STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ka Punawai Ola	91-575 Farrington Highway Kapolei, HI 96707

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on observation, interview, and record review, the facility failed to identify, support, and honor one Resident's (Resident 32) preference to be informed of a time range that rehabilitation therapy services would occur. As a result of this deficient practice, R32 did not have her needs met and was placed at risk of not attaining her highest practicable well-being. This deficient practice has the potential to affect all the residents at the facility receiving therapy services. Findings include: Resident (R)32 is a [AGE] year-old female admitted to the facility on [DATE] for short-term rehabilitation therapy (therapy) following a fall with resulting fractures. R32's admitting diagnoses include, but are not limited to, fractures of her hip and pelvis with surgical intervention, hypertension (high blood pressure), anxiety, insomnia, constipation, and urinary retention. Review of R32's Minimum Data Set (MDS) Admission Assessment with an Assessment Reference Date (ARD) of 03/11/24 noted that R32 was evaluated as having a score of 14 out of 15 for her Brief Interview for Mental Status exam, reflecting a determination of cognitively intact. On 04/24/24 at 11:07 AM, an interview was done with R32 at her bedside. R32 complained that she never knows when therapy will be. She thought she was supposed to have therapy in the morning, but it had not occurred yet. R32 stated that she does not like waiting the whole day. She likes to prepare herself for therapy and wants the ability to plan her day. R32 explained that her grandson wanted to visit in the afternoon, and she did not want to cut the visit short because of therapy. R32 stated that she had asked the therapists repeatedly to give her a time range of when they would visit, but they have not honored her request. On 04/25/24 at 09:05 AM, observed a therapy slip (piece of paper) at R32's bedside indicating that she was scheduled for physical (PT), occupational (OT), and speech therapy (ST). R32 stated that she gets the therapy slips every morning that let her know what type of therapy was scheduled for the day, but I don't know when [what time of day], that's bad! R32 complained again that she would like to know a time range of when therapy would occur, especially when there were multiple types of therapy scheduled for the day. R32 explained that in addition to being able to plan her day with regards to visits and activities, she would like to be able to request pain medications prior to PT, now that she was doing more. It would be nice to be able to do that [pre-medicate]. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/25/24 at 02:31 PM, an interview was done with the Director of Rehab [rehabilitation] (DOR) in the Conference Room. The DOR explained that the therapy schedules are printed the afternoon or evening before and provided to the nursing staff. The night shift nursing staff then make the therapy slips for the following day. When asked about R32 specifically, DOR agreed that she was aware that R32 preferred a set routine regarding the schedule and confirmed that the therapy staff do not schedule residents for specific times or time blocks.

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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** 37954 Based on record review and interview the facility failed to follow-up and ensure residents were informed of their right to develop an advance health care directive (AHCD); or periodically reassessed in his/her decision-making capacity to do such according to State Law, for four of ten residents sampled (Resident (R) 2, R16. R40 and R7). As a result of this deficient practice, the residents were placed at risk of not having their wishes honored for future health care decisions, should they become incapacitated. Findings include: 1) On 04/24/24 at 09:55 AM during record review of R2's Electronic Health Record (EHR), R2's advanced health care directive was not found. R2 is a [AGE] year-old resident who was admitted to the facility on [DATE]. Review of R2's Care Plan (CP) found she has a Focus identified as DISCHARGE PLAN: Resident's Name wishes to discharge home after therapy is completed. Code Status: DNR (Do Not Resuscitate), Comfort measures only, No artificial nutrition by tube. Advanced Directives: Resident's Name (R2) has a completed POA (Power of Attorney) which first representative as daughter's name (daughter) and secondary representative as son's name (son). This problem was initiated on 02/21/23 and revised on 03/23/23. Review of R2's last quarterly Minimum Data Set (MDS) dated [DATE] found she had a Brief Interview for Mental Status (BIMS) with a score of 15 out of 15 identifying her as cognitively intact. On 04/25/24 at 04:10 PM met with and interviewed Social Worker (SW) who provided a copy of R2's POA and found it was for financial powers. SW confirmed the POA is for finances only. SW also provided a copy of the Declaration of Authority to Act As A Surrogate form. The front page of this facility form was filled out and the back was left blank. The back part of this form is filled out by the physician which identifies the resident as not having capacity to make their own healthcare decisions. SW explained facility uses the Declaration of Authority to Act As A Surrogate form internally for residents to fill out with resident identifying who will make healthcare decisions for them if they cannot. SW stated residents either cannot afford or refuse to do the AHCD when it is offered instead choose to use the Declaration of Authority to Act As A Surrogate form. R2 is cognizant and has not been identified by her physician as being incapacitated. Requested SW to provide documentation she met with R2 to discuss AHCD as a follow up. On 04/26/24 at 09:42 AM interviewed SW who was unable to provide any documentation of follow up regarding a meeting to discuss R2's options for AHCD. 2) On 04/23/24 at 03:03 PM reviewed R16's hard medical record for AHCD and none was found. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/24/24 at 10:05 AM during record review of R16's EHR R16's AHCD was not found. R16 is a [AGE] year old resident who was admitted to the facility on [DATE]. Review of R16's CP found he had a Focus identified as DISCHARGE PLAN: Mr. Resident's Last Name wishes to remain in the facility as ICF level. Code Status: Full Code which included the following: Advanced Directives: Mr. Resident's Last Name reported resident's Aunt's first name, Aunty, has copy of AHCD and she is listed as the first agent. KPO surrogate formed [sic.] completed by R16's Aunt's name (Aunty). This problem was initiated on 12/19/2022 and revised on 01/23/2024. Review of R16's last quarterly MDS dated [DATE] found he had a BIMS with a score of 15 out of 15 identifying him as cognitively intact. On 04/25/24 at 04:24 PM interviewed SW, who had provided a copy of R16's AHCD. Review of R16's AHCD found it was not filled out completely, was not signed by two witnesses or notarized when he signed it on 7/10/19. SW confirmed R16's AHCD was not fully filled out and she stated she would ask R16's Aunt for a copy of his AHCD if she has a copy that is fully filled out as she is the person named as his decision maker for healthcare. On 04/26/24 at 09:44 AM interviewed SW who stated she met with R16's Aunt on 04/25/24. R16's Aunt did not have a fully filled out copy of R16's AHCD. SW stated she provided a blank copy of the AHCD and R16's Aunt was receptive to have two witnesses come to the facility to sign the document when the resident fills out this form. 3) On 04/24/24 at 10:30 AM reviewed R40's EHR and hard medical record for AHCD and none was found. R40 is an [AGE] year old resident admitted to the facility on [DATE]. Review of R40's EHR found his diagnosis includes, but is not limited to, vascular dementia, unspecified severity, with agitation. Review of R40's last quarterly MDS dated [DATE] found he had a BIMS with a score of 00 out of 15 identifying him with severe impairment. On 04/26/24 at 09:30 AM met with and interviewed SW who was able to provide a copy of R40's POA which is only for financial. SW confirmed R40 did not have an AHCD. Reviewed copy of Declaration of Authority to Act As A Surrogate form which the front is only completed, back of the form, which the physician would fill out to state resident does not have capacity, is not filled out. SW confirmed R40's copy of Declaration of Authority to Act As A Surrogate form was not fully filled out with the back of the form left blank. SW confirmed there is no documentation the physician was asked to fill out the form. 43414 4) R7 is an [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of, but not limited, to vascular dementia. During R7's stay she was hospitalized twice on 03/04/24 and 03/21/24. On 04/25/24 at 10:56 AM, review of R7's electronic health record (EHR) found no copy of her AHCD. The EHR included a progress note documenting on 01/25/24, Resident has a Hawaii Advanced Health Care Directive/Power of Attorney, she [daughter] will provide copy once found. Copy of Power of Attorney (POA) documentation was not found in the EHR. No further follow-up was found. On 04/26/24 at 09:43 AM, an interview with Social Worker (SW) was done. SW confirmed the facility does not have a copy of R7's AHCD or POA and did not follow-up with R7's daughter to receive a copy. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure Advanced Directives and Advance Care Planning under resident transfers, .If the resident leaves the facility temporarily (e.g., ER visit, hospital stay, or diagnostic procedure), a copy of the advance directive is sent with the resident .Each time the resident is admitted to the facility, quarterly, and when a change in condition is noted in the resident condition, the facility should review the advance directive and advance care planning information.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43414 Based on observation, interview, and record review, the facility failed to provide a clean, comfortable and homelike environment, as evidenced by uncomfortable temperatures in Resident (R) 283's and R284's room(s), and splatters on the kitchen ceiling. In addition, the facility failed to exercise reasonable care for the protection of one resident's clothing from loss, as evidenced by Resident (R)32's complaint that so many of her clothing pieces were not returned to her from laundry that she now had her family doing her laundry. This deficient practice has the potential to affect all the residents at the facility. Findings include: 1) On 04/23/24 at 09:39 AM, made observation of R283 and R284 in their room. R283 was observed to have at least four blankets covering her with a blanket covering her head. R284 was observed sleeping covered with two blankets up to her neck. The blow of the cold air conditioner could be felt when entering the room. The thermostat read 71 degrees Fahrenheit (F). On 04/23/24 at 12:43 PM, observation and interview with R283 and R284 was done in their room. Observed the air conditioner to be off. R283 reported she seems to be always cold, especially at night and early morning. It gets so cold she covers her face and uses multiple blankets. During the day, currently, it is usually comfortable. R284 concurred the room gets very cold during the night and in the early morning. On 04/24/24 at 11:03 AM, made observation of R283 and R284's room. R283 was not in her room, but R284 was sleeping with two blankets covering her from neck to toes. The blow of the cold air conditioner could be felt when entering the room. The thermostat read 71 degrees F. On 04/25/24 at 08:42 AM, observation and interview with R283 and R284 was done in their room. Observed the air conditioner to be off. R283 reported she believes a staff member turns on the air conditioner when providing assistance to them because it is too hot for the staff member, but then does not turn it off, making the room very cold at times. R284 reported she does not mind having the air conditioner on but wants it at a comfortable temperature and not blasting cold air. R284 stated 76 degrees would probably be more comfortable. On 04/25/24 at 01:46 PM, an interview with Certified Nursing Aide (CNA) 31 was done. CNA31 stated R283 and R284's will report the room is cold to her and had noticed R283 blankets covered all the way to her head. On 04/25/24 at 01:48 PM, an interview with Registered Nurse (RN) 12 was done. RN12 reported R283 and R284 will complain if the temperature is too cold and had to turn it down for them yesterday. RN12 noticed R283 wears a lot of blankets. Review of the facility's policy and procedure Resident Rights reviewed on 09/25/23, 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 safety. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) On 04/23/24 at 08:06 AM, during the initial observation of the facility's kitchen with Food Service Director (FSD), observed multiple, various sized light brown splatters, some as big as a quarter, on the ceiling around the speaker in the kitchen. Inquired with FSD what the splatters were, FSD reported he did not know but called someone to clean it this morning. On 04/25/24 at 11:51 AM, a second observation of the kitchen was done. Observed the splatters from the ceiling to be cleaned. Inquired with a dietary staff member, how long had the splatters been there. The dietary staff member stated, a couple of months and someone had been called to help clean the splatters after this surveyor pointed it out on 04/23/24. Inquired with Registered Dietician (RD) 1, the kitchen cleaning schedule, concurrently observed the cleaning schedule on the bulletin board with weeks not completely signed off. The cleaning schedule did not include cleaning the ceiling, inquired with RD1 if maintenance is responsible for cleaning the ceilings if there are food splatters, RD1 reported it would be dietary staff. Review of the facility's policy and procedure Cleaning Schedule reviewed on 04/25/23, The Director of Food and Nutrition Services develops a cleaning schedule, with assistance from the Registered Dietician, to ensure that the Food and Nutrition Services department remains clean and sanitary at all times. 43245 3) Resident (R)32 is a [AGE] year-old female admitted to the facility on [DATE] for short-term rehabilitation therapy (therapy) following a fall with resulting fractures. R32's admitting diagnoses include, but are not limited to, fractures of her hip and pelvis with surgical intervention, hypertension (high blood pressure), anxiety, insomnia, constipation, and urinary retention. Review of R32's Minimum Data Set (MDS) Admission Assessment with an Assessment Reference Date (ARD) of 03/11/24 noted that R32 was evaluated as having a score of 14 out of 15 for her Brief Interview for Mental Status exam, reflecting a determination of cognitively intact. On 04/24/24 at 10:57 AM, and interview was done with R32 at her bedside. R32 stated that when she was first admitted , the facility would wash her clothes for her. She quickly realized that several articles of clothing were not returned to her. When she reported it to facility staff, she was told that she or a family member could go to the laundry room and look through the missing clothes kept there. R32 stated that her daughter had gone to look a couple times but never found her missing items, so now her daughter takes all her clothes home to wash. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/26/24 at 01:22 PM, an interview was done with the Housekeeping Director (HD) in the laundry room. HD explained that residents are instructed to label their own clothing. Sometimes the facility staff may assist residents with labeling their clothes. When asked to show a sample of a properly labeled clothing item, HD provided Surveyor with a woman's top that had the resident's name written in faded black ink on the inside behind the neck area. HD confirmed they recommend using a black permanent marker for labeling. When asked about the process, HD reported that if clothes are 'unlabeled [with a name]', they are placed with the 'missing laundry.' HD explained that missing laundry is placed on a large metal cart, both hanging and folded, of clothing and linen, kept in the back of the laundry room. HD stated that the items stay on the cart for 3 months, then if unclaimed, they are donated to the facility. HD further explained that when a resident says they have missing laundry, laundry staff check the missing laundry cart for the missing items. If the missing items are not on the cart, they let the resident know and invite the resident or family to come in and look for themselves. HD reported that he does not keep track of or log which residents were missing laundry, or what their missing items were. On 04/26/24 at 02:45 PM, an interview was done with the Social Worker (SW) in the Conference Room. When asked about what process is followed when a resident reports missing laundry, SW explained that usually it is a Certified Nurse Aide (CNA) that gets report of missing laundry. The CNA then would notify nursing staff and the unit managers (UMs), and they would look for the missing items. If not located, the Director of Nursing (DON) or UM would notify SW. SW stated she would then investigate the missing item(s) and document the incident on a blue comment card. If it is appropriate to replace the missing items, SW would be responsible for that. SW stated she could not recall being notified that R32 was missing laundry and confirmed that she did not fill out nor did she see a blue comment card for her. A review of the facility policy and procedure, Closet Search - Lost and Unmarked Clothing, last revised 09/24/21, revealed the following: 1. A concern and comment form [blue comment card] should be completed, as appropriate, and turned into the Environmental Services Director [HD] or Social Services [SW] . 2. Using the description given for the lost article of clothing, the Laundry Department will go to each room and search through every closet. Of note is HD seemed unaware of a closet search and only described checking the missing laundry cart when interviewed by the Surveyor.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 42160 Based on interviews and record reviews, the facility failed to ensure written notification of discharge was provided to the resident or resident representative as soon as practicable before transferred or discharged and send a copy of that notice to a representative of the Office of the State Long-Term Care Ombudsman for three Residents ((R)25, R7, and R29) sampled. Findings include: 1) Conducted a review of R25's EHR on 04/23/24 at 10:28 AM which documented R25 was transferred and admitted to an acute hospital, twice, on 01/01/24 to 02/21/24 and 02/24/24 to 03/05/24. Review of the R25's EHR did not contain documentation of a written notification. Requested the Administrator provide documentation of the written notification to R25's resident representative and the Office of the State Long-Term Care Ombudsman for both times R25 was transferred to an acute hospital. On 04/25/24 at 04:15 PM, the Administrator provided an email which documented an email was sent to R25's resident representative on 02/26/24, two days after the resident was discharged to an acute hospital. Administrator confirmed no written notification was sent to R25's resident representative when R25 was discharged to an acute hospital on 01/01/24 and no notice was provided to the Office of the State Long-Term Care Ombudsman for both discharges. 43414 2) R7 was transferred and admitted to the hospital twice on 03/04/24 to 03/06/24 and 03/21/24 to 03/25/24 with diagnosis of stroke. A review of R7's Electronic Health Record (EHR) found no documentation that a written notification for transfer to the hospital was provided to R7 or her representative for both hospitalization s. On 04/26/24 at 10:47 AM, an interview with Administrator was done. Administrator reported the facility did not give written notification for transfer/discharge to R7 or her representatives and to the State Long-Term Care Ombudsman for both hospitalization s. 3) R29 was discharged home on 04/19/24 due to Notice of Medicare Non-Coverage effective 04/18/24. A review of R29's EHR found no documentation that a written notification for discharge was provided to R29 or his representative. On 04/26/24 at 10:47 AM, an interview with Administrator was done. Administrator reported the facility did not give written notification for discharge to R29 or his representatives and to the State Long-Term Care Ombudsman.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43414 Based on interview and record review, the facility failed to ensure written notification of the facility's bed hold policy was provided to one of four residents sampled (Resident (R) 7) and their representative. Findings include: R7 was transferred and admitted to the hospital twice on 03/04/24 to 03/06/24 and 03/21/24 to 03/25/24 with diagnosis of stroke. A review of R7's Electronic Health Record (EHR) found no documentation that a written notification regarding the facility's bed hold policy was provided to R7 or her representative for hospitalization from [DATE] to 03/25/24. On 04/26/24 at 10:47 AM, an interview with Administrator was done. Administrator reported the facility did not give written notification regarding the facility's bed hold policy to R7 or her representative for hospitalization from [DATE] to 03/25/24. Review of the facility's policy and procedure Bed-Hold Policy reviewed on 08/09/23, documented The Bed-hold policy should be given upon admission, upon transfer of a resident to the hospital (if in an emergency within 24 hours), or the resident goes on therapeutic leave of absence. The facility will provide written information to the resident or resident representative the nursing facility policy on bed-hold periods and the residents return to the facility to ensure that residents are made aware of a facility's bed-hold and reserve bed payment policy before and upon transfer to a hospital or when taking a therapeutic leave of absence from the facility.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on record review and interview, the facility failed to ensure that the Discharge Assessment for Resident (R)80 accurately reflected the resident's discharge status. Findings include: Record review done on 04/25/24 at 02:59 PM noted Resident (R)80 was admitted to the facility on [DATE] and discharged to home on 02/17/24. Review of Minimum Data Set (MDS) Discharge Assessment with an Assessment Reference Date (ARD) of 02/17/24 noted R80 was incorrectly documented as discharged to Short-Term General Hospital (acute hospitals, IPPS [inpatient prospective payment system]). On 04/26/24 at 10:31 AM, an interview was done with MDS Coordinator (MDSC)3 in her office. MDSC3 confirmed that R80's Discharge Assessment had been incorrectly documented and transmitted. MDSC3 stated that R80 had been discharged home with home health services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 42160 Based on observations, interviews, and record review, the facility failed to ensure a comprehensive person-centered care plan was implemented for one resident (Resident 6) sampled. Resident (R)6 is totally dependent on staff for all care, was observed lying in bed with no activities implemented. As a result of this deficient practice, dependent residents are at risk of a lack of sensory stimulation. Findings include: On 04/24/24 at 03:03 PM, conducted a review of R6's EHR which documented R6 was admitted to the facility with diagnosis of an intracranial hemorrhage, convulsions, quadriplegia, aphasia (loss of the ability to understand or express speech related to brain damage), with bilateral stiffness and contractures of the shoulders, hands, and knees. Review of R6's most recent annual Minimum Data Set (MDS) with an Assessment Reference Date of 03/14/24, Section GG. Functional Abilities and Goal, documented R6 has impairment of the upper and lower extremities and is dependent on staff for all care. Review of R6's activities care plan documented R6 is dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits and physical limitations. Review of R6's Interventions/Task documented an intervention to Encourage leisure interests such as listening to bedside radio, watching TV and visiting with family was added to the activities care plan on 04/14/23 and was the most recent revision. However, R6 is unable to move or express himself verbally or otherwise, so the resident is reliant on staff to turn on the radio and/or television. Review of R6's activity progress notes through 2024-2023 remain mostly unchanged and appeared to be almost template-like, with the main task rearranged in the order it is mentioned. Observation was made of R6 lying in bed, in the resident's assigned room, without any music, television, or other form of entertainment on 04/23/24 at 08:39 AM, 09:10 AM, 09:45 AM,10:03 AM, 10:55 AM 11:40 AM, 12:03 PM; 04/24/24 at 09: 13 AM, 10:00 AM, 12:12 PM, and 01:57 PM; and 04/25/24 at 08:44 AM and 10:32 AM. On 04/26/24 at 10:50 AM, conducted an interview with an anonymous staff (AS)2. AS2 confirmed R6 is dependent on staff to turn on the radio or television and if staff is unable to turn it on because they are busy, or if they forget, then R6 is lying in bed with no form of stimulation for most of the day. AS2 reported being busy with other residents on 04/23/24 and confirmed the radio or television was not on unless the resident's roommate was in the room.

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Ka Punawai Ola	91-575 Farrington Highway Kapolei, HI 96707

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on observations, interview, and record review, the facility failed to ensure residents receive treatment and care in accordance with professional standard of practice, the comprehensive person-centered care plan, and the resident's choices, for 5 of 21 Residents (R32, R231, R22, R2, and R47) sampled. As a result of this deficient practice, the residents were placed at an increased risk for avoidable declines and/or injuries. This deficient practice has the potential to affect all the residents at the facility. Findings include: 1) Resident (R)32 is a [AGE] year-old female admitted to the facility on [DATE] for short-term rehabilitation (rehab) following a fall with resulting fractures. R32's admitting diagnoses include, but are not limited to, fractures of her hip and pelvis with surgical intervention, hypertension (high blood pressure), anxiety, insomnia, constipation, and urinary retention. Review of R32's Minimum Data Set (MDS) Admission Assessment with an Assessment Reference Date (ARD) of 03/11/24 noted that R32 was evaluated as having a score of 14 out of 15 for her Brief Interview for Mental Status (BIMS) exam, reflecting a determination of cognitively intact. On 04/24/24 at 11:02 AM, an interview was done with R32 at her bedside. R32 complained that sometimes no bowel movement for 5 days, they do nothing, then all of a sudden they come in 3 times a day. When asked to elaborate, R32 explained that she has had a problem with constipation since before admission, and regularly takes medication at home for it. Since she got here, she has had days go by with no bowel movement, has experienced and complained of abdominal discomfort, but felt like the staff doesn't really pay attention to that. R32 stated that once she had 5 days of constipation and not much was done. A review of R32's electronic health record (EHR), specifically her bowel movement log, revealed that there was no bowel movement documented from 04/07/24 to 04/13/24 at 05:17 PM, a period of more than 6 days. A review of her physician orders noted the following: Bisacodyl (a laxative) Suppository 10 milligrams (mg) as needed for constipation if no results from Lactulose. Lactulose (a laxative) 30 milliliters (ml) as needed for constipation if no bowel movement for 3 days. Polyethylene Glycol (a laxative) Powder 17 grams once a day for constipation. Senna Plus (a laxative plus stool softener) 8.6-50 mg two times a day for constipation. Tap water enema 240 ml rectally as needed for constipation if Lactulose and suppository are ineffective. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R32's Medication Administration Record (MAR) for April notes the as needed Lactulose was given once on 04/10/24 and twice on 04/12/24. All 3 doses were marked as ineffective [in resulting in a bowel movement]. Also noted was that there were no Bisacodyl suppositories or Tap Water enemas administered in the month of April. On 04/26/24 at 12:08 PM, an interview was done at the Nurses' Station with Unit Care Coordinator (UCC)3 regarding R32. UCC3 agreed that given her opioid pain medication, admitting diagnosis of constipation, and that she was not ambulating very much, constipation should be expected and monitored for. During a concurrent review of R32's bowel movement log, UCC3 expressed surprise that R32 had gone 6 days with no bowel movement in April. UCC3 agreed that either a Bisacodyl suppository should have been administered on 04/10/24 after the Lactulose had been marked as ineffective, or there should be documentation as to why it was not administered. After a review of the MAR and nurse progress notes, UCC3 confirmed there was no indication/documentation that the constipation the Lactulose had been given for three times in April, had been treated and managed as it should have been. A review of the facility's Bowel Protocol policy and procedure, last revised 09/12/23 revealed the following: The facility in coordination with the resident's attending practitioner will implement standing orders to address a lack of bowel movement. 2) R231 is a [AGE] year-old female admitted to the facility on [DATE] for short-term rehab. Review of her EHR noted she was admitted with lower leg edema (when the tissues or blood vessels in your legs hold more fluid than they should) at a level of +4 (the most severe type of edema), as determined by the Nurse Practitioner (NP)1 at her admission assessment. On 04/23/24 at 09:44 AM, an interview was done with R231 at her bedside. R231 stated she had been at the facility for 2 weeks. Observed R231 with a cast to her lower right leg and moderate to severe swelling visible to both feet. R231 was sitting up in bed with the head of the bed at an 80-degree angle, with both lower legs extending straight out from her hips in approximately a 90-degree angle, resting on the bed. When asked about elevating her lower legs because of the swelling, R231 pointed to one flattened pillow at the foot of her bed and stated that was all she was given to elevate her lower legs and that just doesn't cut it, so she hadn't bothered putting it under her legs. On 04/23/24 at 03:52 PM, observed R231 sitting outside in the sun in a wheelchair with no footrests. When asked about the footrests so that she might elevate her feet while sitting, R231 stated she (facility staff) took them back to the room. R231's left ankle was still visibly swollen along with her right foot and toes. On 04/24/24 at 08:23 AM, a review of R231's EHR noted that despite being admitted with edema, numerous nurse progress notes documenting edema to both lower legs, and being sent out to the emergency roiagnom on [DATE] for increased edema, there was neither a care plan initiated for the edema, nor were there active provider orders to address the edema such as to keep her lower legs elevated, monitor and document level of edema, or apply compression stocking(s). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/26/24 at 11:04 AM, an interview was done with the Director of Nursing (DON) in the Conference Room. The DON agreed there should have been a care plan initiated for R231's lower leg swelling, especially considering that the facility did identify the swelling as a problem. The DON explained that when she spoke to staff, they told her they always encouraged R231 to elevate her legs, however she confirmed that the documentation did not reflect that. The DON also agreed that the nursing staff should have been consistently monitoring and documenting the amount of swelling instead of only documenting its presence. A review of Patient Education: Edema (swelling) (Beyond the Basics), by [NAME] H [NAME], MD, found at https://www.uptodate.com/contents/edema-swelling-beyond-the-basics/print, and current through August 2023, revealed the following: Leg, ankle, and foot edema can be improved by elevating the legs above heart level for 30 minutes three or four times per day. 37954 3) On 04/23/24 at 01:38 PM interviewed R22 who is a [AGE] year old resident admitted to the facility on [DATE]. Inquired if R22 ever has constipation or diarrhea and she stated she has had diarrhea, sometimes it takes her two times for her to use the toilet to empty her bowels. On 04/24/24 Record Review (RR) of R22's last quarterly Minimum Data Set (MDS) dated [DATE] found she had a Brief Interview for Mental Status (BIMS) with a score of 15 out of 15 identifying her as cognitively intact. During RR of R22's last quarterly MDS dated [DATE], found she is continent (uses the toilet) of bowel and bladder and rated 02 = Substantial/maximal assistance - Helper does MORE THAN HALF the effort for toilet transfer, making R22 dependent upon staff to assist her onto the toilet. R22's diagnoses include, but are not limited to, constipation, unspecified, history of falling, and heart failure unspecified. During RR of R22's EHR found the resident had the following physician's ordered medication to help prevent constipation: polyethylene glycol 3350 powder give 17 gram by mouth one time a day for constipation with breakfast. Dissolve in 8 oz of liquid. Hold for loose stools ordered on 08/11/23 and Senna-Docusate Sodium Oral tablet 8.6 - 50 mg (Sennosides-Docusate Sodium) give 1 tablet by mouth one time a day for Constipation hold for loose stools ordered on 11/08/23. Both medications were given every day from 04/01/24 - 04/24/24. Review of R22's documented bowel movements (BM's) found she had four loose BM's on 03/31/24 at 11:03 AM, 04/02/24 at 10:02 AM, 04/14/24 at 03:37 PM, and 04/23/24 at 06:27 PM. On 04/25/24 at 08:34 AM observed medication pass by Licensed Practical Nurse (LPN) 5 to R22. LPN5 gave R22 her Senna-Docusate Sodium Oral tablet 8.6 - 50 mg tablet and polyethylene glycol 3350 powder 17 gram that was dissolved in water. At this time LPN5 did not ask R22 if she had any loose stools and was not observed reviewing R22's EHR for documentation of her last BM. On 04/25/24 09:07 AM interviewed LPN5 and asked if she would ask the resident if she had loose stools before giving medication that states hold for loose stools. LPN5 said no that R22 knows her medications and would tell her if she had a loose stool and that R22 is very vocal. LPN5 stated the CNA's (Certified Nurse Assistants) report if the residents have loose stools to her. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) On 04/24/24 at 09:46 AM interviewed R2 who is a [AGE] year old resident who was admitted to the facility on [DATE]. Inquired if she has a history of constipation or diarrhea. R2 stated sometimes she has diarrhea and has told staff she does not want to take the Miralax (brand name for polyethylene glycol 3350 powder) but the staff give it with her medications. On 04/24/24 RR of R2's last quarterly MDS dated [DATE] found she had a BIMS with a score of 15 out of 15 identifying her as cognitively intact. Review of R2's functional abilities, under section GG of the MDS, found she was rated 01 for toileting hygiene which means she is dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. R2's EHR found her diagnoses include, but are not limited to, constipation, unspecified, unspecified glaucoma, history of falling and muscle weakness (generalized). During RR of R2's EHR found the resident had the following physician's ordered medication to help prevent constipation: polyethylene glycol 3350 powder (polyethylene glycol 3350 (bulk)) give 17 gram by mouth two times a day for Constipation HOLD for loose stools ordered on 02/13/24 and senna oral tablet 8.6 MG (Sennosides) give 1 tablet by mouth in the evening for Constipation; HOLD for loose stools ordered on 08/25/23. On 04/26/24 at 10:43 AM Review of R2's documentation of BM's found from 04/01/24 - 04/25/24 she had 33 loose stools and 7 putty like BM's. During this time reviewed R2 did not have any formed bowel movements. A review of her medications found she received 42 of 51 doses of polyethylene glycol 3350 from 04/01/24 -04/25/24 with 9 doses held and not given. Review of R2's Senna oral tablet given in the evening found R2 received 23 of 25 doses with only 2 doses held and not given. On 04/15/24 R2 received 2 doses of polyethylene glycol 3350 powder and a dose of senna and had four documented loose stools that day at 05:55 AM, 09:41 AM, 11:41 AM and 07:05 PM. R2 also received the 2 doses of polyethylene glycol 3350 powder and a dose of senna the next day. R2 had loose stools 21 days out of 25 days reviewed from 04/01/24 -04/25/24. 04/26/24 at 10:54 AM interviewed Registered Nurse Unit Care Coordinator (UCC) 2 and reviewed R2's documented BM's with her. UCC2 confirmed R2's documented BM's showed R2 had loose stools documented for almost all of April 2024. Inquired if she would ask R2 if she had a loose BM prior to giving medication that states hold for loose BM and UCC2 confirmed she would ask the patient, assess if she had a loose stool before giving these medications. On 04/26/24 at 11:17 AM interviewed DON. Reviewed R2's BM's for April 2024 and she confirmed the resident should not have been given the medications (polyethylene glycol 3350 powder and senna oral tablet) because of the documented loose stools. On 04/26/24 at 01:35 PM interviewed UCC2. Inquired what would happen to the resident if R2 continued to have loose stools and UCC2 stated the resident could experience dehydration. 42160 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5) On 04/23/24 at 08:32 AM, smelled a strong urine odor as this surveyor approached the entrance to R47's room. While at the doorway, observed R47 had a covered catheter bag hanging from the bedframe (on the side closest to the doorway) and the catheter tubing was visibly cloudy. After entering the R47's room, the strong urine odor intensified, observed R47 sitting upright in bed, doing a nebulizer breathing treatment. Made a closer observation of R47's catheter tubing which revealed the entire catheter tubing was cloud with multicolored (white, gray, brown, and reddish) sediment the entire length of the visible catheter tubing. Inquired with R47 about the strong urine smell and the resident confirmed the urine odor was strong and stated, I think it's coming from the catheter. R47 confirmed all meals are eaten in the room and the smell is always there, I just got used to it, but maybe my visitors might not want to stay as long with that smell. R47 confirmed the Foley catheter is for long-term use because the resident has difficulty breathing, especially when having to lay flat when changed due to incontinence. R47 looked at the tube and stated, It's dirty (catheter tubing), they haven't changed it in awhile. On 04/24/23 at 11:08 AM, observed the hospice nurse (HS)1 in R47's room finishing up a physical assessment of the resident. R47's catheter bag and tubing remained unchanged, and the strong urine odor was still present. On 04/24/24 at 02:13 PM, conducted a review of R47's EHR which documented the resident was admitted to the facility on [DATE] and started receiving hospice services on 04/12/24 with diagnosis which include end stage COPD, abnormal weight loss, and a lung mass with the life expectancy of less than six (6) months if disease progresses as expected. Review of R47's most recent quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/02/24, Section C. Cognitive Patterns, Brief Interview for Mental Status (BIMS) score was 15, indicating the resident's cognition is intact and is a reliable source of information. Section H. Bladder and Bowel, documented R47 has an indwelling catheter. Review of the physician's orders documented an order for Indwelling catheter to straight drainage size 18 Fr (French) bulb: 10 cc. Change for leakage or obstruction every day shift starting on the 20th and ending on the 20th every month for Foley care (ordered on 06/22/23 and started on 07/20/23). Other orders related to providing care for R47's Foley catheter included, change for leakage or obstruction, catheter care with warm water and soap, flush with 100cc of sterile water for increased sediment/low urine output, and implementation of enhanced barrier precautions for the resident's Foley catheter. Review of R47's March 2024 and April 2024, Medication Administration Record (MAR) documented on 03/19/24 and 04/20/24 the indwelling catheter was changed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/25/24 at 02:00 PM, conducted a concurrent interview and record review of R47's EHR with Registered Nurse Unit Care Coordinator (UCC)2. Inquired with UCC2 when R47's Foley catheter bag and tubing was last changed. UCC2 reviewed the April 2024 MAR and confirmed nursing staff documented the Foley catheter bag and tubing was changed on 04/20/24. UCC2 stated according to the orders the Foley catheter is not changed unless it is obstructed or leaking and there is an order to flush with sterile water for sediment. At 02:08 PM, UCC2 and this surveyor went to look at R47's Foley catheter bag and tubing. Prior to entering the room, inquired about the strong urine odor coming from and in the resident's room. After investigating the dirty linen bins in the hallway and the soiled laundry room, UCC2 concluded the urine smell was coming from the catheter bag privacy cover. UCC2 stated the privacy bags are not routinely changed and if the clamp is not sealed tightly or there is residual urine in the tubing when it is placed back into the privacy bag, the inside of the privacy bag could be soiled with urine. UCC2 confirmed the strong urine odor in R47's room was not a homelike environment for R47, especially because the resident eats all meals in bed and rarely leaves the room. UCC2 inspected the Foley catheter tubing and confirmed the tubing had a lot of sediment, so much sediment that it could potentially have a negative outcome for the resident and needed to be changed immediately. Then UCC2 pulled the catheter bag out of the privacy cover and the bag was labeled, Change foley set 3/19/24. UCC2 confirmed during review of the April 2024 MAR, staff documented the catheter was changed on 04/20/24. Also, R47 showed us the sticky pad (used to adhere secure a portion catheter tubing to the resident's leg to minimize damage to the resident's urinary structures which are in contact with the catheter) on the resident's left thigh was starting to peel off of the resident's leg. UCC2 confirmed the R47 could potentially be harmed if the catheter tubing was to be forcefully pulled on. UCC2 followed-up with staff who documented (on the April 2024 MAR) the Foley catheter was changed on 04/20/24 and this surveyor was informed, the responsible staff did not change the Foley bag and tubing because there was no obstruction or leakage, and the MAR was marked as done to indicate the Foley catheter was inspected for obstruction and leakage. UCC2 confirmed staff signing off on the MAR indicated the Foley catheter system was changed. UCC2 also confirmed R47's physician orders only addressed changing the Foley catheter for obstruction and leakage but did not include clinical indications, such as visible sediment in the catheter tubing. The facility contacted the nurse practitioner and got a new physician's order which included changing the Foley catheter for clinical indication. Review of the facility's policy and procedure, Indwelling Urinary Catheter (Foley) Management (last reviewed on 08/24/23) and the Center for Disease (CDC) guideline for the prevention of Catheter-Associated Urinary Tract Infections (CAUTI), III. Proper techniques for Urinary maintenance, documented, .it is suggested to change catheter and drainage bags based on clinical indication. However, literature review on the National Institutes of Health (NIH) indicated the long-term use (one month or more) of indwelling catheters should also include the manufacturer's recommendations, which may include recommended changes every 30-days.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on observation, interview, and record review, the facility failed to support and honor the food preferences of one resident (R) in the sample, and one unsampled resident. This deficient practice has the potential to impact all the residents at the facility with food preferences. Findings include: 1) Resident (R)33 is an [AGE] year-old female admitted to the facility on [DATE] for short-term rehabilitation therapy (rehab) following a left hip fracture. R33's admitting diagnoses include, but are not limited to, congestive heart failure, hypertension (high blood pressure), and chronic obstructive pulmonary disease (COPD). Review of R33's Minimum Data Set (MDS) initial 5-day assessment with an Assessment Reference Date (ARD) of 04/01/24 noted that R33 was evaluated as having a score of 13 out of 15 for her Brief Interview for Mental Status (BIMS) exam, reflecting a determination of cognitively intact. On 04/23/24 at 11:25 AM, an interview was done with R33 at her bedside. When asked about unintended weight loss, R33 stated [I] think I lost 6 - 8 pounds since getting here. R33 explained that sometimes she cannot eat the food she is given because the texture is off-putting. R33 stated that for example, she gets oatmeal and mush [a hot porridge] for breakfast a lot, and she will not eat it. R33 stated she has told staff 4-5 times that she doesn't eat oatmeal/mush and has asked that they stop giving it to her, but she still gets it. A review of R33's electronic health record (EHR) revealed her measured weight on admission was 186.4 pounds. Her last measured weight taken on 04/22/2024 was 180.6 pounds, reflecting a 5.8 pound or 3.11% weight loss in less than a month. On 04/25/24 at 08:27 AM, concurrent interview and observation was done with R33 at her bedside. R33 stated there was mush on her breakfast tray, I told them no put mush, they still give me. Observation of R33's meal ticket sitting on her breakfast tray noted that on the left side of the ticket, under Allergies/Dislikes, CEREAL was bolded and at the top of the list. On the right side of the ticket, under Preferences, NO CEREAL was bolded and the second item on the list. On 04/25/24 at 04:04 PM, an interview was done with the Food Service Director (FSD) in his office. FSD confirmed that he was aware that R33 does not like cereal. When asked what cereal means with regards to facility meals, FSD answered that cereal could mean either oatmeal or a hot porridge. FSD stated that he checked the meal tickets himself as the trays were being made that morning and confirmed that R33 should not be receiving oatmeal or hot porridge on her tray. On 04/26/24 at 08:52 AM, conducted a second interview with FSD in his office. FSD explained that with regards to R33's meal ticket, because cereal was listed on the ticket in two places (under Dislikes and Preferences), it shows that it was already a problem of not honoring that preference. Ideally, it should just be there one time, but when there are complaints of it not being followed, he adds it to the ticket in two spots to increase the chance of it being seen. FSD stated he has now added the no cereal preference to R33's meal ticket in a third spot. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	43414 2) On 04/23/24 at 11:51 AM, during a tray line observation in the kitchen, observed an unsampled resident's order form with ordered diet, dislikes, likes, and preferences indicated on the form. The form included the preference service sandwiches on hot plate. Observed the sandwich on the resident's tray not on a hot plate. Registered Dietician (RD) 1 was observed to check the order form twice prior to announcing the cart was ready to go on the unit at 12:15 PM. After RD1 announced the cart was ready to go, inquired with RD1 if the resident's plate was on a hot plate and if it was her preference, both RD1 and FSD reviewed the order form and FSD announced to dietary staff at the tray line that they did not put the sandwich on a hot plate.

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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. 43414 Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards for food service safety. Findings include: On 04/23/24 at 08:06 AM, during the initial tour of the facility's kitchen with Food Service Director (FSD), inquired with FSD if the facility labels food items when the arrive at the facility, FSD reported they label food items when they arrive and when they open them. Observed in the small prep-refrigerator, juice refills of apple juice, orange juice, cranberry juice, and passion orange guava juice for a juice dispenser without a label when the juice arrived. Inquired if the juice had a use-by date, FSD was not able to locate the date on the juice refills. Further observed three boxes of fudge brownie mix, with no use-by-date or date when the facility received the items. Review of the facility's policy and procedure, Food Safety revised on 04/26/23 documented The First In, First Out (FIFO) method is used in food storage or according to state regulations .Food is labeled with the date received if not already indicated on the item.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ka Punawai Ola	91-575 Farrington Highway Kapolei, HI 96707

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42160 Based on interviews and record reviews, the facility failed to ensure a resident's medical record was accurate for one resident (R)6 sampled. R6's hard medical record chart located in the nursing station contained a Physician Orders for Life Sustaining Treatment (POLST) which documented in the event of a medical emergency, R6 should receive cardiopulmonary resuscitation. However, a POLST located in the unit's POLST binder contained a POLST which documented R6 as Do Not Attempt Resuscitation (DNAR). Findings include: On [DATE] at 10:08 AM, conducted a review of R6's electronic health record (EHR). Review of R6's physician's orders documented an order to Do Not Attempt Resuscitate- Full Treatment (ordered on [DATE]). Review of an acute hospital's hospitalist discharge summary ([DATE]) documented .Given patient's multiple medical comorbidities, discussed that if an event were to occur where the patient (R6) would need to need CPR, prognosis would be poor. [Family Member (FM)1] in agreement, patient to be DNAR, okay with emergency protocols . Review of the acute hospital's pulmonary/critical care history and physical ([DATE]) documented R6's code status, FULL SUPPORT patient has POLST done [AGE] years ago expressing DNR preference and [FM] wanted to honor this but after talking with patient's (R6) [FM2], FM1 changed to full code . On the afternoon of [DATE], requested with Social Worker (SW) for R6's AHCD. On [DATE], SW provided R6's POLST and surrogate decision maker documentation. Review of the POLST provided documented R6's code status is DNR-Full Treatment. At 12:04 PM, conducted a review of R6's POLST, located in the resident's hard chart in the nursing station, with SW and Social Worker Assistant (SWA)1, which documented R6 should receive CPR and the marked DNAR box had a strike through it with error [illegible initial] per [FM1], witnessed conversation w(with)/MD (Medical Doctor). SW and SWA1 could not identify the who had initialed the strike through the DNAR box. On the counter located above resident's hard chart was a unit binder labelled POLST. Review of R6's POLST in the unit POLST binder documented R6 was DNAR, and this form was not altered. Inquired with SW and SWA1 as to why there were two different POLST for R6 and which POLST was valid. SW and SWA1 could not provide an immediate answer and needed time to investigate the situation. Compared both POLST forms and SW confirmed it is the same forms, however, the original POLST form was altered when R6's code status was changed to receive CPR. At 02:59 PM, SW confirmed R6's hard chart contained the wrong POLST and if there are any changes made to a resident's POLST, a new POLST should be completed instead of revising the original document.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on observation, interview, and record review, the facility failed to ensure appropriate protective and preventive measures to prevent the transmission of communicable diseases and infections. This is evidenced by the facility failing to ensure staff followed transmission-based precautions (TBP) by wearing the proper personal protective equipment (PPE) and performing the proper form of hand hygiene at all appropriate times while caring for Resident (R)33. In addition, the facility failed to assure staff performed hand hygiene between glove changes while performing perineal care (cleaning genital and anus area) for R131. These deficient practices have the potential to affect all residents in the facility, as well as all healthcare personnel, and visitors at the facility. Findings include: 1) Resident (R)33 is an [AGE] year-old female admitted to the facility on [DATE] for short-term rehabilitation therapy (rehab) following a left hip fracture. R33's admitting diagnoses include, but are not limited to, congestive heart failure, hypertension (high blood pressure), and chronic obstructive pulmonary disease (COPD). On 04/21/23 R33 was placed on contact enteric precautions for a symptomatic and confirmed clostridium difficile infection (C-diff a highly transmissible bacterial infection that can cause diarrhea and an inflammation of the colon). On 04/23/24 at 09:24 AM, observed a contact enteric precautions sign posted outside R33's room door. The sign provided the following instructions: Everyone Must: Clean hands with sanitizer when entering room and wash with SOAP AND WATER upon leaving the room. Doctors and Staff Must: Gown and glove at door. Use patient dedicated or disposable equipment. Clean and disinfect shared equipment. On 04/23/24 at 12:30 PM, observed Registered Nurse (RN)1 deliver lunch tray to R33 as she took in her noon-time medications. Observed R33's lunch was not in disposable containers and was carried in on a non-disposable tray. On 04/23/24 at 02:48 PM, observed Certified Nurse Aide (CNA)3 doff her PPE at the doorway prior to exiting R33's room, however she did not wash her hands, and instead used alcohol-based hand rub (ABHR) to clean her hands after she exited. Surveyor stopped CNA3 and asked her what type of hand hygiene should be performed before exiting R33's room. CNA3 apologized and stated she should have washed her hands with soap and water. On 04/24/24 at 11:17 AM, observed RN21 administer medications to R33 in her room, doff his PPE at the doorway prior to exit, then walk out of the room with no hand hygiene at all. Surveyor immediately stopped RN21 and insisted he return to R33's room to wash his hands. RN21 acknowledged the importance of proper hand hygiene due to R33's level of TBP, apologized, and returned to the room to wash his hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/25/24 at 09:20 AM, informed CNA31 that R33 had requested ice and explained that due to her TBP, her water pitcher could not be carried out of her room, so the ice had to be carried in separately. At 09:23 AM, observed CNA31 carry R33's water pitcher out of her room, take it to the nourishment room to fill it with ice, then return to R33's room with the same pitcher. As she re-entered R33's room, R33 did not don a gown, only a pair of gloves. Observed R33 deliver the water pitcher filled with ice, then pick up R33's non-disposable breakfast tray from her bedside table and exit the room without performing any type of hand hygiene. CNA31 carried the breakfast tray across the hall and discarded all the disposable containers that were on the tray into the trash can. At 09:26 AM, interviewed CNA31 in the hall outside of R33's room as she held the now empty non-disposable breakfast tray. Inquired what PPE should be worn when entering R33's room. CNA31 answered that because R33 had C-diff, she only needed to don a gown when she was toileting her. Asked about hand hygiene, CNA31 admitted that she did not wash her hands and would do it right away. At 09:28 AM, followed CNA31 from our interview in the hall, down the hallway to the kitchen where she returned R33's non-disposable breakfast tray. CNA31 still had not washed her hands and observed her touching door handles and doors along the way. On 04/25/24 at 10:08 AM, an interview was done with the Infection Preventionist (IP) in her office. IP confirmed that staff should be donning gown and gloves when entering R33's room for any reason and should always be washing their hands with soap and water prior to exiting. IP agreed that CNA31 should not have carried R33's water pitcher out of the room and should have instead carried the ice in. IP also explained that R33's meals should be delivered in disposable containers on a disposable tray, however for transport from the kitchen to the room, the entire tray was placed on a non-disposable tray. IP reported that staff should know to leave the non-disposable tray on the transport cart and only take the disposable meal items into the room. A review of the facility's policy and procedure, Clostridium (Clostridioides) Difficile (CDI), last revised 06/20/23, revealed the following: 2. A resident diagnosed with CDI should be placed in a single room on Contact Precautions. 7. Meal trays should be bagged prior to removal from the room . 8. Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. 9. Actively promote adherence to hand hygiene among healthcare personnel, patients, and visitors in patient care areas affected by C-diff. a.Wash hands with non-antimicrobial soap and water or with antimicrobial soap and water if contact with spores (e.g., C. difficile .) is likely to have occurred. 37954 2) On 04/23/24 at 12:38 PM overheard a nurse request Certified Nursing Assistant (CNA) 24 help change R131's adult brief. CNA24 went to R131's room and told resident she will help her right after she assists another resident. CNA24 went to help deliver a resident's lunch tray and open it up for him. CNA24 performed hand hygiene by using the hand sanitizer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/23/24 at 12:42 PM CNA24 returned to R131's room and was observed putting on gown, gloves and mask for Enhanced Barrier Precautions (EBP) with this resident. At this time interviewed CNA24 and asked why R131 had EBP and she stated R131 has EBP for open wounds. On 04/23/24 at 12:46 PM observed CNA24 provide perineal care and adult brief change for R131. CNA24 gathered her supplies. During the interaction CNA24 asked resident if it was ok to lower her back and raise her bed. Curtains were drawn for privacy. During perineal care CNA24 was observed taking off a glove and then putting on a new one, no hand hygiene was performed. On 04/23/24 at 12:58 PM interviewed Registered Nurse (RN) Unit Care Coordinator (UCC) 2 and inquired if staff are to perform hand hygiene between glove change and she confirmed staff are expected to do hand hygiene once they take off gloves and throw them away. On 04/23/24 at 01:01 PM interviewed CNA24 who confirmed she is supposed to use hand sanitizer after she takes her glove off, before putting on a new glove.