STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl City Nursing Home	919 Lehua Avenue Pearl City, HI 96782

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 39754 Based on record review, staff interview and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, Minimum Data Set (MDS), the facility in-accurately coded Restraint use for Resident (R)33 of three residents sampled. As a result of this deficiency, the facility put R33 at risk for further RAI, MDS inaccuracy. Findings include: During review of R33's most recent MDS, Assessment Reference Date 03/15/24, Section P0100 Physical Restraints was coded as Used daily. Review of R33's care plan revealed the use of bed rail for bed mobility and not as a restraint. During staff interview on 04/24/24 at 09:20 AM, MDS Coordinator (MDS1) acknowledged that R33 was in-accurately coded for Restraint use. MDS1 stated that they would do the necessary correction. Review of the Long-Term Care Facility RAI 3.0 User's Manual read the following: The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20(b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status . In addition, an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations . As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48351 Based on interviews and record reviews, the facility failed to include one of the sampled resident's (Resident (R) 89) representatives in developing and implementing a comprehensive, person-centered care plan. Findings Include: R89 is a [AGE] year-old male admitted to the facility on [DATE]. R89 has a medical history that includes, but not limited to, nontraumatic intracranial hemorrhage, chronic respiratory failure, and persistent vegetative state. Interview was conducted with R89's family representative on 04/22/24 at 12:04 PM in R89's room. R89's family representative stated that she does not remember having a meeting with the facility's Interdisciplinary Team (IDT) since R89's admission to the facility. She also added that it would be great if they had a meeting to discuss his plan of care. Interview and record review was conducted on 04/23/24 at 01:03 PM with Social Worker (SW). SW stated that she could not find any IDT documentation in R89's Electronic Health Records (EHR). Interview with the Director of Nursing (DON) was conducted on 04/24/24 at 12:37 PM. DON stated that the facility's process was to notify the family members about the IDT meetings and send them an invitation. The normal process did not happen for R89 and his family representatives. The facility's policy titled, Care Plans, Comprehensive Person-Centered, with a revised date of March 2022, documented, 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representatives, develops and implements a comprehensive, person-centered care plan for each resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47783 Based on observation and interview, the facility failed to ensure one of the 24 residents (Resident (R) 220) in the sample received care and treatment in accordance with professional standards of practice. The intravenous (IV) solution bag and lines were being used past the specified discard date. This deficient practice has the potential to affect all residents at the facility that require IV therapy. Findings include: On 04/22/24 at 09:27 AM during the initial observation, R220 was lying supine in bed and reading some papers. R220 had an IV pole on the side of his bed with a one liter bag of IV fluids being infused via pump. Date written on the IV bag was 04/18/24 and the label on the lines had a start date and time of 04/18/24, 2330 (11:30 PM) and a discard date and time of 04/21/24, 2330. On 04/22/24 at 01:53 PM, an interview was conducted with R220's Family Member (FM) at bedside. FM said the IV bag was hung and infusion started when R220 was admitted on [DATE]. The same IV bag and lines observed earlier in the day were still being used during the interview. On 04/23/24 at 09:56 AM, observed a new set IV bag and lines were being used. Label stated start date and time as 04/23/24, 0830 (08:30 AM) and discard date and time as 04/26/24, 0830. On 04/24/24 at 02:29 PM, an interview was conducted with the Director of Nursing (DON) by the fourth-floor nurses' station. Shared with DON the observations made on 04/22/24 during the initial observation and interview with FM. DON confirmed that the IV bag and lines being used at that time should have been changed the night before, on 04/21/24.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 39754 Based on observation, staff interview and review of manufacturer product description, the facility failed to identify a potential electrical accident hazard for one Resident (R)42 of eight residents reviewed. As a result of this deficient practice, the facility put the safety and well-being of all the residents as well as the public at risk for accident hazards. Findings include: During an observation of R42's room on 04/22/24 at 11:30 AM, a medical device; Air Mattress machine was plugged in to a power strip, then the power strip was plugged in to the wall electrical outlet. During a second observation of R42's room on 04/23/24 at 09:50 AM, the findings were the same as previously described on 04/22/24. Staff interview on 04/23/24 at 10:00 AM, Environmental Services Coordinator (ESC) acknowledged that the medical device; Air Mattress machine should not have been plugged in to the power strip. ESC said that the identified power strip was intended for the television or cell phone and not medical devices. ESC said they will move the medical device plug to the appropriate wall electrical outlet. Review of manufacturer product description read 6-in-1 multi-function power strip can quickly charge mobile phone, tablet computer, other electronic devices .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 47783 Based on observations and interviews, the facility failed to ensure that one of the residents (Resident (R) 46) in the sample that had a urinary catheter received the appropriate treatment and services to prevent urinary tract infections. The deficient practice exposed the resident to contaminants that may cause preventable urinary tract infections and has the potential to affect all residents with a urinary catheter. Findings include: On 04/22/24 at 08:46 AM during the initial observations, R46 was lying supine in bed with head elevated. R46 had a suprapubic catheter (medical device that is inserted into the bladder through an incision in the abdomen to drain urine from the bladder) draining into a collection bag that was in a cloth privacy cover hung on the right side of the bed. The collection bag was touching the floor. During observations on 04/22/24 at 11:50 AM and 04/23/24 at 01:48 PM, catheter bag was again touching the floor. On 04/23/24 at 02:41 PM, concurrent observation and interview done with Registered Nurse (RN) 3 in R46's room. Showed RN3 the catheter bag hanging on the right side of the bed and was touching the floor. RN3 confirmed that the bag was not supposed to be coming in contact with the floor and asked another staff member to move it. On 04/24/24 at 02:25 PM, an interview was conducted with the Director of Nursing (DON) by the fourth-floor nurses' station. DON said the privacy cover acts as a barrier between the collection bag and the floor. Pointed out that the privacy cover is made from cloth and could get wet if left on the floor. DON agreed that if the bag gets wet, there is a potential for the transmission of pathogens (organisms that can cause diseases).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48351 Based on observation, interviews, and facility policy review, the facility failed to store food items under sanitary conditions. This failed practice could place one resident at risk for food-borne illness. Findings Include: Observation was conducted on 04/22/24 at 09:45 AM on the fourth-floor recreation room. The recreation room housed a refrigerator for residents' food items. The refrigerator contained five containers filled with a resident's food items brought in by his/her visitors. The five containers all had a sticker labeled, Use by date, 04/19/24. Interview was conducted with Registered Nurse (RN) 10. RN10 was shown the five food items belonging to a resident. RN10 stated that it should have been thrown away on 04/19/24. Interview was conducted with the Food Service Manager (FSM) on 04/23/24 at 10:55 AM. FSM stated that the diet aids or nursing staff should have discarded the resident's food items on or before 04/19/24. Facility policy titled, Foods Brought by Family/Visitors, with a revise date of March 2022, was reviewed. The policy documented, 6. The nursing staff will discard perishable foods 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. 47783 Based on record review and interviews, the facility failed to maintain accurate medical records for one of the 24 sampled residents (Resident (R) 46) in accordance with accepted professional standards and practices. This deficient practice has the potential to affect medical care provided to all the residents in the facility. Findings include: On 04/22/24 at 08:46 AM, observed R46 lying supine in bed with head elevated. R46 had a urinary catheter bag hanging on the right side of her bed that was touching the floor. On 04/23/24 at 08:29 AM, review of R46's Electronic Health Records (EHR) was conducted. Under Progress Notes, the nurse documented . Catheter in place to prevent soiling of stage 3 or 4 pressure ulcer. on the following dates: 04/23/24 at 02:14 AM; 04/19/24 at 02:57 AM; 04/18/24 at 02:07 AM; 04/12/24 at 01:58 AM; 04/09/24 at 01:58 AM; and 03/28/24 at 01:45 AM. On 04/24/24 at 12:50 PM, a concurrent interview and record review was conducted with Nurse Supervisor (NS) 1 at the fourth-floor nurses' station. NS1 confirmed that R46 does not have any pressure ulcer or pressure injury. Asked NS1 to review the progress notes for the dates mentioned above. NS1 stated that the documented reason why R46 has a urinary catheter was not accurate and said she will speak to the nurse.