POC NOT FINAL

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 125059 | A. BUILDING ______ B. WING ______ | 05/01/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PALOLO CHINESE HOME | 2459 10TH AVENUE HONOLULU, HI 96816 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on April 28, 2025 to May 01, 2025. The facility was found not to be in substantial compliance with 42 CFR §483, Subpart B. In addition, three complaints from the Aspen Complaints/Incidents Tracking System (ACTS) and five Facility Reported Incidents (FRIs) were investigated with the following findings:<br><br>ACTS #11612 no deficient practice found.<br>ACTS #11484 no deficient practice found.<br>ACTS #11573 no deficient practice found.<br>ACTS #11578 deficient practice found.<br>ACTS #11439 no deficient practice found.<br>ACTS #11247 deficient practice found.<br>ACTS #11186 no deficient practice found.<br>ACTS #11138 deficient practice found.<br><br>Survey Dates: 04/28/25 - 05/01/25<br><br>Survey Census: 95 | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>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.<br><br>§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 | F 550 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 05/21/2025 |

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 550 | Continued From page 1<br>individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>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.<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure a resident's right to a dignified existence for two (Residents (R) 395 and R18) of three residents sampled for dignity. As a result of this deficient practice, residents dependent on staff are at risk for more than minimal physical and/or psychosocial harm.<br><br>Findings include: | F 550 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **PALOLO CHINESE HOME** | **2459 10TH AVENUE** **HONOLULU, HI 96816** |

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| F 550 | Continued From page 2<br>1) On 04/28/25 at 08:47 AM, conducted an interview with R394. Inquired if staff provide timely care and respond to call lights in a reasonable time frame. R394 responded, not all the time. R394 explained it depends on who is working, some staff are better than others. R394 reported activating the call light because his/her roommate (R395) needed assistance, and staff took about 25 minutes to respond. R394 stated he/she was worried that his/her call light may not have been working because it took staff a long time to acknowledge the activated call light. R394 activated the call light because R395's legs were dangling off the bed and he/she was concerned the resident was going to fall off the bed.<br><br>On 04/28/25 at 01:19 PM, conducted a telephone interview with R395's Resident Representative (RR) 7. RR7 reported two incidents when R395's family members activated the call light for staff assistance with the resident's care needs. RR7 stated the first incident, family waited approximately an hour for staff to respond to the call light and another incident where the family waited approximately 30 minutes for staff to answer the call light. Inquired why the family had activated the call light and RR7 responded the resident's incontinent brief needed to be changed on both occasions. RR7 stated it is difficult to leave R395 knowing that the resident may not be receiving care when needed.<br><br>On 04/30/25 at 12:31 PM, conducted an interview with the Director of Nursing (DON) in his office. Informed the DON of reports regarding long waiting timeframes for staff to respond to call lights and helping the residents. DON confirmed 30 minutes is too long for call lights to go unanswered and if staff are unable to immediately | F 550 | | |

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| F 550 | Continued From page 3 | F 550 | | |

answer a call light, staff is trained to, at minimum, verbally check in with the resident and inform them that staff will assist the resident as soon as staff is able to.

2) Resident (R)18 is a 41-year-old male re-admitted to the facility on 02/04/25 for long-term care. R18's admitting diagnoses include, but are not limited to, hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) left non-dominant side. A review of R18's Minimum Data Set (MDS) Admission Assessment with an Assessment Reference Date (ARD) of 03/12/25. The assessment indicated R18 had been assessed with a Brief Interview for Mental Status (BIMS) score of 15, indicating a determination that he was cognitively intact.

On 04/28/25 at 09:05 AM, observation and concurrent interview was done with R18 at his bedside. R18 stated facility failed to protect and value his private space by not knocking and asking permission before entering, and staff does not close his bathroom door as requested. Observed signage with instruction of, "Please ... close door all the time." posted on R18's bathroom door. R18 stated that Certified Nurse Aide (CNA)45 let him wait for 30 minutes before assisting him with toileting.

On 04/30/25 at 01:25 PM, interviewed Director of Nursing (DON) in his office. When asked if DON was notified for all R18's complaints and if formal investigation should have been completed, DON confirmed he met with R18 to discuss all his complaints, and formal investigation(s) should have been completed for all of them but had not.

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| F 550 | Continued From page 4<br>DON also stated R18 should be treated with respect and in a dignified manner.<br><br>Review of facility's policy and procedure titled, "Resident Rights" with a revision date of 04/18/24 stated, ". . .[the facility] will treat each resident with respect and dignity ... staff will knock, announce themselves, and provide reason for entry before entering ... staff will await resident approval prior to entry ... " | F 550 | | |
| F 558 SS=D | Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)<br><br>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to provide necessary assistance to help maintain functional mobility and independence on one of two sampled residents (Resident (R)18), for accommodation of needs. This deficient practice has the potential to affect all the residents at the facility.<br><br>Findings include:<br><br>Resident (R)18 is a 41-year-old male re-admitted to the facility on 02/04/25 for long-term care. R18's admitting diagnoses include, but are not limited to, hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) left non-dominant side. A review of R18's | F 558 | | |

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|---|---|---|---|---|
| F 558 | Continued From page 5 | F 558 | | |

Minimum Data Set (MDS) Admission Assessment with an Assessment Reference Date (ARD) of 03/12/25. The assessment indicated R18 had been assessed with a Brief Interview for Mental Status (BIMS) score of 15, indicating a determination that he was cognitively intact.

On 04/28/25 at 09:05 AM, observation and concurrent interview was done with R18 at his bedside. When asked about how often he gets out of his room to participate with any activities, R18 reported that he does not get to participate with activities as often as he wanted to due to his limited mobility. R18 stated staying in his room is not his preference and that on 12/07/24, he had requested the facility provide him with a one-arm-drive wheelchair so that he could safely and independently complete all his Activities of Daily Living (ADLs) including but not limited to grooming, dressing, and toileting throughout the day.

Record review of R18's Electronic Health Record (EHR) revealed a Physical Therapy evaluation dated 03/17/25 documented, ". . .Pt [patient/resident] requires wheelchair for functional mobility due to bilateral amputation ...Pt would have maximum independence with functional mobility with a one arm drive wheelchair. . ."

On 04/30/25 at 01:15 PM, concurrent interview and record review was done with the Social Services Coordinator (SS)1 at the dining area. When asked if the resident's request for a one-arm-drive wheelchair for functional mobility had been addressed, SS1 confirmed that the facility was still waiting for an update from the supplier since 12/07/24. Review of the EHR

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|---|---|---|---|---|
| F 558 | Continued From page 6 | F 558 | | |

revealed a Social Services note that documented, ". . . resident asked for a manual wheelchair to propel himself. This worker will f/u [follow-up]. . ."

On 04/30/25 at 01:25 PM, interviewed Director of Nursing (DON) in his office. DON confirmed that there was no documentation that a timely follow-up had been done.

Review of facility's policy and procedure titled, "Resident Rights" with a revision date of 04/18/24 stated, ". . . [residents] Have the right to meet with and participate in activities of social ... at their own discretion. . ."

F 561 SS=D — Self-Determination — F 561
CFR(s): 483.10(f)(1)-(3)(8)

§483.10(f) Self-determination.
The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.

§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.

§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.

§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the

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NAME OF PROVIDER OR SUPPLIER: **PALOLO CHINESE HOME**

STREET ADDRESS, CITY, STATE, ZIP CODE: **2459 10TH AVENUE, HONOLULU, HI 96816**

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|---|---|---|---|---|
| F 561 | | F 561 | | |

Continued From page 7
facility.

§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on observation, interviews, and record review, the facility failed to ensure the resident's right to choose aspects of the resident's life that are significant to the resident for two (Resident (R) 394 and R395) of two residents sampled. R394 prefers to brush her teeth in the morning, but staff regularly assist the resident in the afternoon. R395 receives hospice service and family reported not wanting the resident up in the wheelchair for more than 15-20 minutes (for meals) to allow the resident to rest in bed. As a result of this deficient practice, residents are at risk for more than minimal negative psychosocial and/or physical outcomes.

Findings include:

1) On 04/28/25 at 08:42 AM, conducted an interview with R394 in the resident's room. R394 reported her preference of brushing her teeth three times a day, when she wakes up and after each meal. However, at the facility, the resident waits long after she wakes up for staff to assist her with brushing her teeth. R394 stated at times she has brushed her teeth around lunch time, well after having breakfast and waking up, which makes the resident feel, "Yucky." R394 confirmed brushing her teeth in the morning is important to her.

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|---|---|---|---|---|
| F 561 | Continued From page 8 | F 561 | | |

Review of the facility task, activities of daily living, personal hygiene which included oral hygiene, revealed starting from 04/14/25 (date of admission) to 04/30/25, staff documented the resident brushing her teeth at 10:21 AM, 12:32 PM, 12:40 PM, 12:27 PM, 08:23 AM, 12:25 PM, 12:09 PM, 10:07 AM, 12:46 PM, 12:33 PM, 12:19 PM, 01:42 PM, 08:23 AM, 12:18 PM, 10:21 AM, and 12:31 PM.

On 04/30/25 at 11:53 PM, conducted an interview with the Director of Nursing (DON) regarding the time R394 is assisted with oral hygiene. DON reviewed the oral hygiene task and confirmed staff is assisting the resident in the afternoon most of the time and that is not aligned with R394's preferences.

2) On 04/28/25 at 08:24 AM, entered the Weinberg unit and observed R395 seated in a wheelchair at a table in the unit dining room until 10:40 AM. During this time the resident was observed sleeping periodically in the wheelchair at the table. During lunch observations at 11:15 AM to 11:50 AM, R395 was observed to still be in the wheelchair in the unit's dining room. Mentioned to Unit Clerk (UC)1 that R395 is still out in the wheelchair and UC1 confirmed it. At 01:19 PM, entered the unit and observed R395 in bed with two Family Members, (FM) 10 and FM 54, visiting. FM54 reported R395 had returned to bed about 10 minutes prior. FM54 reported R395 is unable to tolerate sitting in the wheelchair for long periods of time and the family thinks it's important for the resident to be resting in bed and not sleeping in the wheelchair. FM54 stated they told staff to not keep her (R395) in the wheelchair after breakfast, instead take the resident back to bed to rest.

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| F 561 | Continued From page 9<br><br>Conducted a telephone interview with R395's Resident Representative (RR) 7 on 04/28/25 at 01:18 PM. RR7 reported R395 is on hospice and has a weakened physical state, and is unable to tolerate sitting in the wheelchair for 20 minutes or longer. RR7 stated that family members have come into the facility and found the resident slumped forward while seated in the wheelchair. As a result of this, RR7 requested that R395 not be left seated in the wheelchair in the common area for more than 15-20 minutes.<br><br>On 04/30/25 at 12:05 PM, conducted an interview with DON. Informed DON of the observation of R395 up in the wheelchair for more than 20 minutes and sleeping in the wheelchair, which was not what RR7 and family members wanted for the resident. DON confirmed R395 should have been assisted back to bed when staff was done assisting the resident with her meal and prior to the resident being observed sleeping in the wheelchair. | F 561 | | |
| F 578<br>SS=D | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the | F 578 | | |

POC NOT FINAL

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| F 578 | Continued From page 10<br>requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.<br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.<br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to obtain a copy of the resident's Advance Health Care Directive (AHCD) and did not inform the resident of his/her right to develop one, provide assist in doing so, and/or periodically assess the residents' preference for formulating an AHCD for 2 of 2 residents (Residents (R) 46 and R12) sampled. This deficient practice does not allow residents, when incapacitated, the right to have their health care choices identified and | F 578 | | |

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|---|---|---|---|---|
| F 578 | Continued From page 11 | F 578 | | |

honored.

Findings include:

1) On 04/29/25 at 02:50 PM, review of R46's electronic health record (EHR) revealed a Social Services note dated 09/16/24 at 04:28 PM stating that Social Services to follow-up with hospice provider regarding R46's AHCD. Upon further review of R46's progress notes, no follow-up attempts to obtain the AHCD were documented.

On 04/30/25 at 01:42 PM, interviewed the Social Services Coordinator (SS) 1 in the Social Services office. SS1 confirmed there was no documented follow-up regarding obtaining the AHCD from the hospice provider. SS1 voiced that the Social Worker at the hospice provider is difficult to reach to inquire about the AHCD, but also stated that she could have contacted the visiting Nurse from the hospice provider.

2) On 04/29/25 at 07:51 AM, record review of the R12's Electronic Health Record (EHR) was completed. Advance Health Care Directive (AHCD) could not be found in the EHR.

On 04/30/25 at 01:00 PM, requested AHCD documentation from Director of Nursing (DON). No AHCD documentation was given this day.

On 05/01/25 at 08:16 AM, the facility provided Social Worker (SW)1's progress notes of the AHCD discussion with R12 on 03/05/25. The note details that resident continues to refuse AHCD and is not interested in further discussion. The note was a late entry and created by SW1 on 04/30/25.

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|---|---|---|---|
| | 125059 | A. BUILDING ______ B. WING ______ | 05/01/2025 |

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|---|---|---|---|---|
| F 578 | Continued From page 12 | F 578 | | |

On 05/01/25 at 08:31 AM, interview with SW1 completed. SW1 stated she forgot to document her discussion with R12 on 03/05/25 because she went on vacation. SW1 confirmed she was reminded this week from leadership to complete documentation. SW1 agreed that she should have documented after the discussion, or sooner than 04/30/25, but noted that they have been doing their best to keep up.

On 05/01/25 at 09:30 AM, interview with R12 completed. R12 stated that AHCD was discussed with him when he first came to the facility, but did not remember any discussion recently.

On 05/01/25 at 09:45 AM, a follow up interview with SW1, and Social Services Coordinator (SS)1 completed. When SW1 was asked to provide handwritten notes from the discussion with R12 on 03/5/25, SW1 responded, "I already shredded it today." SW1 noted she shredded her notes as it was her last day with facility, and she was in the process of cleaning up her work. When both SW1 and SSI were asked how often AHCD documentation should be completed, both stated that it should be done quarterly, and documented timely in the EHR. SW1 and SS1 also agreed that timely documentation in the EHR is extremely important because things can change over time, it is a running record of the resident's care, and it reflects the most updated status of the resident.

Review of the facility's "Advance Directive" policy, dated 01/30/19, in the "On-going Review" section, it notes, 1. "Quarterly, Social Service Coordinator will review with resident/resident representative regarding Advance Directive as preferences may change over time. For those that don't have an Advance Directive, Social Service Coordinator will

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|---|---|---|---|---|
| F 578 | Continued From page 13<br>discuss again the option for establishing and Advance Directive." | F 578 | | |
| F 584 SS=D | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature | F 584 | | |

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|---|---|---|---|
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|---|---|---|---|---|
| F 584 | Continued From page 14 | F 584 | | |

levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, and record review, the facility failed to ensure residents' environments were clean and homelike, as well as, protecting residents' personal property from loss, for two of four residents (Resident (R) 8 and R65) sampled for environment. A staff member did not dispose of soiled and dirty trash items properly, leaving it on top of R8's personal property in her room. This has the potential to cause unpleasant odors and an unsanitary environment. R65's personal lamp was removed from his room without explanation or follow-up. The facility did not exercise reasonable care for the protection of the resident's property from loss.

Findings include:

1) Cross reference to F880, Infection Prevention & Control. The facility failed to ensure R8's soiled incontinence bed pads were properly disposed of to decrease the risk of spreading infectious disease.

Review of R8's annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 02/04/25 found R8 with a score of 15 (cognitively intact) when the Brief Interview for Mental Status (BIMS) was administered.

On 04/29/25 at 08:33 AM, during observation and interview with R8, observed a used wrapped-up

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 584 | Continued From page 15 | F 584 | | |

incontinence item and used gloves on top of an opened bag that stored incontinence briefs, this was on top of R8's personal belongings (a green bag filled with other bags, arts and craft supplies, and a reusable bowl to microwave food placed inside a plastic bag). A trash bin was observed to be right next to it. Inquired of R8 what the item was and if she put it there, R8 used her reach grabber tool to pick up the item and stated she did not put that there and described the item as her dirty bed pad. R8 proceeded to throw the dirty bed pad into the trash bin and reported she did not know how long it had been there. R8 stated she was last changed this morning but saw the staff member take it out. R8 proceeded to report that agency staff sometimes don't do their job correctly like leave dirty things in her room and wondered where they get their training from.

On 04/30/25 at 11:38 AM, interview with Assistant Director of Nursing (ADON) and Infection Preventionist (IP) were done. IP reported after a staff member provides incontinence care, the dirty supplies should be disposed in a trash bag and if disposing the item in a resident's trash bin in the room it should be taken out of the room to reduce unpleasant smells.

Review of the facility's policy and procedure "Safe and Homelike Environment" dated 02/28/24 documented "General Consideration" to "Minimize odors by disposing of soiled linens promptly..."

2) Resident (R) 65 is a 69-year-old male, admitted to the facility on 04/22/24. A Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 01/28/25 noted that R65 had a Brief Interview for Mental Status

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|---|---|---|---|
| | 125059 | A. BUILDING ___ B. WING ___ | 05/01/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 584 | Continued From page 16 | F 584 | | |

(BIMS) score of 14, which indicated that R65 had intact cognitive function.

On 04/29/25 at 08:31 AM, interviewed R65 who stated that approximately three months ago, he had a personal black floor lamp and the top broke off. Maintenance took it and never brought it back. No replacement was offered, and R65 felt he needed more lighting in the room. R65 also stated he received no explanation by staff if the lamp was going to be fixed or that he could not keep it in his room.

On 04/30/25 at 11:31 AM, interviewed the Maintenance/Housekeeper Manager (MAINT) outside of the facility's Lehua Wing entrance. MAINT stated that he did not recall a floor lamp being removed from R65's room. MAINT stated if any resident's personal property is removed, it is put on the facility "TELS" work order program and the nursing staff will put a work order in.

On 04/30/25 at 11:38 AM, interviewed Registered Nurse (RN) 6 who stated that she remembered a broken floor lamp and maintenance was told to look at it.

On 04/30/25 at 03:31 PM, a follow-up interview with MAINT was done who confirmed that he could not locate a work order for R65's lamp and the maintenance staff could not recall R65's lamp being removed from his room.

On 05/01/25 at 08:12 AM, interviewed the Assistant Director of Nursing (ADON) in the Activity room. ADON stated that she was made aware that the lamp maybe fell over when staff was providing care. The base and stand were flimsy and had broken. R65 was okay with the

POC NOT FINAL

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 584 | Continued From page 17<br>lamp being removed but was unsure if his consent for removal and explanation for removal was documented.<br><br>On 05/01/25 at 08:29 AM, Interviewed SS1 in the Social Services office. SS1 stated that she was told by the ADON that R65's lamp was in the MDS office and was taken out of his room for safety purposes because it was a tripping hazard, it was shaky, and the facility did not want the electrical outlet to be overloaded.<br><br>On 05/01/25 at 08:48 AM, a black lamp was observed in the MDS office, and a picture was taken.<br><br>On 05/01/25 at 08:51 AM, R65 confirmed the picture of the black lamp was his personal lamp that was taken out his room.<br><br>On 05/01/25 at 11:59 AM, ADON stated that no documentation could be found regarding R65 providing consent for the lamp to be removed from his room or explanation given to R65 for the reason it was being removed. | F 584 | | |
| F 641<br>SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure a resident's comprehensive assessment accurately reflected the resident's status at the time the assessment was completed for one of seven residents (Resident (R) 293) | F 641 | | |

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|---|---|---|---|
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|---|---|
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|---|---|---|---|---|
| F 641 | Continued From page 18 | F 641 | | |

reviewed for falls. Staff members were utilizing the bed/chair alarm as an intervention for falls and it was not reflected in the assessment under restraint. This deficient practice put R293 at risk of an inaccurate assessment of the bed/chair alarm and its appropriateness as an intervention.

Findings include:

Cross reference to F689, Accidents. The facility failed to ensure R293 was free from accidents and hazards. R293 was admitted to the facility with history of recurrent falls and sustained a fracture to her left femur (thigh bone) that required surgery due to an unwitnessed fall at the facility. Upon re-admission, post-fall with major injury, new interventions were not developed and R293 had two more unwitnessed falls at the facility prior to her discharge.

Review of the completed facility report incident (FRI) received by the State Agency (SA) on 08/19/24, documented on 08/12/24 at 06:15 AM, prior to R293's fall with major injury that resulted in fracture to her left femur, the assigned night shift Certified Nurse Aide (CNA) documented, " ...performed a visual check on resident. Without any restlessness observed, and clip [bed/chair] alarm was in place."

Review of R293's care plan found the intervention for bed/chair alarm was not included in the care plan as an intervention to prevent falls until 10/26/24, after R293's second fall. The care plan documented, "The resident uses (SPECIFY: chair/bed) electronic alarm. Ensure the device in in place as needed," initiated on 10/26/24.

Review of R293's progress notes documented

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 641 | Continued From page 19<br>the use of a clip or bed alarm after 08/12/24, 10/26/24, and 11/10/24 falls.<br><br>Review of R293's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 08/22/24 under Section P. Restraints, bed alarm and chair alarms were noted to not be in use.<br><br>On 05/01/25 at 09:19 AM, an interview and concurrent record review with Director of Nursing (DON) was done. DON reported that there was no task area for staff to document whether clip bed/chair alarms were in place when nursing rounds are done. DON reviewed the "MDS Initial Review," by the MDS coordinator, dated 08/19/24 for the quarterly MDS with an ARD of 08/22/24, and during the assessment the bed alarm and chair alarm were not observed to be used. DON stated the MDS coordinator would need to review the progress notes to get an accurate reflection. Upon concurrent review of the progress notes, DON confirmed from 08/16/24 to 08/23/24, during the assessment seven-day look-back, the progress notes documented the clip bed/chair alarms were used. Based on the documentation provided by the progress notes, DON confirmed bed and chair alarm should have been included in the quarterly MDS assessment. | F 641 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§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 | F 656 | | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PALOLO CHINESE HOME** | **2459 10TH AVENUE HONOLULU, HI 96816** |

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|---|---|---|---|---|
| F 656 | Continued From page 20<br>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 -<br>(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<br>(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).<br>(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.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(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.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed. | F 656 | | |

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|---|---|---|---|
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|---|---|---|---|---|
| F 656 | Continued From page 21 | F 656 | | |

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility did not ensure the development and implementation of a comprehensive person-centered care plan for two (Residents (R)30 and R56) of 22 sampled residents. As a result of this deficient practice, residents were placed at risk for decline in their quality of life, and were prevented from attaining their highest practicable physical, mental, and psychosocial well-being.

Findings include:

1) On 04/29/25 at 02:31 PM, conducted a record review of R30's Electronic Health Record (EHR). Review of physician orders documented an order for "Insulin Glargine- Subcutaneous [under the skin] Solution Pen-injector 100 UNIT/ML [milliliter] Inject as per sliding scale [dose is titrated depending on blood glucose result]: if 200 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 600 = 10 units > [if greater than] 400 give 10 units and notify MD [physician] and NP [nurse practitioner], subcutaneously in the morning for DM [diabetes]." Review of R30's comprehensive care plan revealed a care plan was not developed for the use of insulin.

On 04/30/25 at 11:40 PM, conducted a concurrent interview and record review of R30's EHR with the Director of Nursing (DON). DON reviewed R30's physician orders and confirmed R30 has an order to receive a sliding scale dose of Insulin Glargine. DON reviewed R30's comprehensive care plan and confirmed a care plan was not developed for R30's use of insulin.

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|---|---|---|---|---|
| F 656 | Continued From page 22 | F 656 | | |

Review of the facility's policy for baseline, comprehensive, and discharge care plans revealed the following documented: a comprehensive care plan will reflect the resident's stated goals, objectives, and include interventions that address his/her current needs by the nurse observing the needs. The Interdisciplinary team will conduct a care plan meeting to review the comprehensive care plan with the resident/resident representative which should include: Measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment.

2) On 04/28/25, 04/29/25, and 04/30/25 observed R56 comfortably lying in bed with Oxygen (O2) at 4 liters per minute via nasal cannula.

On 04/30/25 at 01:11 PM, interviewed Licensed Practical Nurse (LPN)1 at the nurse's station. During a concurrent review of R56's comprehensive care plan, when asked if R56's Plan of Care included any respiratory care, LPN1 confirmed it did not include/address any respiratory care evaluation(s), including but not limited to, oxygen administration.

On 04/30/25 at 01:28 PM, concurrent interview and record review with the Director of Nursing (DON) was done in his office. DON reviewed R56's physician orders and confirmed R56 had an order to receive oxygen. When asked if R56's comprehensive care plan was developed to include R56's respiratory care, DON confirmed it was not.

On 04/30/25 at 01:46 PM, conducted a record

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| F 656 | Continued From page 23<br>review of R56's Electronic Health Record (EHR). R56 was admitted to the facility on 03/03/25 with diagnoses including, but not limited to, vascular dementia, moderate, with other behavioral disturbance. An order was made on 03/04/25 at 01:44 PM, written by the Assistant Director of Nursing (ADON), ". . . Oxygen at 2 Liters/Minute PRN [as needed] via nasal prong [cannula] or 02 mask. Titrate oxygen up to 5 Liters/Minute to keep 02 saturation >93%. Notify MD [physician] if resident is requiring more than 2 Liters/Minute of oxygen and/or is requiring routine oxygen. . ." Review of R56's admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 03/09/25, Section J. Health Conditions, noted, ". . .Other Health Conditions. . . J1100. Shortness of Breath" (dyspnea) documented R56 does not have any shortness of breath or trouble breathing. Review of the R56's comprehensive person-centered care plan with a revision date of 04/15/25, noted it did not include the resident's respiratory care including the administration of oxygen.<br><br>The facility's policy titled, "Oxygen Administration," with a revised date of 04/09/25, stated, ". . . 4. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as. . . b. When to administer, such as continuous or intermittent. . . c. Equipment setting for the prescribed flow rates. . . e. Monitoring for complications associated with the use of oxygen. . ." | F 656 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans | F 657 | | |

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| | 125059 | A. BUILDING ______ B. WING ______ | 05/01/2025 |

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| F 657 | Continued From page 24<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(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.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interviews, and record review, the facility failed to revise the comprehensive person-centered care plan for one of seven residents (Resident (R) 293) reviewed for falls, and one of one resident (R12) sampled for urinary catheters. R293's care plan did not include new interventions for falls after sustaining a fall with major injury. As a result, R293 experienced additional falls that may have been avoided. By not revising R12's care plan to include urinary catheter care, R12 was placed at | F 657 | | |

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| F 657 | Continued From page 25<br>risk for adverse catheter-related issues.<br><br>Findings include:<br><br>1) Cross reference to F689, Accidents. The facility failed to ensure R293 was free from accidents and hazards. R293 was admitted to the facility with history of recurrent falls and sustained a fracture to left femur (thigh bone) that required surgery due to an unwitnessed fall at the facility. Upon re-admission, post-fall with major injury, new interventions were not developed and R293 had two more unwitnessed falls at the facility prior to discharge.<br><br>Review of the completed facility reported incident (FRI) received by the State Agency (SA) on 08/19/24, documented R293's fall with major injury that resulted in fracture to left femur on 08/12/24. The facility documented under interventions implemented in the report, "Upon readmission, resident will continue with current fall interventions: Bed in lowest position, fall mat, clip alarm, and bed sensor alarm in place. Consider positioning alarms out of reach i.e. [for example] head of bed behind headboard as not to be tampered with. Staff to continue frequent checks to anticipate and meet needs."<br><br>Review of R293's care plan found bed in lowest position, fall mat, clip alarm, bed sensor alarm in place, and/or positioning alarm out of reach not included in the care plan after readmission on 08/16/24.<br><br>On 05/01/25 at 09:19 AM, an interview and concurrent record review with Director of Nursing (DON) was done. Concurrent review of R293's care plan, DON stated the typical interventions | F 657 | | |

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| F 657 | Continued From page 26 | F 657 | | |

were in place, such as, "...call light within reach, ensure wearing appropriate footwear, toilet before and after meals, at bedtime and in the morning..." at were in place at admission prior to the incident on 08/12/24. Inquired after readmission, what new interventions were in place, DON confirmed there were no new interventions and the interventions in the care plan were already in place. DON further confirmed the interventions listed in the FRI were not documented in the care plan and new interventions should have been in place after the fall with major injury on 08/12/24.

Review of the progress notes documented R293 had two subsequent falls after 08/12/24, on 10/26/24 and 11/10/24.

Review of the facility's "Fall Prevention Policy and Procedure" included, if a resident falls, nursing to review and update care plan.

2) On 04/28/25 at 01:05 PM, observed R12 with an indwelling urinary catheter. Concurrent interview with R12 noted that he had the catheter for over a month. Record review noted that resident had the catheter reinserted on 03/16/25. Physician's orders showed catheter care to be done every shift. Review of R12's care plan revealed it was not revised to include goals and interventions for catheter care after it was reinserted on 03/16/25.

On 04/30/25 at 09:00 AM, interview with Registered Nurse (RN)8 completed. RN8 confirmed that care plan was not revised to include catheter care. RN8 also agreed that keeping care plan current is important as it shows what type of care the resident needs.

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| F 657 | Continued From page 27<br>On 04/30/25 at 10:00 AM, interview with Director of Nursing (DON) confirmed that catheter care should have been included in R12's care plan. DON also agreed that the care plan is important as it reflects the current needs of the resident and to ensure that appropriate interventions are taken.<br><br>Review of the facility's "Baseline, Comprehensive, and Discharge Care Plan" policy, revised on 12/06/24, in the "Procedure" section, it notes, 10."Changes will be made as necessary, resulting from significant changes in condition or needs ..." | F 657 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure two of seven residents (Resident (R) 293 and R29) reviewed for falls were free from accident hazards. R293, whom previously had a fall with major injury (a fracture to the left thigh bone that required surgery), had no new interventions care planned for falls, then had a subsequent fall putting R293 at risk for further injuries. R29 was inappropriately transferred via 1-person manual transfer instead of a 2-person mechanical lift, and as a result suffered a fall with a fracture to her right ankle. | F 689 | | |

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| F 689 | Continued From page 28 | F 689 | | |

Findings include:

1) R293 was admitted to the facility on 05/09/24 for skilled nursing with admitting diagnoses of closed distal phalanx (toe) fracture to the right foot, first digit, dementia related to Alzheimer's disease, repeated falls, and osteoarthritis (when the flexible, protective tissue at the ends of bones, called cartilage, wears down) to bilateral knees.

Review of R293's discharge summary from the hospital, prior to admittance to the facility, revealed that in the history and physical section, the resident had been documented with a history of falls and "...admitted with a fall with resultant R [right] foot pain found to have fracture of R 1st distal phalanx." "Recurrent falls-seem mechanical. She lost her balance - wasn't using her walker and walking on a windy day and fell ...There does remain a concern for hypoglycemia [low blood sugar] or hypotension [low blood pressure] since she lives alone and with her memory impairment there is possibility of medications errors leading on to falls."

Review of the completed facility reported incident (FRI) received by the State Agency (SA) on 08/19/24, documented R293's fall with major injury that resulted in fracture to left femur (thigh bone) on 08/12/24. "On 08/12/24 at 6:20am [sic] at shift change between Night Shift and Day Shift, CNA [Certified Nurse Aide] ...was standing in the hall when he heard a garbage can falling to the floor in resident's room. Upon going to check on resident, CNA observed resident in fetal position on her left side by foot of the bed, not on the fall mat ...Resident was admitted ...Surgery planned

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| F 689 | Continued From page 29<br>on 08/13/24." The facility documented under interventions implemented in the report, "Upon readmission, resident will continue with current fall interventions: Bed in lowest position, fall mat, clip alarm, and bed sensor alarm in place. Consider positioning alarms out of reach i.e. [for example] head of bed behind headboard as not to be tampered with. Staff to continue frequent checks to anticipate and meet needs."<br><br>Review of R293's care plan found bed in lowest position, fall mat, clip alarm, bed sensor alarm in place, and/or positioning alarms out of reach not included in the care plan after readmission on 08/16/24. (Cross reference to F657, Revision of Care Plan)<br><br>Review of the progress notes documented R293 had two subsequent falls after 08/12/24, on 10/26/24 and 11/20/24. On 10/26/24, "During medication pass at 05:30AM [sic], CNA alerted this writer that resident was found on the floor next to her bed. This writer rushed to the resident's room and found resident on the floor with head at end of bed. Resident found with brief soiled with fecesand [sic] urine. When asked what happened resident repeated, "shee shee, shee shee." Meaning she wanted to use the toilet. This writer performed nursing assessment and took resident's vitals. Resident noted with small bump to L [left] side of head. No other injuries noted." A follow-up entry on 10/26/24 was completed as a late entry, "Call light was not on at time of writer entering room Call light was in reach when resident found. Fall mat found against wall - unsure when or who moves fall mat. House keeping moves fall mats - interventions added to care plan to ensure bed alarm and fall mat are in place." On 11/10/24, | F 689 | | |

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| F 689 | | F 689 | | |

Continued From page 30

"RN [Registered Nurse] notified by CNA that patient [R293] was found to be sitting on the floor at the End of the patients bed. RN went in to assess patient. Patient sitting on the floor. Bed alarm didn't sound off, patient alarm tested and working, patient clip alarm was off the patient. No head injury noted. Vitals taken, Patient denied pain ...Patient stated she tried to go to the bathroom."

On 05/01/25 at 09:19 AM, an interview with Director of Nursing (DON) was done. During a concurrent review of R293's care plan, DON stated the typical interventions were in place, such as, "...call light within reach, ensure wearing appropriate footwear, toilet before and after meals, at bedtime and in the morning..." that were in place at admission prior to the incident on 08/12/24. Inquired after readmission, what new interventions were added, DON confirmed there were no new interventions and that the interventions in the care plan were already in place. DON further confirmed the interventions listed in the FRI were not documented in the care plan. Although the facility planned to use fall mats, DON confirmed the fall mats were not implemented on 10/26/24 and were only documented in the care plan after the incident. For the incident on 11/10/24, DON confirmed the clip alarm was not on R293 and it was documented she could remove it, DON could not confirm if the intervention listed in the FRI to consider "...positioning alarms out of reach ..." was implemented.

2) On 10/03/24 at 12:47 PM, the State Agency (SA) received a facility-reported incident (FRI) for ASPEN Complaints/Incidents Tracking System (ACTS) #11247, documenting a fall with major

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| F 689 | Continued From page 31 | F 689 | | |

injury (fracture of the right ankle) for Resident (R)29. On 04/28/25, the SA entered the facility to investigate the incident.

R29 is an 86-year-old female admitted to the facility on 09/19/20 for long-term care. A review of R29's most recent Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 03/18/25 noted a Brief Interview for Mental Status (BIMS) score of 15 out of 15, reflecting a determination that she is cognitively intact. R29's diagnoses include, but are not limited to, quadriplegia C5-C7 incomplete (weakness or paralysis in both arms), generalized muscle weakness, contracture (a shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of the right hand, and contracture of muscle of the left hand.

On 04/28/25 at 10:30 AM, an interview was done with R29 at her bedside. When asked about her fall on 10/02/24, R29 stated that Certified Nurse Aide (CNA)33 was transferring her from the bed to a shower chair and she "just crumbled." R29 also stated that staff had transferred her "many times before with only one person."

On 04/28/25 at 02:42 PM, an interview was done with CNA33 in the staff dining room. When asked about the incident, CNA33 stated, "I was not given proper report on this resident [R29]." CNA33 explained that she had never been assigned to R29 before, when her assignment suddenly changed to R29 "at the last minute." CNA33 further explained that usually she will receive a verbal report from the previously assigned CNA, but they were both so busy at the time that the only information she received from

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| F 689 | Continued From page 32<br>the off-going CNA was that R29 needed a shower. CNA33 acknowledged that since she was not familiar with R29, she "should have checked the Kardex [CNA care plan]." At the time of the incident, CNA33 stated that she "knew about the Kardex, but I didn't know how to access it." CNA33 stated R29 started to fall as soon as she got her up off the bed. When asked about the ankle fracture, CNA33 stated "I heard a crack [as R29 fell]," so she was not surprised to learn that R29 had a major injury.<br><br>On 04/30/25 at 09:17 AM, an interview was done with the Director of Nursing (DON) in his office. During a concurrent review of her electronic health record (EHR), DON confirmed that R29 had been a 2-person mechanical lift transfer since 2020, and that this information was reflected in the Kardex. DON also confirmed that CNA33 should have checked the Kardex before transferring a resident she was not familiar with. | F 689 | | |
| F 726 SS=D | Competent Nursing Staff<br>CFR(s): 483.35(a)(3)(4)(c)<br><br>§483.35 Nursing Services<br>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 §483.71.<br><br>§483.35(a)(3) The facility must ensure that | F 726 | | |

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| F 726 | | F 726 | | |

Continued From page 33

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 interview and record review, the facility failed to ensure staff competency in completing Fall Risk Evaluations accurately for 3 of 7 residents (Residents (R)293, R294, and R28) sampled for falls. This deficient practice placed the affected residents at risk of avoidable adverse outcomes.

Findings include:

1) Cross reference to F689, Accidents. The facility failed to ensure Resident (R)293 was free from accidents and hazards. R293 was admitted to the facility with history of recurrent falls and sustained a fracture to left femur that required surgery due to an unwitnessed fall at the facility. Upon re-admission, post-fall with major injury, new interventions were not developed and R293 had two more unwitnessed falls at the facility prior to discharge.

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| F 726 | Continued From page 34<br>Review of R293's fall risk assessments instruct a total score of 10 or higher indicates the resident is a high risk of fall. R293's assessments concluded a score of 13 during the admission fall risk assessment on 05/09/24, a score of 11 on 08/11/24, a score of 21 upon readmission on 08/16/24, and a score of 17 on 10/26/24. On 11/11/24, after the third fall on 11/10/24, the assessment had a score of six, much lower than previous scores. Review of the 11/11/24 assessment was noted to be incomplete in "Gait/Balance" and "Medications" and completed by Registered Nurse (RN)4.<br><br>On 05/01/25 at 09:19 AM, an interview and concurrent record review with Director of Nursing (DON) was done. DON confirmed the 11/11/24 fall risk assessment was incomplete and did not accurately reflect R293's status.<br><br>2) Review of R294's progress notes document he had an unwitnessed fall on 04/05/25. R294 was found at approximately 02:40 AM, on the " ...left side laying next to his bed with head ...facing the end of his bed. Resident reports he was attempting to use restroom. Did not use call light, Denies head injury."<br><br>Review of R294's fall risk assessments instruct a total score of 10 or higher indicates the resident is a high risk of fall. R294's admission fall risk assessment concluded a score of 12 on 04/02/24. On 04/05/25, after R294's fall, the assessment had a score of 10, lower than the previous score. A review of the 04/05/25 assessment was noted to be incomplete in "Gait/Balance" and "Medications."<br><br>3) On 03/17/25 at 03:44 PM, the State Agency | F 726 | | |

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| | 125059 | A. BUILDING ______ B. WING ______ | 05/01/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PALOLO CHINESE HOME | 2459 10TH AVENUE HONOLULU, HI 96816 |

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|---|---|---|---|---|
| F 726 | Continued From page 35<br>(SA) received a facility-reported incident (FRI) for ASPEN Complaints/Incidents Tracking System (ACTS) #11578, documenting a fall with major injury (fracture of a left rib) for Resident (R)28 on 03/14/25. On 04/28/25, the SA entered the facility to investigate the incident. Review of R28's electronic health record (EHR) revealed that R28 had another unwitnessed fall (without injury) on 03/27/25.<br><br>Further review of R28's EHR noted the following Fall Risk Evaluations (and their results):<br><br>On 03/13/25 at 04:30 PM, prior to the falls, an assessed score of 16, with a "Score 10 or higher indicated the resident is at high risk of fall."<br><br>On 03/14/25 at 11:00 PM, after the fall with major injury (FMI), an assessed score of 14.<br><br>On 03/18/25 at 12:38 PM, after the FMI, an assessed score of 14.<br><br>On 03/27/25 at 08:59 AM, after the second fall, an assessed score of 2, indicating a low risk for falls. This Fall Risk Evaluation was marked as completed by Registered Nurse (RN)16.<br><br>On 04/30/25 at 09:38 AM an interview was done with the Director of Nursing (DON) in his office. During a concurrent review of R28's Fall Risk Evaluations, DON confirmed that he does expect licensed staff to question when fall risk evaluation scores are vastly different from previous scores, and/or do not match the resident. DON agreed that RN16 should have questioned a fall risk evaluation score of 2 for R28 and that she had "completed" the form improperly. | F 726 | | |

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|---|---|---|---|---|
| F 726 | Continued From page 36<br>On 05/01/25 at 10:15 AM a second interview was done with DON in his office. DON confirmed that RN16's current assignment is as the "day shift Charge Nurse," and she should have known how to complete a fall risk evaluation accurately. | F 726 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interviews, and review of facility's medication administration policy, the facility failed to keep medications secured for one | F 761 | | |

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| F 761 | Continued From page 37 of twelve residents (Resident (R), 69) observed during medication administration. This deficient practice has the potential to affect all residents in the facility taking medications.<br><br>Findings include:<br><br>On 04/30/25 at 08:00 AM, observed Registered Nurse (RN)16 during medication administration for R69. RN16 walked out of the room to get correct size glove, leaving multiple medications on R69's bedside table unattended and accessible to anyone who could have entered R69's room. Concurrent interview with RN16 noted that she should not have left medications out of her sight as anyone could have taken the medications and R69 could have taken the wrong dose. RN16 agreed that it is also for safety reasons.<br><br>On 4/30/25 at 10:00 AM, interview with Director of Nursing (DON) completed. DON confirmed that RN16 should not have left the medications unattended for safety reasons.<br><br>Review of the facility's "Medication Administration" policy, dated 01/23/07, in the "Procedure" section, it notes, 10." Administer medication and remain with resident while medication is swallowed. Do not leave medication in a resident's room without orders to do so ..." | F 761 | | |
| F 803 SS=D | Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)<br><br>§483.60(c) Menus and nutritional adequacy. Menus must- | F 803 | | |

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|---|---|---|---|---|
| F 803 | Continued From page 38 | F 803 | | |

§483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;

§483.60(c)(2) Be prepared in advance;

§483.60(c)(3) Be followed;

§483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;

§483.60(c)(5) Be updated periodically;

§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and

§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure a resident's menu with selected food choice was followed for one of two residents (Resident (R) 66) sampled for food preferences. The facility did not follow-up/communicate with R66's food choice after identifying the selection may have an ingredient he is allergic to, and did not give R66 the opportunity to choose what he wanted to eat. As a result, R66 received a meal that was not listed on the menu provided in advance that he did not want to eat, causing the resident confusion.

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|---|---|---|---|---|
| F 803 | Continued From page 39 | F 803 | | |

Findings include:

On 04/28/25 at 11:17 AM, during lunch dining observation, observed R66 sitting in the dining room with two other residents (R35 and an unidentified resident). R66 had his meal tray on his table and was confused on what was on his plate. The other two residents did not receive their meal tray at this time. He asked R35 what was on his plate for lunch and R35 was observed to take a look at the meal ticket on R66's plate, and stated it was chicken, rice, and cauliflower. R35 explained to R66 that the meal ticket indicated his lunch was supposed to be beef tomato, but it was crossed out and chicken was written on it, and his vegetable was supposed to be bean sprouts, but it was crossed out and cauliflower had been written on instead. R66 stated he did not want chicken and wanted the beef tomato, and that he does not like cauliflower, but likes bean sprouts.

On 04/28/25 at 11:21 AM, inquired of R66 if he had concerns with his lunch provided, R66 reported he did not know why they crossed out beef tomato on his meal ticket and gave him chicken and rice and that he does not like cauliflower but was supposed to have bean sprouts. While explaining his concern, Recreation Aide (RA) 1 suddenly removed R66's meal tray without informing him and R66 asked where he was taking his lunch. RA1 stated he was going to get R66 something else. Registered Dietician (RD) was then observed to approach R66 to find out what was going on and stated she will go ask what happened with the kitchen.

On 04/28/25 at 11:48 AM, observed R66 eating a sandwich. R66 stated they got him a roast beef

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|---|---|---|---|---|
| F 803 | Continued From page 40 | F 803 | | |

sandwich and was told by a staff member that they did not serve him the beef tomato because he is allergic to pineapple, and they put pineapple in the sauce. No one had approached R66 prior to lunch to inform him that the beef tomato had pineapple in it, and if he wanted to change his selection. R66 stated "I only ordered the chicken once over here" and that he was not interested in eating chicken at this time. R66 stated they get a weekly menu and he circles the items he wants to eat ahead of time, and it is posted on his bedroom wall.

Review of the menu posted in R66's room with his circled preference(s) was done for week 04/27/25 to 05/03/25. The lunch menu for 04/28/25 included the options of beef tomato, mediterranean turkey burger with tater tots, roast beef sandwich, or chef salad. The menu further documented the regular entrée items are served with rice or mashed potatoes, bean sprout salad, Italian vegetable mix, and mandarin oranges. R66 had circled beef tomato, rice and mandarin oranges.

On 04/28/25 at 12:01 AM, an interview with RD was done. RD confirmed the kitchen used pineapple in the beef tomato and R66 is allergic. She stated the other choice was turkey burger but R66 is allergic to turkey, so the kitchen staff decided to give him chicken. RD further confirmed that no one approached R66 prior to serving his lunch to inform him that his choice was not available due to his allergies and did not attempt to inform him of other options to choose from.

Review of a progress note dated 04/29/25 documented "late entry 4/28/25 1200pm: res

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|---|---|---|---|---|
| F 803 | Continued From page 41<br>[R66] selected the beef tomato for lunch. Res did not receive the beef tomato due to his pineapple allergy which is in the teriyaki sauce used in the beef tomato. The alternative entrée was turkey which res is also allergic to. Res was given chicken instead since res does eat chicken. Writer was notified after investigating ..., writer explained to res that due to the allergy, res did not receive the beef tomato. Res stated he preferred to have the roast beef sandwich instead so writer went to the kitchen and brought the roast beef sandwich immediately. Res did eat the sandwich and tolerated well." | F 803 | | |
| F 805<br>SS=D | Food in Form to Meet Individual Needs<br>CFR(s): 483.60(d)(3)<br><br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(3) Food prepared in a form designed to meet individual needs.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to provide food in the consistency ordered by the physician to meet the needs of 2 of 2 residents (Resident (R) 13 and R69) sampled for appropriate preparation of food. This deficient practice increases the risk of aspiration for residents who have a modified consistency diet order for dysphagia (difficulty swallowing).<br><br>Findings include:<br><br>1) On 04/28/25 at 11:31 AM, observation of R13's meal ticket noted it stated diet as chopped, regular diet with thin liquids. Observation of the | F 805 | | |

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|---|---|---|---|---|

F 805 | F 805

Continued From page 42
beef tomato entrée on his meal tray noted the tomato was not chopped, and the beef and vegetables were of varying sizes. The Infection Prevention Coordinator (IP) was asked to make a concurrent observation and confirm if the beef tomato entrée was an appropriately chopped consistency. IP responded that it depended on the consistency of the food item and that the tomato was not chopped because it was soft.

On 04/28/24 at 11:43 AM, Certified Nurse Aide (CNA) 31 was asked to make a concurrent observation and confirm if the beef tomato entrée was an appropriately chopped consistency. CNA31 stated that chopped consistency should be less than one inch by one inch in size and confirmed some of the beef and vegetables were bigger than that.

On 04/28/24 at 11:45 AM, Certified Nurse Aide (CNA) 45 stated that chopped consistency is "coleslaw size." When asked to make a concurrent observation, CNA45 confirmed that not all the meat and vegetables for R13's beef tomato entrée were appropriately chopped.

On 04/30/25 at 11:12 AM, observation of R13's lunch tray was done, and the bean sprouts were full-sized and not chopped. Interviewed Certified Nurse Aide (CNA) 19 who confirmed that the bean sprouts were not chopped and stated that her reference for a chopped consistency is sugar cube sized, and bigger than minced.

2) On 04/28/25, observation of R69's meal ticket revealed it documented his/her diet as chopped, consistent carbohydrate with thin liquids. The following two observations of food items not appropriately chopped and inconsistent in size

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|---|---|---|---|---|

F 805 — Continued From page 43 — F 805

were made:

On 04/28/25, observed lunch tray with varying sizes of beef and vegetables for beef tomato entrée.

On 04/30/25, observed breakfast tray with varying sizes of food items. Sausage patty was cut into sugar cube sized pieces, but waffle was cut into silver dollar sized pieces.

On 05/01/25 at 08:02 AM, interviewed the Executive Chef (EC) who stated that the facility's definition for chopped consistency is bite-sized. When asked to define bite-sized, EC stated there is no reference size for chopped consistency because each individual food item will be different.

Review of the Complete IDDSI (International Dysphagia Diet Standardization Initiative) Framework Detailed definitions 2.0 | 2019, found at https://www.iddsi.org/, noted the following definition of bite-sized: "Adults, 15 mm = 1.5 cm pieces (no larger than)."

F 812 SS=D — Food Procurement,Store/Prepare/Serve-Sanitary — F 812

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

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|---|---|---|---|---|
| F 812 | Continued From page 44 | F 812 | | |

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 and interviews, the facility failed to check the refrigerator temperature for one of five refrigerators in the kitchen for two consecutive days on the evening shift. This deficient practice puts resident at risk for foodborne illness.

Findings include:

On 04/28/25 at 08:00 AM, initial walkthrough of the kitchen completed. Observed the temperature log for refrigerator #10 was missing "PM" temperature readings and initials for 04/25/25-4/26/25. Concurrent interview with Executive Chef (EC) noted that he was not sure why it was missed. EC also stated that it might be due to the new system implemented since he started.

On 04/30/25 at 10:00 AM, interview with Director of Nursing (DON) confirmed that refrigerator temperature settings should be checked every day on both the AM and PM shifts to ensure avoiding food spoilage.

On 04/30/25 at 11:30 AM, follow up interview with EC confirmed that temperatures should be checked every day on both AM and PM shifts to

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|---|---|---|---|---|
| F 812 | Continued From page 45<br>prevent any food spoilage and resident illness. | F 812 | | |
| F 880<br>SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions | F 880 | | |

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|---|---|---|---|---|
| F 880 | Continued From page 46<br>to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure a resident's (Resident (R) 8) soiled incontinence item and dirty gloves were properly disposed of, and a staff member used appropriate personal protective equipment (PPE) for a resident (R84) under enhanced barrier precautions (EBP) for one of four units (Unit W) observed for infection control. | F 880 | | |

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|---|---|---|---|---|
| F 880 | Continued From page 47 | F 880 | | |

Continued From page 47

These deficient practices increase the risk of the development and transmission of communicable diseases and infections which may affect the health and safety of residents, staff, and visitors.

Findings include:

1) Cross reference to F584, Clean Homelike Environment. The facility failed to ensure a soiled incontinence bed pad was discarded appropriately, the item was placed on R8's personal belongings and visible for visitors to see which had the potential to cause unpleasant odor and an unsanitary environment.

On 04/30/25 at 11:38 AM, interview with Assistant Director of Nursing (ADON) and Infection Preventionist (IP) were done. IP reported after a staff member provides incontinence care the dirty supplies should be disposed in a trash bag and if disposing the item in a resident's trash bin in the room it should be taken out of the room. IP confirmed the incontinence brief bag, gloves, and bed pad would be considered dirty and are infection control concerns when left on and touching a resident's personal items.

Review of the facility's policy and procedure "Infectious Waste Management" dated 02/22, documented to prevent occupational exposure to infectious waste, "Solid disposable diapers and underpads are securely wrapped in a plastic bag and discarded as regular trash."

2) On 04/28/25 at 08:31 AM, during an initial observation of Unit W, observed an EBP sign posted on R84's room door with blue painter's tape, on the top of the sign that specified R84's room number and bed was under precautions.

POC NOT FINAL

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 125059 | A. BUILDING ____ B. WING ____ | 05/01/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PALOLO CHINESE HOME | 2459 10TH AVENUE HONOLULU, HI 96816 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 48<br>The sign instructed for those providing direct care or close contact to wear a surgical mask, gloves, and gown.<br><br>At 08:39 AM, during observation of R84's room, R84 was not in her room but the bathroom door was observed to be closed and the sound of running water from the shower was heard. Certified Nurse Aide (CNA) 16 was observed to come out of the bathroom wearing gloves and a surgical mask but did not have a gown on. Inquired if she was showering R84, CNA16 confirmed she was then proceeded to look at the EBP sign on the door. CNA16 mumbled "they said it's okay now ...they said its okay ..." then was observed to walk to Registered Nurse (RN) 13 and then walk back to R84's room, donned instructed PPEs for EBP, and continued to return to R84 in the bathroom.<br><br>At 08:46 AM, an interview with RN13 was done. RN13 reported R84 had a skin rash on her arms and on her right upper back. Her arms were cleared by the physician but they were not sure about her right upper back and so she was put on EBP. RN13 confirmed CNA16 should have had a gown on when showering R84.<br><br>Review of R84's Electronic Health Record (EHR) found in the dermatologist's physician progress note, R84 was seen on 04/21/25 due to a rash that had been present for three weeks. Upon examination, it was noted R84 had erythematous crusted papules with severe excoriation (redness, raised bumps, and a crusty, often raw appearance, potentially caused by scratching or rubbing) distributed on the right upper arm, left upper arm, and right upper back. Diagnoses included dermatitis unspecified: "Drug Eruption | F 880 | | |

POC NOT FINAL

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 125059 | A. BUILDING ______ B. WING ______ | 05/01/2025 |

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|---|---|
| PALOLO CHINESE HOME | 2459 10TH AVENUE HONOLULU, HI 96816 |

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|---|---|---|---|---|
| F 880 | Continued From page 49<br>vs. [versus] Allergic Contact Dermatitis vs Scabies vs Atopic Dermatitis." Under physician orders, R84 was prescribed Valtrex oral tablet one gram (GM), give one tablet by mouth three times a day for shingles for seven days, started on 04/26/25 and to end on 05/03/25. Review of progress notes documented R84 was monitored and receiving treatment for rash and on 04/26/25 was put on contact isolation for possible shingles. On 04/28/25 at 05:29 AM, a progress note documented "Shingles - left arm appears improved, resident denies pain to the arm but states it feels a little itchy." At 07:14 AM, an RN noted, the physician visited the resident and " ...assessed skin and noted pustules to left forearm were gone ...ordered to discontinue Contact/Airborne Precautions." At 09:16 AM the Infection Preventionist (IP) noted the physician " ...ok to discontinue Contact, EBP, and Airborne precautions due to shingles no longer active."<br><br>On 04/30/25 at 11:40 AM, interview with Assistant Director of Nursing (ADON) and Infection Preventionist (IP) were done. IP reported when a resident is under EBP and direct care such as dressing, grooming, and showering, the PPEs, gown, gloves and surgical masks, should be donned. IP further reported when a resident is taken off transmission-based precautions (TBP), housekeeping will first deep clean the room and the resident's status will be discussed prior to taking the sign down.<br><br>On 04/30/25 at 11:54 AM, second interview with RN13 was done. RN13 reported on 04/28/25 at approximately 07:00 AM, after she assessed R84's skin to be crusted or scabbed she informed the physician while he was doing his onsite rounds if contact precautions could be | F 880 | | |

POC NOT FINAL

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 125059 | A. BUILDING ______ B. WING ______ | 05/01/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PALOLO CHINESE HOME** | **2459 10TH AVENUE HONOLULU, HI 96816** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 50<br>discontinued. The physician agreed to discontinue contact precautions, but it was decided to put her on EBP because she still had a rash, to protect R84 and others. Two hours after the physician discontinued contact precautions, another nursing staff called the physician and all precautions were discontinued. Inquired if EBP was activate on 04/28/25 when we first interviewed and observed CNA16 not wearing a gown while showering R84, RN13 confirmed it was still activate. | F 880 | | |