STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125014	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Retirement Residence	1434 Punahou Street Honolulu, HI 96822

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48351 Based on interview and record review, the facility failed to provide information of the risks and benefits of using psychotropic medications to three out of five sampled residents (Resident (R) 29, R63, and R46). This deficient practice has the potential to negatively affect the residents wellbeing and has the potential to affect all the residents in the facility on psychotropic medications. Findings Include: 1) R29 is an [AGE] year-old male admitted to the facility on [DATE]. R29 has a medical history that includes, but not limited to, dementia with psychotic disturbance, Parkinson's disease, and generalized anxiety disorder. On 10/03/24, a review of R29's Electronic Health Record (EHR) noted that R29 had a medication order for antidepressant since 05/30/24. There was no documentation found in R29's EHR that noted a facility consent form was provided to R29 or R29's representative that went over the risks and benefits of using the antidepressant medication. Interview was conducted with the Administrator on 10/04/24 at 11:23 AM. The Administrator stated that the facility usually has the resident or the representative sign a consent form prior to treatment with psychotropic medications. The Administrator confirmed that R29 and or his representative did not sign a consent prior to the use of antidepressant. 2) R63 is a [AGE] year-old female admitted to the facility on [DATE]. R63 has a medical history that includes, but not limited to, Alzheimer's disease, dementia with behavioral disturbances, and generalized anxiety. On 10/03/24, a review of R63's EHR noted that R63 had medication orders for an antipsychotic since 01/04/24 and an antidepressant since 12/23/23. There was no documentation found in R63's EHR that noted a facility consent form was provided to R63 or R63's representative that went over the risks and benefits of using antipsychotic and antidepressant medications. Interview was conducted with the Administrator on 10/04/24 at 11:23 AM. The Administrator stated that the facility usually has the resident or the representative sign a consent form prior to treatment with psychotropic medications. The Administrator confirmed that R63 or her representative did not sign a consent prior to the use of antidepressant and antipsychotic medications. (continued on next page)

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.

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	37954 3) R46 is a [AGE] year old male admitted to the facility on [DATE]. R46 has a medical history that includes, but not limited to, unspecified dementia, unspecified severity, with mood disturbance, and depression, unspecified. On 10/04/24 a review of R46's EHR revealed R46 had a medication order for an antidepressant since 09/06/24 and an antipsychotic since 07/03/24. There was no documentation found for R46's facility consent form for an antipsychotic and an incomplete facility consent form was found for R46's antidepressant. On 10/04/24 at 09:02 AM requested copies of R46's informed consents for his antidepressant and antipsychotic medications from the Administrator. On 10/04/24 at 11:05 AM interviewed Administrator who provided a copy of R46's antidepressant consent form which she confirmed was not fully filled out, it did not include a check mark for the type of medication with the list of side effects and indication for use. Administrator confirmed the resident or their representative should have been given a consent form fully filled out prior to signing and prior to taking the medications.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39754 Based on record review, staff interview and review of policy on Advance Health Care Directives (AHCD), the facility failed to ensure that the code status was consistent with the AHCD for one Resident (R)51 of two residents sampled. As a result of this deficient practice, there was the potential for R51 to receive unnecessary Cardiopulmonary Resuscitation (CPR). Findings include: Review of the Electronic Health Record (EHR), on [DATE], showed R51 was admitted on [DATE] with diagnosis including Supranuclear Opthalmoplegia (unable to move eyes at will in all directions), Chronic Kidney Disease, Alzheimer's, Dementia, and High Cholesterol. A doctor's order, dated [DATE] read Full Code, Active which was not what R51 wanted according to the AHCD. Review of R51's AHCD instructions for health care, on [DATE] at 10:10 AM, showed the following choice; to not prolong life if the following is present: an incurable and irreversible condition that will result in my death within a relatively short time, I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, the likely risks and burdens of treatment would outweigh the expected benefits. Review of R51's AHCD, Provider Orders for Life-Sustaining Treatment (POLST), on [DATE] at 10:20 AM, also showed the choice; Do Not Attempt Resuscitation (DNAR). On [DATE] at 10:05 AM, Social Worker (SW)1 was queried about R51's current code status and acknowledged that it was not consistent with the AHCD. SW1 stated that they will follow up and make the necessary correction. On [DATE] review of facility policy on Advance Directives and POLST read: Purpose, to encourage all residents to complete an Advance Directive and POLST form. Procedure, upon entry to Arcadia, residents are encouraged to submit an Advance Directive and POLST. Social Services verifies whether the resident would like to change or update the Advance Directive and/or POLST during admission and annually. Assistance will be offered if needed. The POLST form is placed in the resident chart. The Medical Records Department will scan the documents into the resident's electronic medical record. In the event of an emergency, or in case of transfer to the hospital, a copy of the POLST, Advance Directive and other necessary information from the resident's record will be sent with the resident to the acute care facility.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48351 Based on record review and interview, the facility failed to revise one of 18 sampled residents (Resident (R) 63) care plan after she sustained two falls. This deficient practice places R63 at risk for future falls and may affect all the residents in the facility who have fallen. Findings Include: A review of R63's Electronic Health Record (EHR) was conducted on 10/02/24. R63's EHR noted that she had a fall on 07/26/24 and 09/03/24. A review of R63's care plan did not contain new interventions that were implemented after her fall on 07/26/24 and 09/03/24. Interview was conducted with the Director of Nursing (DON) on 10/04/24 at 08:23 AM in his office. DON reviewed R63's care plan and confirmed that new interventions should have been placed in the care plan after R63's two falls. A review of the facility policy titled, Falls, dated 02/08/24 was conducted on 10/03/24. The policy noted, The IDT [Interdisciplinary Team] will meet the next business day to review falls, do a root cause analysis, follow-up actions with further recommendations when indicated and update care plan. A review of the facility policy titled, Fall Charting Protocol, dated 12/04/23 was conducted on 10/03/24. The policy noted, The resident's care plan will be updated with appropriate interventions following each fall including assessment of adequate supervision and measures for prevention of subsequent falls.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39754 Based on observations and staff interview, the facility did not follow proper sanitation practices in the kitchen. As a result of this deficiency, there was an increase risk for foodborne illness and an increase risk for hazards such as a fire. Findings include: 1)During observation of the kitchen on 10/01/24 at 08:00 AM, the area between the stoves appeared dirty and not cleaned. The area had crumpled paper, dirty plastic bags, dirty napkins, and dirty paper bowls. Staff interview, on 10/01/24 at 08:05 AM, Kitchen Supervisor (KSupvr) acknowledged that the area previously mentioned was dirty and not cleaned. KSupvr said they will have the area cleaned and addressed for future cleaning services. 48351 2)Observation was conducted on 10/03/24 at 07:52 AM in one of the unit kitchens. A metal pan was observed filled with condiments and sauces. The metal pan contained a large container of creamy peanut butter labeled, Best if Used by August 31, 2024. The pan also contained yellow mustard labeled, Best by date of July 16, 2024. Interview was conducted with the night shift Licensed Practical Nurse (LPN)10 on 10/03/24 at 07:54 AM in the kitchen. LPN10 was shown the creamy peanut butter and yellow mustard. LPN10 confirmed that the two food items should have been discarded. 3)Observation was conducted on 10/03/24 at 08:23 AM in one of the unit kitchen's refrigerators. The refrigerator contained a bottle of cranberry juice with an expiration date of 08/22/24. Interview was conducted with the night shift LPN11. LPN11 was shown the cranberry juice bottle, and LPN11 confirmed that it should have been discarded. A review of the facility policy titled, Food Brought by Family/Visitors, dated 09/19/2024, was conducted on 10/04/24. The policy noted, The nursing staff is responsible for discarding perishable food on or before the use by date .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 37954 Based on observations, record review and interview the facility failed to correctly identify on Resident (R)13's Care Plan (CP) that she would be residing with her husband in a shared room. The deficient practice could affect all residents in the facility who are residing in a shared room with their husband or wife if they are not correctly identified as so. Findings Include: On 10/01/24 at 11:14 AM observed R46 sleeping in his bed and observed R13 resting in her bed in the shared room, each on their own side of the room. On 10/02/24 at 11:25 AM while observing lunch delivery to resident rooms observed R46 in his bed resting and R13 in her bed resting in their shared room. During record review on 10/04/24 found R13 had a CP with a Psychosocial Management/ Well-being problem with the following Resident is pleasant and easy to engage into conversation. Resident may not initiate conversations and seems to be more on the quiet side. Resident husband has also moved into HCC but per resident and family request, they will not be moved in to a shared room together. On 10/04/24 at 02:33 PM interviewed Administrator who stated resident's husband has documented on his CP that he and his wife would be in shared room and provided an email from the Power of Attorney (POA) stating the two residents would be in a shared room. Administrator confirmed R13's CP was not updated to reflect this.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 39754 Based on observations, staff interview and review of policy, the facility failed to secure an electrical panel on the third-floor nursing unit. As a result of this deficiency, the facility put the safety and well-being of the residents as well as the public at risk for accident hazards. Findings include: During an observation of the third-floor nursing unit on 10/02/24 at 09:20 AM, one electrical panel was not secured. The padlock was not latched on and there was no staff in the immediate vicinity to prevent any residents and/or visitors from accessing the panel. Staff interview on 10/02/24 at 09:30 AM, Maint Staff 2 acknowledged that the electrical panel is supposed to be secured and the door should have been locked. Review of policy on Control of Hazardous Energy (Lockout/Tagout) read the following: Policy, company adheres to a strict Control of Hazardous Energy Policy (Lock-Out/Tag-Out). Purpose, to ensure the health and safety of staff and residents in compliance with State and Federal Laws and regulations . Definitions, lockout is the physical placement of a lock on an energy isolating device. The device must physically prevent the release or transmission of energy. The lock must be facility issued, must be uniform for the facility, and must indicate the identity of the person who applied the lock . Procedure, company will ensure that new or overhauled equipment can accommodate locks, lockout/tagout will be placed only by an authorized person of the Environmental Services Department. The Lockout/Tagout can be released only by the same authorized person who locks/tags out the equipment and/or power. Locks or tags must be uniform and standardized, must be durable, must not be used for any other purpose . An annual inspection of the Lockout/Tagout program will be conducted to ensure the procedures are being followed and are effective. The authorized supervisory and management staff will document and confirm that the inspections have been performed . Machinery and equipment covered by the Lockout/Tagout program include but not limited to the following: Any electrical circuit breaker .