 02/28/25 at 11:13 AM, an interview was done with Director of Nursing (DON) in her office. During a concurrent review of MDS Quarterly Assessment with ARD of 12/19/24 revealed PROM and Splint application was documented as being performed 2 days out of the 7-day observation period. DON explained that the data is compiled through observation and review of POC responses. DON agreed that if splints are ordered for daily application, the expectation is that the assessment result should be 7 of 7 days.	F 688		
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	F 689		

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F 689	Continued From page 7 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure residents remain as free of accident hazards as possible for two of six residents (Resident (R) 35 and R42) sampled for accidents. The facility failed to identify and eliminate a known and foreseeable accident hazard in the resident environment (wet floor); failed to lock up R35's cigarettes and lighter; and failed to ensure R42's seizure pads were in place. The deficient practices have the potential for ambulatory residents on the unit to sustain a preventable injury; the potential of a fire accident in the facility that has residents who are on oxygen; and the potential for R42 sustaining injuries in bed when having a seizure. Findings include: 1) On 02/26/25 at 07:38 AM, clear colored wetness was noted on the hallway floor outside of rooms 111-118 and extended to the floor inside resident room 120. From the initial observation at 07:38 AM until 08:02 AM, multiple staff were observed walking on and around the wetness observed on the floor in the hallway and resident room 120, taking no action to wipe it up. There were no "wet floor" caution signs observed on the areas of wetness. On 02/26/25 at 08:28 AM, Director of Nursing (DON) was interviewed and stated that a cone with a "wet floor" sign should typically be placed.	F 689		

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F 689	Continued From page 8	F 689		

Housekeeping should be notified if staff cannot get to it in time to clean it up. DON confirmed the wetness in the hallway and in resident room 120 remained, and agreed that it should have been wiped up.

2) On 02/25/25 at 09:36 AM, observed R35 smoking in the designated smoking area. Review of the list of residents who smoke in the facility, R35 was not included on the list.

On 02/25/25 at 10:12 AM, an interview and observation of R35 was done in his room. Observed in his left breast pocket on his shirt a green box. R35 confirmed that the green box was his cigarettes, and he also had his lighter. R35 reported a staff member is usually with him when he smokes and helps him light his cigarettes except when he gets back from dialysis in the evening. Before coming in the building, he will smoke, they give him his cigarettes and lighter when he leaves for dialysis. R35 further reported he is blind and only smokes half of his cigarette, so he does not burn himself. R35 admitted he was supposed to forfeit his cigarette and lighter to the nurse, but he forgot to.

On 02/26/25 at 08:09 AM, observed R35 in the common dining room tapping his green cigarette box on the dining room table. His lighter was observed to be on his left side visibly on top of the table. Other residents and staff members were around and the tapping sound he was making was audibly loud. When asking for the nurse, two staff members approached him, cigarettes and lighter visibly on the table.

On 02/26/25 at 09:09 AM, a staff member was observed to take R35 outside, cigarette pack and

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F 689	Continued From page 9	F 689		

lighter was visibly outlined in left breast pocket on his shirt. At 09:12 AM, R35 was observed smoking.

On 02/27/25 at 08:59 AM, observed R35's cigarettes and lighter on the table in the dining room while he was eating breakfast.

On 02/27/25 at 01:44 PM, a concurrent observation and interview was done with Resident Care Manager (RCM) 21 and Infection Preventionist (IP). Inquired about the facility's smoking policy on locking residents' cigarettes and lighter, RCM21 reported the facility locks up residents' cigarettes and lighter, and when a resident wants to smoke, they can request it from the nurse. There are no situations where a resident is allowed to hold on to their cigarettes or lighter in the facility. Concurrent observation of R35 in the dining room with his cigarettes and lighter on the table with RCM21 and IP. Inquired with R35 if the cigarettes and lighter was his on the table, R35 stated it was. IP confirmed the resident should not have had his cigarettes and lighter with him in the facility and reported it was for safety because the facility would not know if a resident smoked inside their room or somewhere in the facility, and there are residents that use flammable oxygen.

Review of the facility's policy and procedure "Smoking" effective 04/02/22, documented "Residents regardless of smoking privileges are not permitted to keep cigarettes, e-cigarettes/vaping devices, pipes, tobacco, and other smoking articles in their possession. Those grandfathered in prior to the date of this policy and assessed as safe to smoke on their own may keep their supplies in a locked box in their room

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F 689	Continued From page 10 when not in use, which will be audited regularly for safety. If resident is non-compliant, supplies will be removed from room ...Smoking materials must be checked out and in with the nurse and stored by the nurse ..." 3) R42 is a 72-year-old male, admitted to the facility on 06/20/24. R42 has medical diagnosis include, but not limited to epilepsy. Multiple observations were conducted from 02/25/25 to 02/27/28 of R42's bed rails. The right side of R42's bed rail was covered with a blue padding. The left side bed rail did not have a blue padding. Record review of R42's Electronic Health Record (EHR) was conducted on 02/27/25. R42's EHR noted a progress note that on 02/26/25, R42 was witnessed having a tonic seizure during the evening. Interview was conducted with RCM54 in R42's room on 02/27/25 at 09:33 AM. RCM54 was shown R42's bed, which had the blue padding only on the right-side rail. RCM54 confirmed that seizure pads should have been placed on the left-side rail as well for R42's safety since he is on seizure precaution. A review of the facility document titled, "Seizure management," with an effective date of 06/19/23 was conducted. The document noted, "EQUIPMENT...Padding for side rails and bed headboard."	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		

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F 695	Continued From page 11 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide the physician ordered oxygen therapy during assistance with a meal for one of two residents (Resident (R) 2) sampled for oxygen use. This deficient practice has the potential for R2 to encounter difficulty breathing and discomfort. Findings include: On 02/27/25 at 07:58 AM, Certified Nurse Aide (CNA) 7 was observed removing R2's oxygen mask and replacing it with a nasal cannula. The flow rate of oxygen was observed to be set at five liters per minute via oxygen concentrator. CNA7 stated that she was informed by the nurse that the resident must always have oxygen on, and it was okay to replace the face mask with the nasal cannula. A review of the physician orders for R2 noted the following 06/05/21 oxygen order: "Difficulty breathing: Oxygen 5-10 (five to ten) LPM (liters per minute) via face mask for SOB (shortness of breath) or SpO2 (oxygen saturation) < 90%. Special Instructions: Notify MD (physician) if O2 (oxygen) is applied or increased as needed."	F 695		

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F 695	Continued From page 12 On 02/27/25 at 08:07 AM, Registered Nurse (RN) 4 was interviewed. She stated that when the resident eats, the face mask is switched to the nasal cannula and the certified nurse aides are aware to do that. She also confirmed that there was no order for that.	F 695		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to adequately assess for and identify past trauma experienced by one of one residents (Resident (R) 41) sampled for trauma-informed care (TIC). As a result of this deficient practice, R41 did not have her trauma triggers identified, placing her at increased risk of re-traumatization, and was hindered from attaining her highest practicable mental and psychosocial well-being. Findings include: R41 is a 73-year-old female admitted to the facility on 09/26/24. A review of R41's electronic health record (EHR) noted that she was admitted with diagnoses that include cerebral infarction affecting left non-dominant side, major depressive disorder, anxiety disorder, and post-traumatic stress disorder (PTSD). The initial	F 699		

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physician (MD) 2 note for R41, dated 10/26/24, noted a psychiatric history of post-traumatic stress disorder with avoidant behavior.

On 02/25/25 at 02:00 PM, R41 was interviewed in an unoccupied resident room (resident requested privacy) and stated that she is unable to sleep because of hearing other residents and past roommates having "personal emergencies" like falling out of bed and coughing all night. R41 also stated that loud disruptive noises and staff talking loud in the hallway keep her awake at night.

On 02/27/25 at 09:33 AM, an interview with Director of Nursing (DON) was conducted. DON stated that Social Services Director (SSD) 46 meets with the resident on admission. If the resident has a history of trauma or PTSD then a TIC care plan should be initiated.

On 02/27/25 at 09:42 PM, an interview and concurrent review of R41's care plan was conducted with SSD46. During the interview, SSD46 confirmed that there was no TIC care plan addressing R41's specific trauma triggers and needs. During concurrent review of the facility's TIC policy with SSD46, the following was noted: "A resident will be screened for trauma upon admission, quarterly, annually, and as needed using the tool in the electronic medical record." SSD46 stated the quarterly screen was not done.

On 02/28/25 at 07:19 AM, a review of R41's Comprehensive Care Plan and facility TIC policy was conducted. The TIC policy noted that trauma events and triggers identified through screening will be used to develop a care plan. Review of R41's "Mood State" care plan noted some resident triggers in the "Problem" area of that

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F 699	Continued From page 14 care plan. However, there were no interventions listed to address them.	F 699		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not	F 756		

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limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to ensure that medication regimen irregularities/recommendations were addressed by the physician for one of five residents (Resident (R) 7) sampled for unnecessary medications. As a result of this deficient practice, R7 was placed at risk of avoidable complications related to continuing an as needed psychotropic (a drug taken to exert an effect on the chemical makeup of the brain and nervous system) past 14 days without a clinical rationale.

Findings include:

R7 is a 75-year-old female admitted to the facility on 04/02/14 for long-term care. A review of R7's Minimum Data Set (MDS) Quarterly Review Assessment with an Assessment Reference Date (ARD) of 12/03/24 noted that her diagnoses include, but are not limited to, dementia with behavioral disturbance-aggression, and left-sided weakness and paralysis following a stroke.

A review of R7's electronic health record (EHR) noted the following open-ended physician order on 08/26/24:

"Lorazepam 0.5 mg [milligrams] PO [by mouth] or dissolve in water and place under tongue every 4 hours as needed for Anxiety."

Review of R7's Medication Regimen Reviews (MRRs) revealed the following recommendation

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F 756	Continued From page 16 made by the pharmacist on 08/31/24: "This resident is currently receiving the PRN [as needed] psychotropic medication lorazepam ... Please provide a specific stop date or time period (e.g [sic] six months) AND a clinical rationale to continue PRN psychotropic medication past 14 days:" The physician made the following response and signed the MRR form on 09/10/24: "Nonpharmacological interventions are either ineffective or not practical for this resident's situation ..." Further review of the MRRs noted the pharmacist made the same recommendation the following month, on 09/30/24, however, this recommendation had no documented physician response. On 02/27/25 at 09:13 AM, an interview was done with Director of Nursing (DON) in her office. When asked about the MRR process, DON explained that the facility gives themselves thirty (30) days to receive and print the recommendations from the pharmacy, place it in the appropriate provider/physician binder, receive a response from the provider/physician, and make the appropriate changes to close it out. During a concurrent review of the 08/31/24 MRR recommendation, DON agreed that the physician response did not align with or address the pharmacist's recommendations, specifically, "provide a specific stop date or time period... AND a clinical rationale to continue PRN psychotropic medication past 14 days." DON stated that either the Resident Care Manager	F 756		

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F 756	Continued From page 17 (RCM) or DON "should catch it" when the provider/physician response does not match the pharmacist's request/recommendation. DON agreed that the inappropriate response should have been noticed and addressed with the physician prior to the receipt of the same recommendation being made the following month. Review of the facility policy and procedure Medication Regimen Review and Reporting, last revised 01/24, revealed the following: "A record of the consultant pharmacist's observations and recommendations is made available in an easily retrievable format ... within 48 hours of completion." "The nursing care center follows up on the recommendations to verify that appropriate action has been taken. Recommendations should be acted upon within 30 calendar days ..."	F 756		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5%, as evidenced by five medication errors observed out of 31 opportunities for errors, for an error rate of 16%. Safe and timely medication administration	F 759		

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practices are essential for the health and well-being of the residents. As a result of this deficient practice, three residents (Residents (R) 37, R7, and R52) were placed at risk of negative outcomes due to medication errors. This deficient practice has the potential to affect all residents in the facility taking medications administered by staff.

Findings include:

1) On 02/27/25 at 07:46 AM, observations were done of Registered Nurse (RN) 1 preparing medications for R37 at a medication cart outside of room 124. Review of R37's Medication Administration Record (MAR) and medication orders noted there was an Amlodipine 2.5 mg (milligrams) due at 08:00 AM that RN1 was not observed preparing or administering, and that she had documented on the MAR as "Not Administered: Drug/Item Unavailable". Further review of the MAR revealed the medication had been documented as "Not Administered: Drug/Item Unavailable" since 02/22/25, with the last time it was administered documented as 02/21/25.

On 02/27/25 at 01:49 PM, an interview was done with RN1 outside of room 124. RN1 confirmed that she did not administer R37's Amlodipine as it was out of stock in the medication cart. When asked what is usually done when a medication is out of stock, RN1 stated that the nurse should call the pharmacy and find out when it was being delivered. RN1 acknowledged that she had not done this.

On 02/27/25 at 02:01 PM, an interview was done with Director of Nursing (DON) in her office.

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When asked about the process that should be followed when a medication is found to be out of stock, DON stated first, the nurse should check the RX NOW system (electronic medication storage) to see if the medication is in the machine. If it is, and the medication is overdue, the nurse calls the provider to get a one-time order to administer the medication late. Whether the medication is in the machine or not, the pharmacy is called to find out when the medication will be delivered. This information is documented in a progress note and passed off in shift report to the oncoming nurse. DON checked the RX NOW system and confirmed that the medication is available and should have been given.

2) On 02/27/25 at 08:05 AM, observations were done of RN1 preparing medications for R7 at a medication cart outside of room 124. Observed RN1 crush all the prepared tablets together then mix them into one (1) teaspoonful of applesauce. RN1 then opened an Omeprazole DR (delayed release) 20 mg capsule, emptied its contents on top of the same spoonful of applesauce, and mixed it in.

Review of the facility's Medication Administration General Guidelines, last revised, 01/25, revealed the following:

"Long-acting, extended release or enteric-coated dosage forms should generally not be crushed; an alternative should be sought."

On 02/27/25 at 01:54 PM, an interview was done with DON in her office. DON confirmed that the Omeprazole DR capsule should not be opened and mixed in with applesauce. During a

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concurrent review of the medication orders, DON stated that the Omeprazole DR had a 'Do Not Crush' special instruction.

3) On 02/27/25 at 08:05 AM, observations were done of RN1 preparing medications for R7 at a medication cart outside of room 124.

Review of R7's MAR and medication orders noted there was Polyethylene Glycol (a laxative) 17 gm (grams) due at 08:00 AM that RN1 was not observed preparing or administering, and that she had documented on the MAR at 10:22 AM as "Charted late ... given on time".

On 02/27/25 at 12:18 PM, an interview was done with RN1 outside of room 124. RN1 stated that she gave R7 the Polyethylene Glycol with her other medications that morning. State Agency Surveyor (SA) reminded her that she did not take any medication that was not in the spoonful of applesauce into the room that morning. At 12:24 PM, RN1 prepared and administered the Polyethylene Glycol, mixed in approximately 60 ml (milliliters) of fluid to R7. R7 drank a little more than half the fluid, then handed the cup back to RN1. RN1 placed the remaining fluid (with medication) on R7's bedside table and left the room.

Review of the facility's Medication Administration General Guidelines, last revised, 01/25, revealed the following:

"The resident is always observed after administration to ensure that the dose was completely ingested."

"The individual who administered the medication

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dose, records the administration on the resident's MAR immediately following the medication being given."

On 02/27/25 at 01:54 PM, an interview was done with DON in her office. DON confirmed that no medication should be left at the bedside to finish unless the resident has orders to self-administer. DON also confirmed that a medication should not be documented as given until after it is administered. Review of R7's provider/physician orders noted that she did not have an order to self-administer.

4) On 02/27/25 at 08:19 AM, observations were done of RN1 preparing medications for R52 at a medication cart outside of room 129. Amongst other medications, observed preparation of the following:

Sennosides-Docusate Sodium 8.6-50 mg (a stimulant laxative with stool softener combination)

At 08:23 AM, observed RN1 administering a total of six (6) tablets/medication to R52. At this time, observed RN1 ask R52 if he wanted his "stool softener," which he refused. RN1 did not inform R52 at any time that one of the medications she had given him contained a stool softener.

Review of R52's MAR and medication orders noted there was Polyethylene Glycol (a laxative) 17 gm (grams) due at 08:00 AM that RN1 was not observed preparing or administering, and that she had documented on the MAR at 08:28 AM as "Not Administered: Refused".

On 02/27/25 at 12:27 PM, interviewed RN1 outside room 124. RN1 confirmed that R52

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refused the stool softener and after prompting by the SA, acknowledged that she did give a stool softener to him at that time. RN1 explained that R52 "doesn't like the powder [Polyethylene Glycol] because he thinks it makes him go more." RN1 also stated that (the Polyethylene Glycol) is what she meant when she asked R52 if he wanted the stool softener. RN1 did not seem aware that Polyethylene Glycol is a laxative and not a stool softener.

Review of the facility's Medication Administration General Guidelines, last revised, 01/25, revealed the following:

"Explain to resident the type of medication being administered ..."

On 02/27/25 at 02:01 PM, an interview was done with DON in her office. DON agreed that if R52 refused a stool softener, he either should not have been given the Sennosides-Docusate Sodium, or he should have been informed that there was a stool softener component in the medication he was given and been allowed the opportunity to refuse it.

5) On 02/27/25 at 08:19 AM, observations were done of RN1 preparing medications for R52 at a medication cart outside of room 129. At 08:23 AM, observed RN1 administering a total of six (6) tablets/medication to R52. At this time, observed RN1 telling R52, "I didn't bring your ... [Acetaminophen], is that OK?"

Review of R52's MAR and medication orders noted there was Acetaminophen 1000 mg due at 07:00 AM that RN1 was not observed preparing or administering, and that she had documented

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F 759	Continued From page 23 on the MAR at 08:20 AM as "Not Administered: Refused". Review of the facility's Medication Administration General Guidelines, last revised, 01/25, revealed the following: "Medications are administered within 60 minutes of scheduled time ..." On 02/27/25 at 02:01 PM, an interview was done with DON in her office. DON agreed that medication cannot be marked as refused before it is offered and should be offered and/or administered within one hour of its scheduled time.	F 759		
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	F 880		

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F 880	Continued From page 24 arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880		

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F 880	Continued From page 25 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement the facility's infection prevention and control measures for one of two residents (Resident (R) 35) sampled for Transmission Based Precautions (TBP). The facility did not ensure nursing staff hand hygiene between glove use while providing wound care for R35. This deficient practice has the potential to put residents at risk of spreading infections and communicable diseases. Findings include: R35 was admitted to the facility on 04/03/24 with diagnoses of acute osteomyelitis on right ankle and foot, stage 4 pressure ulcer of right heel, non-pressure chronic ulcer of right lower left with fat layer exposure and left lower left limited to breakdown of skin, local infection of the skin and subcutaneous tissue, and pseudomonas. Review of R35's Electronic Health Record (EHR) found R35 started contact precautions on 02/22/25 due to lab results of methicillin-resistant Staphylococcus aureus (MRSA) infection (a bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infection) to leg wound. On 02/25/25 at 11:47 AM, observation of Resident Care Manager (RCM) 21 and Director of	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125048	A. BUILDING _____ B. WING _____	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN PEARL NURSING FACILITY	45-181 WAIKALUA ROAD KANEOHE, HI 96744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 26 Nursing (DON) cleaning and changing the wound dressing to R35's leg wounds was done. DON was observed to hold R35's right leg up, take off the old wound dressing and helped direct RCM21 with cleaning and redressing the wounds. DON and RCM21 ran out of the dressing and the DON directed RCM21 to ask for more silver alginate wound dressing. RCM21 took off her gloves, radioed for someone to bring more silver alginate, threw her gloves in the trash, walk to the entrance door to R35's room, grabbed a pair of gloves and donned them without hand hygiene between glove use. RCM21 proceeded to dress the wounds after receiving the silver alginate wound dressing. At 12:09 PM, after NM21 completed R35's wound dressing with DON, an interview with RCM21 was done. Inquired if she hand-sanitized before donning the new pair of gloves while providing wound dressing care for R35, NM21 confirmed she did not and stated she was supposed to hand-sanitize between gloves.	F 880		