STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hale Nani Rehabilitation and Nursing Center	1677 Pensacola Street Honolulu, HI 96822

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42160 Based on interviews and facility policy review, the facility failed to ensure residents were treated with respect and dignity in an environment that promotes maintenance or enhances his or her quality of life, recognizing the resident's individuality for four out of 37 sampled residents (Resident (R)50, R113, R29, and R126). Findings Include: Review of the facility's policy and procedure RESIDENT RIGHTS Respect and Dignity revised on 03/2023, document The resident has a right to be treated with respect and dignity. 1) Review of R50's most recent quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/06/24, documented R50 had a score of 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition is intact (a reliable source of information). Section GG- Functional Abilities and Goals documented R50 has functional limitation in Range of Motion (ROM) with impairment on both sides of the upper (shoulder, elbow, wrist, hand) and lower (hip, knee, ankle, foot) extremities. R50 is dependent (helper does all of the effort, resident does none of the effort to complete activity) on staff for toileting hygiene, shower/bathe, lower body dressing, personal hygiene, putting on/taking off footwear, sitting to standing, chair to bed transfers, getting off and on the toilet, and the ability to get in and out of a shower. During an interview on 07/16/24 at 08:30 AM, R50 reported having to wait more than 30 minutes for staff to address the resident after activating the call light. R50 stated that she relies on staff to clean her after soiling herself and having to wait more than 30 minutes is a long time to be sitting in your waste. R50 added, staff don't come to the room to let you know that they are with another resident or are busy, I understand if the staff that's supposed to help me is busy with another resident, but instead you're wondering the whole time if anyone even knows that you need help. At least if staff addressed me then I would at least have some sort of timeframe went I would be helped. After having to wait for a while and staff not checking in on you, it makes you feel kind of bad and the whole time you're waiting in your [NAME] (urine) or doo doo (feces). I feel sorry for the residents who cannot use the call light. R50 added that staff do not always knock or tell you they are coming into your room, especially float staff, they come onto the floor and just want to rush to get through their task and want to do everything their way, instead of asking the resident about their preferences. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125011	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/19/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the interview, R50 yawned several times and overall physical presentation appeared that the resident was tired. Inquired if the R50 was feeling tired. R50 stated she is sleepy this morning because staff came into her room last night to assist another resident. Staff were speaking loudly and did not consider that there were other residents in the room sleeping, waking R50 from sleep. R50 reported that she understood that they have a job to do, and the other resident can hear just fine, so there was no need for staff to be as loud as they were. Just then, staff walked by R50 and commented that the resident looked tired and if she was ready to do ROM exercises. R50 declined and informed the staff that maybe later she will do the exercises because she is too tired right now and it may not be safe. 2) Review of R113's most recent annual MDS, with an ARD of 05/07/24, the resident's BIMS score was 14, indicating R113's cognition is intact and is a reliable source of information. Section GG. Functional Abilities and Goals, documented R113 has functional limitation in ROM with impairment on one side for the upper (shoulder, elbow, wrist, hand) and lower (hip, knee, ankle, foot) extremities. R113 is dependent (helper does all the effort. resident does none of the effort to complete activity) on staff for toileting hygiene, shower/bathe, lower body dressing, personal hygiene, putting on/taking off footwear, and chair to bed transfers. During an interview on 07/15/23 at 03:31 PM, R113 reported that there are times when he must wait up to an hour for staff to answer his call light. Asked R113 if any staff check-in with him and alert him that staff will assist him when they are available. R113 confirmed staff does not always check-in with him. 43414 3) On 07/15/24 at 10:09 AM, R29 expressed she was confused on why she was in this room. Observed her room to have no personal belongings or personalization in the room and wearing a hospital gown. On 07/16/24 at 08:40 AM, R29 was observed to be groomed by a staff member near the exit of her room. R29 was wearing a hospital gown provided by the facility and not her own clothes. The staff member mentioned going downstairs to activities. On 07/16/24 at 09:29 AM, observed R29 sitting in her room, still wearing the hospital gown provided by the facility, staring out of the window. On 07/16/24 at 10:12 AM, an interview with Family Member (FM)4 was done. FM4 reported R29's room was on a different unit but when she was hospitalized and returned to the facility she was placed in another room in a different unit. The facility did not bring her belongings with her, and it was not communicated when she would return to her previous room. FM4 stated not even her clothes were brought to the room and R29 likes to wear her clothes when out in her wheelchair. FM4 reportedly expressed R29 does not like her current room and has become suspicious of staff. On 07/16/24 at 12:41 PM, a second interview with FM4 was done. FM4 reported she went to R29's previous room to get some clothes for her and the staff members on that unit did not even know she returned to the facility, the facility did not communicate with each other that she moved rooms and is back. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/17/24 at 01:48 PM, interview and concurrent record review with Nurse Manager (NM)1 was done. During review of R29 Electronic Health Record (EHR), NM1 reported R29 returned to the facility on [DATE] and was admitted to a different room and unit. NM1 reported because R29's return was anticipated, her belongings remained in her room when transferred to the hospital. However, if the resident was transferred to a different room when readmitted her belongings should go with her. On 07/17/24 at 02:27 PM, interview with Certified Nurse's Aide (CNA)5 was done. CNA5 did not know R29 returned to the facility and was in another room. If she had returned to the facility, her belongings would have followed her. R29 prefered to wear her gown in bed but liked to wear her clothes when going to activities. Review of the facility's policy and procedure, RESIDENT RIGHTS Respect and Dignity revised on 03/2023, documented The resident has the right to retain personal possessions, including furnishings and clothing as space permits, unless to do so would infringe upon the right or health and safety of others. 4) On 07/18/24 at 01:57 PM, during an interview with Resident Council members, R78 reported there is a staff member that has no respect, a Certified Nurse's Aide will come into the room and pretend she is working but R78 stated she does not do anything in the room. She stays in the room for a very long time and then when you ask for something she suddenly says she is going on her break. R50 chimed in and stated she knows what staff member R78 is talking about and stated it was CNA13. R78 agreed it was CNA13 and R202, roommate to R78, reported he was waiting to use the bathroom and CNA13 told him she was going on break. R78 also reported she was upset one day and threw a glass bottle of coffee in the trash can roughly and is not respectful when in their room. R50 reported she heard complaints from others about this CNA and it has been brought up to staff members, but no one wants to say her name. On 07/19/24 at 09:05 AM, observation was done in the hallway outside of R126's room. Observed CNA13 in R126's room with linens in her hands, curtains were drawn for R126 and her roommate's area. At 09:07 AM, continued observation of CNA13 in R126's room, CNA13's feet could be seen next to R126's bed behind the curtain with little to no movement. At 09:13 AM, observed Housekeeper (HK)1 go into R126's room, take out the trash, and leave the room. At 09:17 AM, this surveyor went into R126's room and observed CNA13 with a clipboard and electronic tablet in her hands at the foot of R126's bed. R126's bed was located next to the window, furthest away from the entrance door. R126 was observed to be in bed and her roommate was not in the room. As soon as CNA13 saw this surveyor, CNA13 was observed to quickly take a towel and cover her clipboard and tablet and place them at the foot of R126's bed. This surveyor went into the bathroom across from R126's bed and found an open trash bag of dirty linens on top of the toilet. CNA13 quickly grabbed the bag of dirty linens and tied it together. Inquired what CNA13 was doing in R126's room, CNA13 stated she was feeding the resident. R126's meal tray was not observed to be in the room and asked where the meal tray was if she was feeding R126, CNA13 stated she just finished and put it in the hallway. Inquired when she did this, she stated just now. CNA13 was not observed to go out of R126's room since 09:05 AM and bring a tray of food in the hallway or go to the hallway as soon as this surveyor went in the room. Inquired what CNA13 was doing on the clipboard, CNA13 stated she was writing down the resident's vitals. The vitals cart was not observed to be in R126's room. CNA13 quickly left R126's room and left the clipboard and tablet on the foot of R126's bed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 09:20 AM, an interview with HK1 was done. Inquired with HK1, what CNA13 was doing when she went into R126's room. HK1 reported CNA13 was on her tablet. At 09:23 AM, an interview with CNA8 and CNA9 was done. Inquired how they chart vitals or their tasks, both CNA8 and CNA9 reported they use their clipboard and bring that into the resident's room to document the vitals and then use the tablet on the wall to input the vitals and document their tasks. Both stated they do not bring an electronic tablet into the room and just use the one connected to the wall. At 09:24 AM, an interview with RN5 was done. RN5 reported CNA staff use the tablets on the wall. Inquired if any of the staff use tablets they can hold, she stated there are some and showed this surveyor the tablets stored in the medication storage room. Electronic tablets were observed to be in a plastic drawer. Concurrent review of the sign-out sheet for the tablets, RN5 stated no one has signed any of the tablets out. Concurrent observation of R126's room, the clipboard and tablet were observed to be on R126's bed. Inquired if the tablet was the facility's tablet, RN5 reported it was not and it was a personal tablet. Inquired if CNA staff should be using personal tablets in residents' rooms, RN5 stated they should not and they should not be leaving their clipboard for vitals or personal items in the resident's room and on their bed. At 10:15 AM, an interview with Director of Nursing (DON) was done. DON stated staff should not use their personal electronic tablets or phones to chart their vitals or tasks. They should not leave items or personal items in the rooms unattended. DON stated, This is their .[residents'] .home and it does not belong there.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42160 Based on interviews and record review, the facility failed to ensure a Resident Representative's (RR) 21 right to exercise the resident's rights to the extent provided by state law for one Resident (Resident (R) 5) sampled. RR21 is the Durable Power of Attorney (DPOA) for R5 and identified by the facility as the R5's healthcare decision-maker. R5 has a diagnosis of Alzheimer's Disease and does not have the capacity to make medication related decisions. Review of R5's Electronic Health Record (EHR) documented an informed consent for the use of an antidepressant medication signed by R5 and not RR21. Also, an Interdisciplinary (IDT) care plan meeting form documented RR21 attended the meeting on 04/23/24 and participated via phone and declined dental, vision, podiatry, and hearing services for R5. Closer review of the IDT care plan meeting form documented a voicemail was left for RR21 and he/she had not participated in the meeting, but services were declined. Findings include: Review of R5's EHR documented R5 was readmitted to the facility on [DATE] from the hospital after falling and fracturing her left hip. Review of the hospital's discharge summary documented while in the hospital, R5 was unable to make medical decisions and RR21 was making the medical decisions at the time. Review of R5's most recent Minimum Data Set with an Assessment Reference Date (ARD) of 01/25/24 Section C- Cognitive Patterns, documented a Brief Interview for Mental Status (BIMS) score of 3, indicating R5 had severe cognitive impairment. R5 was not oriented to the correct year, month, or day of the week. Also, R5 was unable to recall all three words the resident was asked to remember. A significant change MDS with an ARD of 04/25/24, which was conducted when the resident returned to the facility, documented the resident BIMS score was 2, indicating a worsening of R5's cognitive impairment. Review of an informed consent form for the use of an antidepressant medication was e-signed by Nurse Manager (NM)2 on 06/18/24, R5's signed the form on 06/27/24 and a verbal consent was received. However, the following areas of the Informed Consent form were blank, 1. Resident/Responsible Party Signature and date, 3. Verbal/phone consent received from, 3a. Date verbal/phone consent received, and Relationship to Resident. Review of the IDT care plan meeting on 04/23/24, Social Service Assistant (SSA) documented RR21 as R5's general POA and had declined services for dental, vision, hearing, and podiatry services. During a concurrent record review and interview with Nurse Practitioner (NP)8 on 07/18/24 at 10:19 AM, confirmed at the time the Informed Consent form for the use of an antidepressant medication was signed, R5 did not have the cognitive ability to understand the information and make an informed decision consenting to the use of an antidepressant medication. On 07/16/24 at 10:05 AM, conducted an interview with Registered Nurse (RN) 43 regarding R5's cognition. RN43 confirmed R5 can effectively communicate her needs to staff but lacks the cognitive ability to understand the side effects, risk, and benefits related to medications use and would not be able consent for the use of a medication. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/18/24 at 01:14 PM, conducted a concurrent interview and record review with the Director of Nursing (DON). After reviewing R5's EHR, DON confirmed there was no documentation that RR21 participated in the IDT care plan meeting on 04/23/24 or that RR21 verbally declined dental, vision, podiatry, and hearing services for R5. There was no additional documentation to support RR21 provided a verbal informed consent for the use of an antidepressant medication. DON also confirmed that there is a discrepancy with the date NM2 electronically-signed the Informed Consent form (06/18/24) and when R5 signed the same form (06/27/24). DON could not provide an explanation of how and/or why the forms would have different dates. Called RR21on 07/16/24 at 09:31 AM, for an interview regarding the informed consent and participation in the IDT meeting on 04/23/24 but was unable to make contact.

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F 0558

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Reasonably accommodate the needs and preferences of each resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43245

Based on observation, interview, and record review, the facility failed to honor the shower preferences of 2 of 3 residents (Residents 171 and 199) sampled for accommodation of needs. As a result of this deficient practice, Resident (R)171 and R199 did not have their needs met and were placed at risk of not attaining their highest practicable well-being. This deficient practice has the potential to affect all the residents at the facility.

Findings include:

1) Resident (R)171 is a [AGE] year-old male admitted to the facility on [DATE] for long-term care. R171's admitting diagnoses include, but are not limited to, heart disease, diabetes, dementia, depression, and history of a right above the knee amputation. A review of R171's Minimum Data Set (MDS) Admission Assessment with an Assessment Reference Date (ARD) of 02/05/24 noted R171 had been assessed with a Brief Interview for Mental Status (BIMS) score of 13, indicating a determination that he was cognitively intact.

On 07/15/24 at 10:52 AM, observed R171 lying in bed wearing a facility gown visibly soiled at the chest with food and/or drink.

On 07/16/24 at 08:40 AM, observation and concurrent interview was done with R171 at his bedside. R171 was noted to be wearing the same soiled gown from the previous day. When asked about how often he is showered and has his gown changed, R171 reported that he receives a bed bath about once a month, and that his gown only gets changed when it has poop on it. R171 stated bed baths were not his preference and that he would occasionally like to shower but is never offered the choice.

A review of R171's Comprehensive Care Plan (CCP) under the focus of Activities of Daily Living (ADL) revealed the following:

BATHING/SHOWERING: . [R171] to shower 2X [two times] a week and as needed.

On 07/18/24 at 10:34 AM, an interview was done with Certified Nurse Aide (CNA)2 at the Unit 2 Nurses' Station (U2NS). When asked when he had last gotten out of bed, CNA2 responded that prior to today, she could not remember when R171 had last gotten up. When asked how often he is showered, CNA2 responded that R171 receives a shower twice a week. When asked how R171 could receive a shower if he isn't getting out of bed, CNA2 responded that he gets a shower in bed. After further discussion and clarification, CNA2 confirmed that R171 has been receiving bed baths and not showers.

On 07/18/24 at 10:46 AM, an interview and concurrent record review was done with Nurse Manager (NM)2 at the U2NS. After reviewing his CCP, NM2 confirmed that R171 should be receiving a shower twice a week as per his ADL care plan.

(continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) R199 is a [AGE] year-old male admitted to the facility on [DATE] for long-term care related to his diagnosis of Amyotrophic Lateral Sclerosis (ALS), a disease affecting nerve cells in the brain and spinal cord, causing progressive loss of voluntary movements and muscle control, and eventually leading to death. A review of R199's MDS Significant Change in Status Assessment with an ARD of 04/05/24 noted R199 had been assessed with a BIMS score of 15, indicating a determination that he was cognitively intact. On 07/18/24 at 04:20 PM, R199 reported that he only receives bed baths despite requesting a shower multiple times. R199 expressed frustration that he was not allowed to shower, stating that he knew the unit had a shower gurney but that he had been told it was only for the use of one specific resident. A review of R199's CCP under the focus of ADL revealed the following: BATHING/SHOWERING: . [R199] to shower 2X a week and as needed. On 07/19/24 at 08:04 AM, an interview was done with CNA2 at the U2NS. CNA2 reported that the unit had one shower gurney but that they only used it for R67, stating, it has been designated for . [R67]. When asked if other residents could use it, CNA2 answered yes, but no one else wants it. When asked specifically about R199, CNA2 insisted that R199 only wants a bed bath. Upon inspection of the device CNA2 called a shower gurney, stored in the unit shower room, it was observed that the device could not lay flat. The device had a back that reclined to a 45-degree angle at the most, and a rigid seat. When the back was in the upright position, the seat was flat. When the back was reclined 45-degrees, the seat was tilted up. CNA2 confirmed the reclining shower chair was the device designated for R67. There were no shower gurneys observed on the unit. On 07/19/24 at 08:33 AM, during an interview with R199 at his bedside, he confirmed that he has never been offered a shower or the use of the reclining shower chair. R199 reiterated that when he has specifically asked to shower using the reclining shower chair (which he was told was a gurney), he was told no because it was reserved for only one specific resident. On 07/19/24 at 08:37 AM, an interview was done with the Director of Nursing (DON), the Director of Infection Control (DIC), and the Assistant Administrator in the Administration Office. The DON stated the facility did not have any shower gurneys that she knew of. The DIC and Assistant Administrator acknowledged that without a shower gurney on the unit, there was no way to accommodate a shower preference for residents like R177 and R199.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on interview and record review, the facility failed to ensure the individual financial record of 1 of 1 resident sampled for personal funds was made available to Resident (R)20 through quarterly statements. As a result of this deficient practice, R20 was not aware of her current balance and was not afforded the opportunity to periodically reconcile her account unless she made a request. Findings include: Resident (R)20 is a [AGE] year-old female admitted to the facility on [DATE] for long-term care. R20's admitting diagnoses include, but are not limited to, left-sided paralysis and weakness following a stroke, heart disease, peripheral vascular disease, and lymphedema (swelling that generally occurs in an arm or leg, caused by a blockage in the lymphatic system). A review of R20's Minimum Data Set (MDS) Annual Assessment with an Assessment Reference Date (ARD) of 05/29/24 noted R20 had been assessed with a Brief Interview for Mental Status (BIMS) score of 14, indicating a determination that she was cognitively intact. On 07/16/24 at 09:35 AM, an interview was done with R20 at her bedside. When asked about the individual account she had at the facility, R20 reported that she does not get any statements. R20 continued stating that she thought perhaps her sister in Texas was getting them, but she herself had not received any since being admitted . When asked how she knew how much money was in the account, R20 answered that she had no idea what her balance was. On 07/17/24 at 11:19 AM, a phone interview was done with the Business Office Manager (BOM). BOM stated that she herself sends out the Personal Funds statements every quarter. When asked what the general process was, BOM reported that if there is a responsible party, the quarterly statement is sent to them. When asked about R20 specifically, BOM stated that R20 is responsible for herself, but she could not recall if her quarterly statements were being sent to her, or her daughter. BOM reported that she would have her staff print up R20's last quarterly statement (sent out in June 2024), and whatever address was on the statement was where it was sent. BOM confirmed that if daughter's address is on there, it means it was sent to Texas, and only to Texas. However, if the facility address is there, then the Business Office would've given the statement to Social Services and either they or Recreation Services would have hand-delivered it. BOM agreed that to meet the requirement, if it is currently getting sent to [sister in] Texas, it should also be delivered to R20 herself since she is self-responsible, however, it is not their current practice to send it to two places. On 07/17/24 at 11:36 AM, the Assistant Administrator delivered R20's last quarterly statement showing her sister's address in Texas. The Assistant Administrator stated that BOM confirmed that meant R20 had not been issued a copy.

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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** 42160 Based on observations and interviews, the facility failed to ensure the resident's right to a clean and homelike environment. The facility's wallpaper/paint was peeling off the wall, ceilings had water damage, and toilets were not properly working. As a result of this deficient practice, there is the potential to affect the resident's overall mood and psychosocial well-being. Findings include: Review of the facility's policy and procedure RESIDENT RIGHTS, Safe, Clean and Comfortable Environment, dated 03/2023, documented The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. 1) During an interview with R50 on 07/16/24 at 08:30 AM, the resident stated that the building is falling apart and does not feel homelike. R50 pointed out in the restorative room, the wallpaper was peeling off the wall, observed patches of exposed drywall in the restorative room and throughout the unit. Ceiling tiles in the hallway, near room [ROOM NUMBER] on Unit 5, appeared to have water damage. R50 reported the unit's physical appearance has an impact on her overall feeling of well-being and it can be depressing at times. On 07/19/24 at 10:52 PM, conducted an interview with Director of Maintenance (DOM) regarding the water damage, peeling wallpaper, and exposed drywall in the restoration therapy room on Unit 5. DOM confirmed this surveyor's observations 43414 2) Cross Reference to F550. The facility failed to ensure R29 are treated with respect, dignity, and care in a manner and in an environment that promotes maintenance or enhancement to her quality of life. R29 was not provided accessibility to her belongings, including clothes, when moved to a different room/unit after returning to the facility. On 07/15/24 at 10:09 AM, R29 expressed she was confused on why she was in this room. Observed her room to have peeled paint behind her bed. R29 inquired why the facility would put her in a room with wall damage and pointed out the paint peeling all around her room. Concurrently observed the paint to be peeled off all around the room. On 07/18/24 at 11:18 AM, an interview with DOM was done. DOM reported the maintenance department does a walk around the facility once a week and if they see paint peeling in a room, they will patch the room when it is unoccupied due to the smell. It takes about 24 hours for them to mud, sand, and paint the walls. DOM stated they just patched up R29's room yesterday, 07/17/24, after the resident moved back to her previous room. DOM confirmed the maintenance department did not get a work order to patch the peeled paint in the room prior to the facility putting R29 in the room with peeled paint across the walls. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Hale Nani Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1677 Pensacola Street, Honolulu, HI 96822	

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) On 07/18/24 at 01:57 PM, during a meeting with Resident Council members, R231 reported her toilet has not been flushing properly for weeks and feels it is not sanitary if the residents are unable to flush. R231 share the bathroom with three other residents. R231 stated that maintenance would come in and fix it, but it would just break again. On 07/19/24 at 08:56 AM, an observation was done of R231's bathroom. The toilet water could be heard running and when attempted to flush the toilet the toilet did not flush. Attempted to flush the toilet three more times and the toilet flushed on the fourth try. Attempted to flush six more times and the toilet flushed on the seventh try. At 08:58 AM, an interview with CNA5 was done. CNA5 confirmed the toilet sometimes does not flush and it depends on how you push the flush lever down. On 07/19/24 at 10:56 AM, a concurrent observation and interview with DOM done. DOM stated the facility had work orders on R231's bathroom in June regarding the toilet, dated 06/15/24, 06/17/24, and 06/18/24. The facility replaced the inside of the toilet then. Concurrent observation of R231's toilet, DOM reported the toilet will not flush properly because the handle was bent, and the seal was off set. The toilet will continue to not flush properly unless they fix the bent handle.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on observation, interview, and record review, the facility failed to ensure that 1 of 2 residents (Resident 92) sampled was free from physical restraints that were not required to treat her medical symptoms. As a result of this deficient practice, Resident (R)92's patient rights were violated, and she was placed at risk of avoidable injury and/or a decline in her psychosocial well-being. Findings include: Resident (R)92 is a [AGE] year-old female admitted to the facility on [DATE] for long-term care. On 07/15/24 at 11:05 AM, the state agency (SA) observed R92 quietly lying at the far end of the Unit 2 hallway in a Geri-chair that was fully reclined, with a wheelchair wedged under the extended/elevated footrest of the Geri-chair in such a way that even if R92 could physically put the Geri-chair down (using the side handle to set the chair upright), the chair would not go down. A review of the facility's Physical Restraint policy and procedure (P&P), last revised 03/2023, revealed the following: The resident has the right to be free of abuse and is not limited to freedom from . any physical or chemical restraint not required to treat the resident's medical symptoms. The P&P defines a physical restraint as: . any manual method, physical or mechanical device, equipment or material that meets all the following criteria: a. Is attached or adjacent to the resident's body; b. Cannot be removed easily by the resident; and c. Restricts the resident's freedom of movement or normal access to his body; d. The resident will be able to be [sic] remove the restraint or device intentionally by the same manner as it was applied by the staff. On 07/17/24 at 09:38 AM, an interview was done with Nurse Manager (NM)2 at the Unit 2 Nurses' Station (U2NS). When alerted of the observation on 07/15/24, NM2 did not appear surprised, and agreed that wedging a wheelchair under the extended footrests of a Geri-chair is a physical restraint, and should never happen. NM2 confirmed that due to restless/anxious behavior and a history of falling, R92 required frequent supervision and ongoing medication adjustment, however, physical restraints were not appropriate.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on observation, interview, and record review, after receiving report of an injury of unknown origin from Resident (R)25's wife, the facility failed to report the allegation to the State Survey Agency (SA) and adult protective services (APS). In addition, the facility failed to report an allegation of abuse for one other Resident (R209), out of three residents sampled for abuse, to other officials, including Adult Protective Services (APS). As a result of this deficiency, the facility did not allow the resident further review of the abuse by APS. Findings include: 1) Resident (R)25 is an [AGE] year-old male admitted to the facility on [DATE] for long-term care. R25's diagnoses include, but are not limited to, dementia, heart failure, muscle weakness, and lack of coordination. A review of R25's Minimum Data Set (MDS) Quarterly Review Assessment with an Assessment Reference Date (ARD) of 04/24/24 noted R25 had been assessed as completely dependent for all eating, hygiene, toileting, and mobility activities. In addition, his Staff Assessment for Mental Status indicated he had Memory problem[s], was not oriented to place, time, or staff names and faces, and his Cognitive Skills for Daily Decision Making had been determined as Severely impaired - never/rarely made decisions. On 07/16/24 at 03:30 PM, observations of R25 and a concurrent interview was done with his family member (FM)2 at the bedside. FM2 reported that on 07/15/24, she noticed that R25's right hand, which he doesn't move [on his own], was all bruised and swollen. FM2 stated that she noticed the injury when she went to hold his right hand and he screamed in pain. When she questioned him about how it happened, R25 indicated to her that a small man had hurt his hand. Observation of R25's right hand noted dark purple bruising of the thumb pad portion of his palm extending to the lateral surface of his thumb. An interview was attempted with R25 by the SA however, he was unable to respond verbally to any questions asked. FM2 also reported that a few weeks ago R25 had a suspicious bruise on the bridge of his nose, like someone hit him, and several months ago, he had a bruise on his right hip that she had no idea how he could have gotten. On 07/18/24 at 08:04 AM, an interview was done with the Assistant Director of Nursing (ADON) and the Director of Infection Control (DIC), in the Administration Office. The ADON and DIC stated that the injury to R25's right hip occurred in February 2024 and had been reported to the SA, but not to APS. The two more recent incidents had not been reported to either agency. On 07/18/24 at 01:32 PM, an interview was done with the Assistant Administrator in the Conference Room. The Assistant Administrator confirmed that the bruising to R25's right hip was not reported to APS, but it should have been. She also confirmed that the bruising to R25's nose from a few weeks ago was not reported to the SA or to APS but should have been since it was an injury of unknown origin. Regarding the current bruising to R25's right hand, the Assistant Administrator reported that the facility had classified it as an injury of known origin, and therefore had not reported it to the SA or to APS. The SA asked how it was determined to be an injury of known origin if the injury was initially identified by FM2 and reported to the facility for investigation? The Assistant Administrator stated she would check with the Director of Nursing (DON) and the DIC and report back. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/18/24 at 02:36 PM, an interview was done with the ADON, the DIC, and the Assistant Administrator in the Administration Office. The three confirmed that the facility initially investigated the right-hand injury as an injury of unknown origin, and through the process of investigation, determined that the source of the injury was known. A review of the facility's policy and procedure (P&P) for Abuse Reporting and Responsibilities of Covered Individuals, last revised 03/2023, revealed the following: Allegations of abuse . including injuries of unknown source . will be reported to the State Survey Agency and other agencies in accordance with applicable law. In response to allegations of abuse . the facility will: a. Report immediately, but not later than 2 hours, all alleged violations involving abuse . including injuries of unknown source . 39754 2) Review of an allegation of abuse event report for R209, the report was forwarded to the State Survey Agency but not to APS. During staff interview on 07/17/24 at 03:15 PM, Assistant Administrator (AA) acknowledged that the abuse event report for R209 was not sent to APS. AA said they were not aware that they were obligated to report this event to APS. Review of policy on Freedom from Abuse, Neglect and Exploitation read Purpose, to ensure reporting any reasonable suspicion of crime against a resident or individual receiving care from the facility within prescribed time frames. To ensure alleged violations involving abuse, neglect, exploitation, or mistreatment are reported and the results investigations of the allegations are reported within the prescribed timeframes. Policy, the facility will report to the State Agency and law enforcement any reasonable suspicion of a crime against any individual who reside or who is receiving care from the facility within the time frames required by federal and state law. The facility will notify covered individuals at least annually of their reporting obligations related to reasonable suspicion of a crime against a resident. The facility will report alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, and submit investigation results, according to regulatory guidelines and in accordance with State law and within the time frames required by federal and state law . Alleged violations will be reported to the facility administrator and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on interview and record review, after being informed by adult protective services (APS) of an allegation of abuse of 1 of 3 residents (Resident 569) sampled, the facility failed to document and provide evidence that the allegation had been thoroughly investigated. Findings include: Resident (R)569 is a [AGE] year-old female admitted to the facility on [DATE] for short-term rehabilitation and skilled nursing services. R569 was transferred to an acute care hospital on 04/26/24 with a diagnosis of hyperkalemia (a high level of the electrolyte potassium in her blood), and after refusing to go to hemodialysis. On 05/21/24, the State Agency (SA) received a referral from APS (ACTS #10973) as a result of allegations of neglect made by R569 against facility staff. A review of the referral from APS revealed possible indicators that R569 had been physically and/or sexually abused at the facility as well. On 07/16/24 at 10:45 AM, the SA requested from the Assistant Administrator the facility's investigation packet related to R569's allegation(s). On 07/18/24 at 07:54 AM, an interview was done with the Assistant Administrator and the Director of Infection Control (DIC) in the Administration Office. The DIC confirmed that on 05/23/24, APS requested R569's entire record directly from medical records. APS also asked that someone from facility administration contact them. The interim Director of Nursing (IDON), who no longer works for the company, was responsible to contact APS at that time. The DIC reported that the facility was unable to locate any documentation by IDON of what her conversation with APS entailed. IDON simply reported that she had taken care of it. The DIC and Assistant Administrator both agreed that they would have wanted to know what specifically APS was investigating so that the facility could initiate their own investigation into it. They also confirmed that they would expect to see the APS discussion documented somewhere, but since there was no documentation, a facility investigation was not initiated, and nothing had been reported to the SA. In addition, both acknowledged that if APS was investigating, it stood to reason that it involved allegations covered under the facility's Freedom from Abuse, Neglect and Exploitation P&P. A review of the facility's Freedom from Abuse, Neglect and Exploitation policy and procedure (P&P) for Abuse Reporting and Responsibilities of Covered Individuals, last revised 03/2023, revealed the following: Allegations of abuse, neglect, exploitation, or mistreatment . will be reported to the State Survey Agency and other agencies in accordance with applicable law.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48351 Based on record reviews and interviews, the facility failed to provide written transfer notification to the resident or the resident's representative for five out of five sampled residents (Resident (R)29, 49,128,182, and 266). This deficient practice has the potential to affect all the residents that are transferred to an acute care hospital. Findings include: A review of the facility's policy titled, Admission, Transfer, and Discharge, dated 03/2023 was conducted. The facility policy noted, Before the facility transfers or discharges a resident, the facility will notify the resident and the resident's representative of the transfer/discharge and the reasons for the move in writing, in a language and manner they understand. 1) R266 is a [AGE] year-old female transferred and later admitted to an acute care hospital on 05/02/24. A review of R266's Electronic Health Record (EHR) was conducted. R266's EHR did not contain documentation that R266 or R266's representative was provided a written notification of her transfer to the acute care hospital. An interview with Social Worker (SW) 1 was conducted on 07/17/24 at 02:29 PM. SW1 stated that the facility did not provide R266 or R266's representative a written notification of her transfer to an acute care hospital. 43414 2) R29 was transferred and admitted to the hospital on 06/28/24 for wound infected with pseudomonas orzyhabitans and gangrenes of the left big toe. A review of R29's EHR found no documentation that a written notification for transfer to the hospital was provided to R29 or her representative. On 07/17/24 at 02:54 PM, an interview with SW1 was done. SW1 reported the facility does not provide written notification of transfer/discharge to the resident or representative when sent to acute care. A written transfer/discharge notification was not sent to R29 or her representative. 3) R182 was transferred and admitted to the hospital on 04/21/24 for a fracture on his right femur and on 04/27/24 for pneumonia. A review of R182's EHR found no documentation that a written notification for transfer to the hospital was provided to R182 or his representative. On 07/17/24 at 02:54 PM, an interview with SW1 was done. A written transfer/discharge notification was not sent to R182 or his representative. 47783 (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4) R49 was admitted to the facility on [DATE]. On 10/26/23, R49 was transferred to an acute care hospital for sepsis (life-threatening complication of an infection). Review of the EHR was conducted and no documentation was found of the facility providing a written notification of transfer to R49 or her representative. 5) R128 was admitted to the facility on [DATE]. On 05/20/24, R128 was transferred to an acute care hospital for complaints of left shoulder pain. Review of the EHR was conducted and no documentation was found of the facility providing a written notification of transfer to R128 or her representative. On 07/17/24 at 02:30 PM, an interview was conducted with SW1 in the conference room. SW1 confirmed that the facility does not give a written notification of discharge to the residents or their representative when they are transferred to an acute care hospital.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 48351 Based on record reviews and interviews, the facility failed to provide written notification of the bed hold policy to the resident or the resident's representative for five out of five sampled residents (Resident (R) 29, 49,128, 182, and 266). This deficient practice has the potential to affect all the residents that are transferred to an acute care hospital. Findings include: A review of the facility's policy titled, Admission, Transfer, and Discharge, with a revised date of 03/2023 was conducted. The policy noted, The facility will provide written information to the resident or resident representative specifying the duration of the state bed-hold policy, if any, during which time the resident is permitted to return and resume residence in the facility .This information will be provided to the resident and the resident representative before a transfer or therapeutic leave and at the time of transfer of a resident for hospitalization or therapeutic leave. 1) R266 is a [AGE] year-old female transferred and later admitted to an acute care hospital on 05/02/24. A review of R266's EHR was conducted. R266's EHR did not contain documentation that R266's representative was provided a written notification of the facility's bed hold policy. An interview with Social Worker (SW) 1 was conducted on 07/17/24 at 02:29 PM. SW1 stated that the facility did not provide R266's representative a written notification of the facility's bed hold policy. 43414 2) R29 was transferred and admitted to the hospital on 06/28/24 for wound infected with pseudomonas orzyhabitans and gangrenes of the left big toe. A review of R29's EHR found no documentation that a written notification of the facility's bed hold policy was provided to R29 or her representative. On 07/17/24 at 02:54 PM, an interview with SW1 was done. SW1 reported the facility does not provide written notification of the bed hold policy to the resident or representative when sent to acute care. A written notification of the bed hold policy was not sent to R29 or her representative. 3) R182 was transferred and admitted to the hospital on 04/21/24 for a fracture on his right femur and on 04/27/24 for pneumonia. A review of R182's EHR found no documentation that a written notification of the facility's bed hold policy was provided to R182 or his representative. On 07/17/24 at 02:54 PM, an interview with SW1 was done. A written notification of the bed hold policy was not sent to R182 or his representative. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	47783 4) R128 was admitted to the facility on [DATE]. On 05/20/24, R128 was transferred to an acute care hospital for complaints of left shoulder pain. A review of the EHR was conducted and no documentation was found of the facility providing a written notification of the bed hold policy to R128 or her representative. 5) R128 was admitted to the facility on [DATE]. On 05/20/24, R128 was transferred to an acute care hospital for complaints of left shoulder pain. A review of the EHR was conducted and no documentation was found of the facility providing a written notification of the bed hold policy to R128 or her representative. On 07/17/24 at 02:30 PM, an interview was conducted with SW1 in the conference room. SW1 confirmed that the facility does not give a written notification of the bed hold policy to the residents or their representative when they are transferred to an acute care hospital.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47783 Based on observation, interviews and record review, the facility failed to complete a comprehensive assessment for one resident sampled for being a smoker. As a result of this deficient practice, the facility failed to identify resident (R) 38 as a smoker and no plan of care was developed to address the health and safety risks associated with smoking. Findings Include: On 07/15/24 at 12:24 PM, observed R38 up in his wheelchair in the hallway at Unit 4, propelling himself to one of the doors that open to the parking lot. R38 stopped to talk to Registered Nurse (RN) 6 as she was preparing medications. R38 then proceeded to exit Unit 4 and went to the parking lot unsupervised. Asked RN6 where R38 was going, she said he was going to the parking lot to smoke. At 01:13 PM, observed R38 come back into Unit 4. R38 had a pack of cigarettes and a lighter in his shirt pocket. Asked R38 how long he has been smoking. R38 responded, Since I was [AGE] years old. On 07/16/24, a review of R38's Electronic Health Record (EHR) was conducted. R38 was admitted to the facility on [DATE]. Review of current care plan dated 06/05/24 revealed that there was no documentation of the resident being a smoker and no smoking assessment was found in the EHR. On 07/18/24 at 07:56 AM, interview was conducted with RN6 outside of R38's room. Asked RN6 if they keep R38's cigarettes and lighter locked in the medication cart. RN6 said they do not since he is cognitively intact and only smokes when he goes outside to the parking lot or when he goes out of the facility for his dialysis treatments. On 07/18/24 at 11:16 AM, a concurrent interview and record review with the Director of Nursing (DON) was conducted in the conference room. Asked DON if there should be a care plan for residents that smoke. DON said, Yes. Reviewed care plan for R38 with DON, no care plan was found to address him being a smoker. DON said she will check if the assessment was done. On 07/18/24 at 01:27 PM, an interview with Licensed Practical Nurse (LPN)2 was conducted at the Unit 4 nurse's station. LPN2 confirmed that the comprehensive assessment did not identify the resident as a smoker, so no smoking assessment was done. LPN2 added that since he was not identified as a smoker, there was also no care plan developed. Review of facility policy titled Physical Environment, Facility with Independent and Supervised Smokers stated, . Residents who wish to smoke will be assessed for smoking safety by nursing. assessment will be completed on admission, quarterly, . and as needed .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43414 Based on observation, interview, and record review the facility failed to develop a comprehensive person-centered care plan for one of 37 residents sampled (Resident (R) 29). R29's was not care planned for diabetic foot nail care. Findings include: Cross reference to F677. The facility failed to carry out daily living activities (ADLs) to maintain good grooming for R29 dependent on ADL care. R29 did not receive proper foot nail care. This puts the resident at risk for cuts and wounds on her feet. R29 was admitted to the facility on [DATE] with diagnoses, not limited to, restless legs syndrome, type 2 diabetes, hyperlipidemia, hypertension, dementia, and peripheral vascular disease. On 07/16/24 at 10:11 AM, an interview with Family Member (FM) 4 was done. FM4 reported R29's left big toe was amputated due to an infection and gangrene. FM4 was not sure how she got the wound on her toe in the first place because R29 was not mobile and stated after the facility informed her of the wound and the progression to an infection, it happened so fast. FM4 mentioned that the facility does not cut R29's toenails, her toenails are long, thick, and close to the nail bed. FM4 did not recall the last time R29 had her toenails cut, and believed she did not get them cut since she was admitted in 2022. FM4 stated R29 has not seen a podiatrist. On 07/16/24 at 01:00 PM, concurrent observation of R29's right foot toenails with FM4 were done. R29's toenails were long, thick, and digging into her nailbed. On 07/17/24 at 02:27 PM, an interview with Certified Nurse's Aide (CNA) 5 was done. CNA5 reported the facility had never cut R29's toenails because she was diabetic. On 07/17/24 at 01:48 PM, an interview and concurrent record review with Nurse Manager (NM) 1 was done. NM1 reported that nail care for diabetic residents is done by the charge nurse, however, for toenails, it is normally referred to the podiatrist if the nails are thickened and the resident is diabetic. Concurrent review of R29's EHR, found R29's care plan did not include foot nail care for diabetes and/or to be referred to a podiatrist for foot care. NM1 stated this should be care planned.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 42160 Based on interview and record review, the facility failed to ensure resident's care plan meetings were completed quarterly, and resident's care plans was revised and prepared by an Interdisciplinary (IDT) team, that includes but is not limited to the attending physician, registered nurse, nurse aide, and the resident's representative(s) for four residents (Resident (R) 58, R168, R253, and R38) sampled. Findings include: 1) Reviewed R58's EHR. Reviewed documentation of R58's most recent IDT meeting, conducted on 06/25/24 and 03/21/24, revealed the disciplines represented in the IDT meetings were social services and recreation services staff and did not include the resident's attending physician, registered nurse, or a nurse aide. During an interview with R58 on 07/18/24 at 09:43 AM, it was confirmed the resident's attending physician, a registered nurse, and a nurse aide did not attend or participate the resident's IDT meeting conducted on 06/25/24. On 07/18/24 at 01:14 PM, conducted a concurrent record review and interview with the Director of Nursing (DON) regarding R58's IDT care plan meetings. DON confirmed social services and recreation services were the only disciplines which attended R58's care plan meetings on 03/21/24 and 06/25/24. DON also confirmed the resident's attending physician, registered nurse, and if possible, a nurse aide should be attending each resident's IDT care plan meetings. 43414 2) On 07/16/24 at 08:59 AM, an interview with R168 was done. R168 reported he had not been invited to his care plan meeting regarding his nursing care and treatment. R168 stated if they did invite him, he would go. Review of R168's last IDT meeting on 01/22/24 documented the social services assistant and a recreation staff member attending the IDT meeting. The attending physician, a registered nurse, and nurse aide was not documented to attend the meeting. The sign-in sheet did not include R168's signature, the signature line was left blank. On 07/17/24 at 02:56 PM, an interview with Social Worker (SW) 1 was done. SW1 reported IDT meetings are conducted quarterly and annually and for long-term care residents, nursing staff and the physician do not attend the IDT meetings. SW1 confirmed the last IDT meeting for R168 was done on 01/22/24 and the next quarterly meeting should have been done in April. 3) On 07/16/24 at 09:15 AM, an interview with R253 was done. R253 expressed she does not recall a care plan meeting regarding her nursing care and treatment and stated it would be helpful to have one and wouldn't mind attending. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R253's last IDT meeting on 06/20/24 documented the social services assistance, the registered dietician, and a recreation staff member attending the IDT meeting. The attending physician, a registered nurse, and nurse aide was not documented to attend the meeting. The sign-in sheet did not include R253's signature, the signature line was left blank. On 07/17/24 at 02:56 PM, an interview with SW1 was done. SW1 confirmed nursing staff and the physician did not attend the IDT meeting. 47783 4) On 07/15/24 at 01:33 PM, an interview was conducted with R38. Asked R38 if he was invited to his care plan meetings or participated in the development of his plan of care. R38 replied that he would like to attend in person but was not given a choice. R38 stated that the paper invitation he gets from the facility has the option to attend crossed out with a note stating that option was not available. On 07/16/24, a review of R38's EHR was conducted. Reviewed the last three IDT meetings on 11/10/23, 03/29/24 and 07/12/24. On the attendance sign-in sheet for all three IDT meetings, only the social services and recreational services staff attended. Resident's name was also on the sign-in sheets but there was no signature. Review of the invitation letters for all three meetings also revealed that the option to attend the meeting in person was crossed out with a notation that stated, Option 1 not available at this time. On 07/18/24 at 08:51 AM, an interview with SW1 was conducted. Asked SW1 why the option to attend the IDT meeting was not available. SW1 said, It's an old letter used during COVID time. SW1 added that they did meet with R38 on 07/12/24 to go over his care plan. SW1 said that if R38 wanted to change something, they would note it. If R38 had any questions, they would bring it up with the physician, registered nurse or dietitian as needed. SW1 confirmed that the care plan was already completed before they met with R38 on 07/12/24. When asked why the physician and the registered nurse did not attend the IDT meeting with R38, SW1 said, They may have not been available at the time. On 07/18/24 at 10:48 AM, an interview with the DON was conducted in the conference room. DON confirmed that the all the IDT members which included the physician and the registered nurse need to be present for the care plan meetings.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43414 Based on observation, interview, and record review, the facility failed to carry out daily living activities (ADLs) to maintain good grooming for one of two residents sampled (Resident (R) 29) dependent on ADL care. R29 did not receive proper foot nail care. This puts the resident at risk for cuts and wounds on her feet. Findings include: R29 was admitted to the facility on [DATE] with diagnoses, not limited to, restless legs syndrome, type 2 diabetes, hyperlipidemia, hypertension, dementia, and peripheral vascular disease. Review of R29's Electronic Health Record (EHR) found on 06/16/24 R29 had a wound to her left big toe. A nursing progress note dated 06/16/24 documented a skin check and assessment of R29 left big toe done, .a small amount of pus came out when .cleaned .up .dry skin on the front of the toe came out, showing a pinkish red color. Bottom of the resident left big toe was reddish purplish in color. On 06/28/24, R29 was sent to the emergency room for further evaluation of an infection of the left big toe and admitted to the hospital due to wound infected with pseudomonas orzyhabitans and gangrene of the left big toe. On 07/07/24 R29's left big toe was amputated. R29 was readmitted to the facility on [DATE]. On 07/16/24 at 10:11 AM, an interview with Family Member (FM) 4 was done. FM4 reported R29's left big toe was amputated due to an infection and gangrene. FM4 was not sure how she got the wound on her toe in the first place because R29 was not mobile and stated after the facility informed her of the wound and the progression to an infection, it happened so fast. FM4 mentioned that the facility does not cut R29's toenails, her toenails are long, thick, and close to the nail bed. FM4 did not recall the last time R29 had her toenails cut, and believed she did not get them cut since she was admitted in 2022. FM4 stated R29 has not seen a podiatrist. On 07/16/24 at 01:00 PM, concurrent observation of R29's right foot toenails with FM4 were done. R29's toenails were long, thick, and digging into her nailbed. On 07/17/24 at 02:27 PM, an interview with Certified Nurse's Aide (CNA) 5 was done. CNA5 reported the facility had never cut R29's toenails because she was diabetic. On 07/17/24 at 01:48 PM, an interview and concurrent record review with Nurse Manager (NM) 1 was done. NM1 reported that nail care for diabetic residents are done by the charge nurse, however, for toenails, it is normally referred to the podiatrist if the nails are thickened and the resident is diabetic. Concurrent review of R29's EHR, found there was no indication that R29 had seen or was referred to a podiatrist since she was admitted to the facility. No documentation that R29 had toenail care while in the facility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure QUALITY OF CARE Foot Care dated 03/2023, documented The facility will provide care and treatment to maintain mobility and good foot health. Foot care and treatment will be in accordance with professional standards of practice, including efforts to prevent complications from the resident's medical conditions. The facility will assist in making necessary appointments with a qualified person and arranging transportation to and from appointments .1. Treatment includes preventive care to minimize podiatric complications in residents with diabetes and circulatory disorders. 2) Residents with complicating disease processes will be referred to qualified professionals for foot care.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on observation, interview, and record review, the facility failed to ensure there was an ongoing resident-centered activities program that fully identified and met the resident's needs, for 2 of 3 residents sampled for activity (Residents 171 and 198). As a result of this deficient practice, both residents were placed at risk of experiencing a decline in their psychosocial well-being and quality of life. This deficient practice has the potential to affect all residents at the facility. Findings include: 1) Resident (R)171 is a [AGE] year-old male admitted to the facility on [DATE] for long-term care. R171's admitting diagnoses include, but are not limited to, heart disease, diabetes, dementia, depression, and history of a right above the knee amputation. A review of R171's Minimum Data Set (MDS) Admission Assessment with an Assessment Reference Date (ARD) of 02/05/24 noted R171 had been assessed with a Brief Interview for Mental Status (BIMS) score of 13, indicating a determination that he was cognitively intact. On 07/16/24 at 08:36 AM, an interview was done with R171 at his bedside. When asked about activities, R171 stated that staff do not take him out of his room to activities. When he asks to get up out of bed for activities, he is told you cannot walk, you have to lay there. R171 complained that staff never get him up out of bed, and no one comes into his room to offer him individual activities such as puzzles or books either. R171 stated he would like to go out to activities occasionally, but staff refuse to get him up. On 07/17/24 at 01:01 PM, an interview was done with the activities director (AD) in her office. When asked how often one-to-one activities are offered to residents who do not leave their rooms, AD responded that in-room activities should be offered 3-4 times a week. R171's activity log for the last three months was requested, however AD reported she can only provide a log for the last 30 days. During a concurrent review of R171's activity log for the last 30 days, AD confirmed that she did not see documentation of any activities being offered to R171. AD reported that the facility does have dog therapy three times a week, and that she knows R171 enjoys that, but that too should be documented on the activity log. AD could not explain why there was no documentation found of any activities being offered. AD confirmed that even if R171 had been offered but refused activities, it should still be documented on the activity log. 2) R198 is a [AGE] year-old male admitted to the facility on [DATE] for long-term care. R198's diagnoses include, but are not limited to, left-sided paralysis and weakness following a stroke, aphasia (a language disorder that affects how you communicate; caused by damage in the part of the brain that controls language expression and comprehension), depression, and generalized muscle weakness. On 07/15/24 at 09:16 AM, an observation was done of R198 lying in bed awake in a silent room. R198 had no visible television or radio and appeared bored. On 07/16/24 at 08:20 AM, observed R198 again lying awake in bed in a room that was completely silent. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/17/24 at 08:43 AM, an interview was done with R198 as he lay in bed. When asked about activities, R198 stated that he does not want to go out to activities but would like to listen to music in his room. R198 expressed that he was often bored with nothing to do and confirmed that he had no access to a radio or television. A review of R198's Comprehensive Care Plan (CCP) notes the following under the Focus of Activity/Recreation: Staff to provide/encourage 1:1 [one-to-one] visits with resident consist [sic] with music and sensory. On 07/17/24 at 01:10 PM, an interview was done with the AD in her office. During a concurrent review of R198's activity log for the last 30 days, the AD noted documentation of 1:1 activities being offered five times in 30 days. The AD stated that she knew R198 often declined activities that were offered, however, reviewing his activity log, it did not appear that staff were documenting his declinations as they should be. The AD stated she would expect to see 1:1 activities offered 3-4 times a week. When asked about a television or radio for him, the AD stated televisions must be provided by the resident, but she could offer R198 a radio to keep at his bedside.

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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 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 42160

Based on observation, interview, and record review, the facility failed to ensure the nursing treatment and care provided met the needs of 2 of 37 residents (Residents 188 and 171) in the sample and was in alignment with standards of good clinical practice. As a result of this deficient practice, the residents were placed at risk of avoidable injury and/or complications and were hindered from attaining their highest practicable well-being.

Findings include:

1) R188 was returned to the facility on [DATE] from an acute hospital. Review of the acute hospital's discharge summary, R188 presented on 04/03/24 with sepsis with suspected sacral Skin and Soft Tissue Infection (SSTI) and associated complications. A blood culture confirmed bacteremia with gram positive cocci which is known to cause skin infections, pneumonia, endocarditis (life-threatening inflammation of the inner lining of the heart's chambers and valves), septic arthritis (painful infection in a joint that travel through the bloodstream to other parts of the body), osteomyelitis (swelling or inflammation that occurs in the bone), and abscesses (a buildup of pus under the skin which can affect any part of the body).

Review of R188's skin assessments confirmed the resident currently has a stage 4 Pressure Ulcer (PU) (full thickness tissue loss with exposed bone, tendon, or muscle) on the sacral region; stage 4 PU of the left hip; a Deep Tissue Injury (DTI) which is a purple/maroon localized area of blood filled blister due to damage of underlying soft tissue due from pressure and/or shearing; and four (4) open lesion to the front left knee, the front loser lateral leg, right dorsum foot, and front right knee. R188 is currently on contact precautions, which require staff to don gloves and a gown for all interactions that may involve contact with the resident or resident's environment to contain pathogens which could be spread to other residents.

Review of R188's most recent annual MDS, with an ARD of 02/27/24, documented the resident BIMS score of 11 indicating the resident has moderate cognitive impairment. Section GG- Functional Abilities and Goals documented R113 has functional limitation in ROM with impairment on one side for the upper (shoulder, elbow, wrist, hand) and lower (hip, knee, ankle, foot) extremities. R188 is dependent (helper does all the effort. resident does none of the effort to complete activity) on staff for toileting hygiene, shower/bathe, lower body dressing, personal hygiene, putting on/taking off footwear, and chair to bed transfers.

- Observations of R188's physical environment on 07/17/24 at 09:17 AM, the shower room contained dark green and black organic growth, which was fuzzy and raised in appearance, with a strong musty smell on the shower floor room, wall, the connection points of the handheld showerhead tubing, and showerhead spout. The organic growth was persistent throughout the handheld shower that it clogged the small holes on the showerhead which the water comes out of directly onto the resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/19/24 at 10:30 AM, conducted an interview with HK2 regarding the visible organic growth in the resident's shower room. After viewing the shower room with this surveyor and CNA59 it was confirmed shower rooms should be cleaned daily by housekeeping staff and the amount of organic growth in R188's shower appears as if it had not been cleaned in over 2 weeks, at a minimum. CNA59 also confirmed R188 currently uses this shower at least twice a week. HK2 cleaned the shower, however, was not able to entirely remove all the organic material and has not cleaned the showerhead. - On 07/18/24 at 10:58 AM, while sitting at the nursing station, this surveyor heard R188 calling out for staff, saying Hello, can anybody hear me? Hello and calling out for RN42. Observed two CNAs walk past R188's room and did not address the resident's calls for help. A moment later, RN42 walked to the medication cart located across R188's room door, while the resident continued to yell out for staff. RN42 was on the computer located on the medication cart and not passing any medication. At 11:12 AM, RN42 entered the room and addressed R188's calls for staff assistance. Review of R188's fall care plan documented interventions including, Anticipate and meet the resident's needs, he usually doesn't call for assist (date revised 04/26/2024). and Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all request for assistance (Date initiated: 11/21/2023). - On 07/19/24 at 11:27 AM, entered R188's room and observed the resident's right foot was not properly placed in the boot for pressure ulcer prevention and the open lesion on the side of the resident's big toe was in direct contact with the bed sheet. There were dried blood stains on the bedsheet from the open lesion indicating the resident's foot had not just recently become dislodged from the protective boot. Observed R188's catheter bag in direct contact with the ground. The catheter bag cover was present but had not been properly applied. on the ground with no covering. The resident appeared to be struggling to grab the side rail attached to the bed. When asked what he was doing, the resident requested for this surveyor to pass him the pancake call light which was located on top a drawer located out of the resident's reach. Inquired why the call light was on the drawer out of reach the resident's reach. R188 reported that staff often puts the call light on the drawer because staff tell him he calls for staff too much. At 11:31 AM, CNA81 entered R188's room and inquired about R188's boot, which was not properly applied, the catheter bag uncovered and, on the floor, and the call light being out of the resident's reach. CNA81 confirmed R188 is totally dependent on staff and confirmed R188's foot should have been placed in the boot properly, the catheter bag should have been covered and hanging off the ground, and the call light should have been within the resident's reach but was not. CNA81 then placed the call light next to the resident, picked up and covered the catheter bag and hung it from the bedside, then grabbed the resident's hand and assisted the resident with grabbing the side rail and was not wearing a gown or gloves. Inquired if CNA81 should be wearing a gown and gloves to be following proper PPEs for a resident on contact precaution. CNA81 confirmed he/she should have donned a gown and glove prior to being in direct contact with R188 or the resident's physical environment. 43245 (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Resident (R)171 is a [AGE] year-old male admitted to the facility on [DATE] for long-term care. R171's admitting diagnoses include, but are not limited to, heart disease (with a pacemaker), diabetes, dementia, depression, and history of a right above the knee amputation. A review of R171's Minimum Data Set (MDS) Admission Assessment with an Assessment Reference Date (ARD) of 02/05/24 noted R171 had been assessed with a Brief Interview for Mental Status (BIMS) score of 13, indicating a determination that he was cognitively intact. On 07/16/24 at 08:52 AM, observed R171 lying in bed with both arms severely bruised with old and new bruises. His left leg was also noted to have extensive old and new bruises. R171 stated he did not know how he was getting the bruises because he is never allowed to get up out of bed. A review of R171's physician orders noted R171 was taking Apixaban (an anticoagulant that decreases the clotting ability of the blood and helps prevent harmful clots from forming) 5 mg (milligrams) twice a day. A review of R171's Comprehensive Care Plan (CCP) for the Focus of Anticoagulant/Antiplatelet revealed the following intervention: Bleeding Precautions: Report any bruising to the nurse. Observe gentle handling during care. For the Focus of Skin Impairment, the following intervention was noted initiated on 06/05/24: The resident needs protective sleeves for the arms. A follow-up review of the physician orders noted no orders for any type of skin protection or covering to help minimize the risk of bruising. On 07/17/24 at 09:58 AM, an interview was done with Nurse Manager (NM)2 at the Unit 2 Nurses' Station (U2NS). NM2 confirmed that R171 rarely is gotten up out of bed into a wheelchair because he has poor trunk control. When asked about the bruising on R171's extremities, NM2 reported that staff is aware of the bruising, but does not think R171 has been offered skin protection before. NM2 agreed given the extent of the bruising despite being bed-bound, skin protection is something that should have been implemented. On 07/18/24 at 10:46 AM, a follow-up interview was done with NM2 at the U2NS. NM2 confirmed that after finding no Geri-sleeves (skin protection for arms) in R171's possession the previous day, she had the facility issue him a pair and they were applied. NM2 agreed that the intervention should have been implemented before.

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F 0688

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43245

Based on observation, interview, and record review, the facility failed to ensure 2 of 3 residents (Residents 199 and 20) sampled for limited range of motion (ROM) received the appropriate treatment and services to prevent, or delay, further decrease in their ROM, mobility, and independence. As a result of this deficient practice, Resident (R)199 can no longer be transferred into his motorized wheelchair, and R20 now has contractures to her left hand that were not present at admission. These outcomes hinder both their abilities to reach their highest practicable well-being. This deficient practice has the potential to affect all the residents at the facility.

Findings include:

1) Resident (R)199 is a [AGE] year-old male admitted to the facility on [DATE] for long-term care related to his diagnosis of Amyotrophic Lateral Sclerosis (ALS), a disease affecting nerve cells in the brain and spinal cord, causing progressive loss of voluntary movements and muscle control, and eventually leading to death. A review of R199's MDS Significant Change in Status Assessment with an ARD of 04/05/24 noted R199 had been assessed with a BIMS score of 15, indicating a determination that he was cognitively intact.

On 07/15/24 at 01:57 PM, an interview was done with R199 at his bedside on Unit 2. When asked about staffing, R199 stated that since November 2023, there has been a real lack of staff. As a result, he feels that the care has decreased since he got here a year ago. R199 reported that the unit seems especially short in the mornings because of showers, morning hygiene, toileting, and breakfast. R199 explained that he has filed multiple grievances regarding staffing and quality of care, but things have not changed. States that he is so tired of being told we [the facility] are short-staffed by management. When asked how the staffing problems may have contributed to a specific outcome for him, R199 stated that from January through March of 2024, he should have had half an hour of Restorative Nurse Assistant (RNA) services five (5) days a week, but he didn't. As a result of his ALS, R199 is paralyzed from the neck down, and needs passive range of motion (PROM) to be performed regularly. During those 3 months I should have been getting it [PROM] 5 days a week, I think I got it maybe 5 times total. R199 further explained that on Christmas Day 2023, he was able to stand and pivot with assistance and sit in his $50,000 motorized wheelchair. Now he cannot even be mechanically transferred to sit in his wheelchair because his knees have locked up and can no longer bend. R199 feels that if he had received the RNA services as scheduled, he would still be able to bend his knees, sit in his wheelchair, and have home visits. R199 stated he has not been out since Christmas day. R199 also stated that he has not had RNA services for weeks because they are always pulling the RNA to do CNA [Certified Nurse Aide] duties.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/17/24 at 10:15 AM, an interview was done with RNA1 on Unit 2. RNA1 stated he has been an RNA at the facility since 2020. RNA1 confirmed that R199 should be receiving RNA services 5 days a week. RNA1 also confirmed that the facility is aware of the contractures (permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) to R199's knees and that they can no longer bend without great pain. RNA1 could not remember when he first noticed the knee contractures but confirmed that R199 did not have them on Christmas day 2023 when he sat in his motorized wheelchair and went home for a visit. RNA1 acknowledged that the unit was especially short-staffed from January to March 2024, yeah, it was bad. Explained that RNAs are responsible for RNA treatments Monday through Saturday, and to weigh the residents on Sundays. RNA1 stated that there are no relievers so when he is off, there is no RNA coverage on the unit. When asked about how often R199 has missed receiving RNA/PROM services, RNA1 explained that the RNAs are like the CNAs, we're short-staffed and we get to as many people per day as we can. RNA1 stated that there are 31 residents on Unit 2 scheduled to receive RNA services 5 days a week, there is no way one RNA can get through that many residents in one day. A review of the RNA logs for January through March 2024 revealed documentation of R199 receiving RNA services 14 out of the 65 times it was scheduled in that 3-month period. A review of the RNA log for July 1-17, 2024, revealed documentation that R199 had received RNA services 1 out of the 12 times he was scheduled. On 07/18/24 at 02:13 PM, an interview was done with the Director of Rehabilitation (DOR) and Occupational Therapist (OT)1. While both were unsure if contractures were unavoidable in residents with ALS, OT1 (who has worked with R199) agreed that his knee contractures would not have occurred at the rate and severity it is now had he received the RNA services/PROM 5 times a week as ordered. On 07/18/24 at 03:00 PM, an interview was done with the Director of Nursing (DON) in her office. DON acknowledged that contractures do occur when ROM/PROM is not done. Stated that she was uncertain if contractures were avoidable in residents with ALS and was looking for documentation. 2) Resident (R)20 is a [AGE] year-old female admitted to the facility on [DATE] for long-term care. R20's admitting diagnoses include, but are not limited to, left-sided paralysis and weakness following a stroke, heart disease, peripheral vascular disease, and lymphedema (swelling that generally occurs in an arm or leg, caused by a blockage in the lymphatic system). A review of R20's Minimum Data Set (MDS) Annual Assessment with an Assessment Reference Date (ARD) of 05/29/24 noted R20 had been assessed with a Brief Interview for Mental Status (BIMS) score of 14, indicating a determination that she was cognitively intact. On 07/16/24 at 09:32 AM, an interview was done with R20 at her bedside. R20 stated that she currently has left finger contractures that she did not have when she was admitted here 2 years ago, somebody thought they were helping me and massaging my tendons and they went a little too far. As a result, R20 reported that she wears a hand splint for a few hours every day. R20 stated that the contractures did not bother her or hinder her from performing her activities of daily living. On 07/18/24 at 10:59 AM, an interview was done with Registered Nurse (RN)15 and Nurse Manager (NM)2 at the Unit 2 Nurses' Station (U2NS). During a concurrent review of R20's electronic health record (EHR), both confirmed that R20 was not admitted with any contractures and that they should not have occurred.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 43245 Based on observation, interview, and record review, the facility failed to ensure there was sufficient nursing staff to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, in addition to their physical, mental, and psychosocial well-being. As a result of this deficient practice, the residents experienced a decreased quality of life and were unable to attain their highest practicable well-being. Findings include: 1) Cross-reference to F688 Increase/Prevent Decrease in ROM/Mobility. The facility failed to provide Restorative Nurse Assistant (RNA) and other services as scheduled to help prevent/minimize the formation and worsening of contractures in Residents (R)199 and R20. 43414 2) On 07/18/24 at 01:57 PM, during an interview with resident council members, R50 reported during their monthly resident council meetings, residents expressed the facility is short staffed and it has not been resolved. Resident council members reported that the residents have been told there should be at least six certified nurse's aides (CNA) on each floor, the same number of workers, but not based on units' acuity and census. However, residents are finding that there are only four to five CNAs on the units. Resident council members expressed the facility should staff the units based on acuity and census, and there are units with residents who need one on one supervision, but the facility cannot provide an assigned person which effects the other residents' care. Staff who are floaters, take long to provide care because they are not familiar with the resident and their routine. Instead of following the residents wishes on how they prefer to receive care they treat them as a task and just do it how they want to provide the care. Review of the resident council minutes for May 2024, June 2024, and July 2024 document short staffing on all floors, Nurses not assisting w/CNA when short on the floor, More Staffing on the floor. Scheduler removing staff who has already completed 3 hrs. [hours], More Staffing (CNA), Resident express more staffing (CNA) is needed on the floors, Resident had concerns regarding floating probation. DON [Director of Nursing] to follow up with staffing, and More Staffing. On 07/18/24 at 10:57 AM, during an interview with Director of Nursing (DON), DON reported staff members have expressed they are short staffed, and the RNA staff will volunteer to provide extra support when short staffed. On 07/19/24 at 12:12 PM, interview with Scheduler (S) 1 and S2 was done. S1 reported there is a criteria flow sheet (CNA matrix) they follow based on the census amount for each unit and staff accordingly. If there are residents who need one to one supervision, nursing staff communicate this and the schedulers will try to accommodate. Concurrent review of the facility's CNA matrix includes the ratio of one CNA for seven residents (1:7). During a full census on sampled units, Unit 2, Unit 4, and Unit 5, a minimum 36 residents. the matrix indicates six CNA's to be scheduled during the day shift on each unit. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reviewed a sample of three days of the facility's schedule and census, 06/05/24, 06/22/24, and 07/12/24. On 06/05/24, Unit 2 had a census of 44 residents with five CNAs assigned and working that day, a ratio of approximately 1:9. Unit 5 had a census of 50 residents with three CNAs assigned and working that day, a ratio of approximately 1:16. On 06/22/24, Unit 2 had a census of 44 residents with three CNAs assigned and working that day, a ratio of approximately 1:14. Unit 4 had a census of 43 residents with four CNAs assigned and working that day, a ratio of approximately 1:10. Unit 5 had a census of 49 residents with three CNAs assigned and working that day, a ratio of approximately 1:16. On 07/12/24, Unit 2 had a census of 44 residents with four CNAs assigned and working that day, a ratio of approximately 1:11. Unit 5 had a census of 50 residents with five CNAs assigned and working that day, a ratio of approximately 1:10. 47783 3) On 07/15/24 at 08:29 AM, initial interview conducted with R42 in his room. R42 said staffing has declined since COVID started in 2020 and it has affected the care provided to the residents. On 07/16/24 at 09:13 AM, a follow-up interview was conducted with R42. Asked R42 how his care has been affected by the staffing decline he mentioned in an earlier interview. R42 said that Unit 4 was supposed to have six CNAs on day shift but there are some days when they would only have five. R42 said that when they don't have enough staff, he would have to wait longer for service, up to 20 minutes. R42 stated, I would suffer a bit since I'm not able to move. I always ask for two people to move me. If there's only one, it's hard on them and me. It's safer if there are two. R42 added that when they are short of staff, he would have to wait longer for his meals, would not get his scheduled shower, and the dressing change for his wounds are delayed. On 07/17/24 at 08:23 AM, observed the staffing board at Unit 4 listed two registered nurses (RN) and five CNAs scheduled to work. Asked RN5 if they had enough staff schedule for the shift. RN5 said they were short one CNA since they are supposed to have six. When asked how often are they short of staff, RN5 did not answer the question. RN5 instead said, The administration tries their best to get us staff by asking for OT (overtime) or calling agency staff. Census for Unit 5 was 40. On 07/19/24, the staffing board at Unit 4's nurse's station had two registered nurses and five CNAs scheduled to work. Census for Unit 5 was 40. On 07/19/24 at 12:34 PM, an interview with S1 was conducted in his office. Asked S1 how many CNAs were supposed to be scheduled at Unit 4 on 06/22/24 with a census of 43. S1 said there were supposed to be six CNAs. When asked S1 if they had six CNAs working at Unit 4 on 06/22/24, S1 looked in the computer and said only five CNAs were working that day including one working overtime.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48351 Based on observations and interviews, the facility failed to ensure that one of the licensed nurses had the specific competencies and skill sets necessary to care for residents' needs. This failed practice has the potential to affect all the residents on one of the five nursing units. Findings include: R239 is an [AGE] year-old female admitted to the facility on [DATE]. A review of R239's Brief Interview for Mental Status (BIMS), with an Assessment Reference Date (ARD) of 05/09/24 was conducted. R239's BIMS score was an 11, meaning R239 had moderate cognitive impairment. Observation was conducted on 07/15/24 at 09:00 AM in R239's room. R239 was lying in bed watching television. On her bedside table was a medication cup with four different pills. When asked about the medication cup, R239 stated that she forgot it was there. She stated it was her morning medications that were left there by Registered Nurse (RN) 10. State Agency (SA) then exited the room to look for RN10. RN10 was observed at the other end of the hallway performing medication administration. Registered Nurse Manager (NM) 1 was observed at the nurse's station. Interview was conducted with NM1 on 07/15/24 at 09:04 AM. NM1 stated that medications should not be left in the room. NM1 added that the nurse administering the medication should wait with the resident until she observes the resident taking it. Interview was conducted on 07/18/24 09:03 AM with RN10 in the hallway. RN10 stated the R239 did not want to take her medications when it was offered to her. RN10 added that when a resident is not ready to take their medications, the nurse would normally take the cup of medicine out of the room, but this time RN10 left it on top of R239's bedside table. Interview was conducted with Director of Nursing (DON) on 07/19/24 at 10:30 AM. DON stated that when a resident is not ready to take his/her medications when it is offered, the nurse must take the medications out of the room and properly store it, until the resident is ready.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 43414 Based on observation, record review and interview, the facility failed to ensure the nurse staffing data was posted daily at the beginning of each shift, in a prominent place readily accessible to residents and visitors, and ensure staffing information was complete with specific units reflected on the posting. Findings include: On 07/15/24 at 08:13 AM, during observation of Unit 3, including the nurse's station, the bulletin board, and the elevators, the nurse staffing data posting was not found. Inquired with other surveyor team members if postings were found on their assigned units to screen, Unit 2 and Unit 4 were observed to not have the postings. The postings were not found at the entrance of the facility, near the facility elevators, or on the bulletin boards on the ground level. On 07/15/24 at 08:32 AM, during a tour of Unit 2, no staff posting was observed near the elevators, on the bulletin board, or at the Nurses' Station. On 07/15/24 at 10:43 AM, observed a staff posting had been brought up and placed on the bulletin board near the Unit 2 Nurses' Station. Review of the staff posting however, noted it pertained to the entire facility and did not provide residents and visitors information regarding the census and staffing hours specific to Unit 2. On 07/17/24 at 08:51 AM, observed the posting on ground level at the bulletin board where staff members clock in and out, and announcements and information for staff members are posted. On Unit 3, observed the posting on the bulletin board next to the nurse's station dated Tuesday, 07/16/24, yesterday. The posting on Unit 3 did not have specific information regarding Unit 3 on the posting. On 07/18/24 at 08:14 AM, interview and concurrent observation with Unit Manager (UM) 4 was done. Inquired where the facility posts their nurse staffing data, UM4 reported she did not know and inquired with the nurse on the floor, who pointed to the whiteboard with staff names but not the nursing staffing data with required information. This surveyor directed UM4 to the bulletin board next to the nurse's station and concurrently observed the posting. UM4 confirmed the date on the posting was from two days ago, 07/16/24. Concurrent observation of the ground level posting on the staff bulletin board was conducted. Inquired if the posting was in area where residents or visitors would look when coming in and out of the facility, UM4 confirmed it was not, and stated it was not in an area visible to residents and visitors but more for staff members to see. On 07/19/24 at 10:20 AM, interview with Director of Nursing (DON) and concurrent observation of the nurse staffing data posted on the ground level staff bulletin board was conducted. Inquired if the facility posts the document anywhere else. DON reported it should be on every unit. Inquired if the postings on the units include information related to the unit, DON reported it does not but includes the information for the entire facility. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's policy and procedure NURSING SERVICES Posted Nurse Staffing Information dated 03/2023, documented At the beginning of each shift, on a daily basis, the facility will post: 1) the facility name; 2) the current date; 3) the total number and the actual hours worked by . [nursing staff] .responsible for resident care per shift, and; 4) resident census. Data will be in a clear and readable format in a prominent place readily accessible to resident and visitors.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 43245 Based on observation, interview, and record review, the facility failed to implement a thorough process in narcotic log documentation and reconciliation. This deficient practice hinders the process necessary to promptly identify loss or potential diversion of the controlled medications used to meet the needs of the residents. Findings include: On 07/17/24 at 09:22 AM, an inspection of the Unit 2 Medication Cart #1 was done with Nurse Manager (NM)2. While reviewing the narcotic log, the following discrepancies in narcotic log documentation and actual narcotic count were observed by the State Agency (SA) and confirmed by NM2: Oxycodone IR [immediate release] 5 milligrams (mg). Narcotic log shows there should be twenty-three (23) tablets remaining in the blister pack; only twenty-one (21) tablets observed. Clonazepam 0.5 mg. Narcotic log shows there should be sixteen (16) tablets remaining in the blister pack; only fifteen (15) tablets observed. Interview done with NM2 at the time confirmed that all narcotics should be signed out on the narcotic log when pulled from the medication cart, not after the medication(s) are given. On 07/19/24 at 10:54 AM, an interview was done with the Director of Nursing (DON) in the Conference Room. DON stated the expectation is that narcotics should be signed out on the narcotic log as soon as they are dispensed from their containers/blister packs.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on observation, interview, and record review, the facility failed to ensure all medications used in the facility were labeled in accordance with professional standards. Proper labeling of medications is necessary to promote safe administration practices, decrease the risk for medication errors, and decrease the risk for the diversion of resident medications. This deficient practice has the potential to affect all residents in the facility who take medications. Findings include: 1) On [DATE] at 08:54 AM, an inspection was done of the Unit 2 medication cart #2 with Registered Nurse (RN)15. Observed a vial of Lantus insulin for Resident (R)8 where the open dates and discard dates written on both the vial itself, and the box it was in, were completely unreadable. RN15 confirmed that since the information was indecipherable, the insulin vial needed to be discarded to ensure R8 would not be administered expired insulin. At 09:03 AM, observed an Admelog Solostar insulin pen for R8 that was labeled with an open date of [DATE] but no discard date. RN15 confirmed that the insulin pen was not labeled correctly as it should also have a discard date written in. Review of the facility's policy and procedure (P&P) Labeling and Storage of Drugs and Biologicals, last revised ,d+[DATE], revealed the following: Drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 47783 2) On [DATE] at 12:55 PM, concurrent inspection of the medication cart in Unit 5 and interview with Registered Nurse (RN) 7 was conducted. An insulin pen was found with no open and discard dates in the top drawer of the cart. A pink sticker was on the pen that stated, Discard 28 days after opening. RN7 verified that the insulin pen did not have open and discard dates and said it was used to administer a dose on [DATE]. RN7 confirmed that the staff are supposed to write on the pink sticker the day it was first used as the open date and 28 days after the open date as the discard date. On [DATE] at 11:23 AM, an interview was conducted with the Director of Nursing (DON) in the conference room. DON confirmed that the insulin pen is only good for 28 days after opening and that is why it is important to note the open and discard dates on the supplied sticker.

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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 observations, interviews, and record review, the facility failed to date and label a food item to prevent the potential for foodborne illness. This deficient practice has the potential to affect all the residents on one of the five nursing units. Findings include: Observation was conducted on 07/17/24 at 09:22 AM in one of the facility nutrition rooms. The freezer contained an unlabeled brown colored ice cream. Interview was conducted with Registered Nurse Supervisor (RN) 12. RN12 stated that nursing staff usually checks expiration dates and throws them away if needed. When shown the unlabeled ice cream, RN12 stated that it must have been from one of the resident's food trays and one of the staff had placed it in the freezer. RN12 added that the staff should have labeled the ice cream with the resident's name and date. A review of the facility's policy titled, Food Safety, dated 03/2023 was conducted. The policy noted, Food, including leftovers, will be labeled and dated in the refrigerator.

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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. 39754 Based on observation, staff interview, and review of policy, the facility failed to safeguard medical record information against unauthorized use by not logging off of the Electronic Health Record (EHR) on a computer laptop left unattended in a nursing unit hallway. As a result of this deficiency, there was risk for violations of the Health Insurance Portability and Accountability Act (HIPAA) privacy or security rules. Findings include: During observation of the second-floor nursing unit hallway on 07/16/24 at 08:15 AM, a computer laptop showing resident EHR was left unattended. No staff was in the immediate vicinity and there was risk of unauthorized access to the information. During staff interview on 07/16/24 at 08:20 AM, the Unit Manager was made aware of the situation and acknowledged that the EHR should have been logged off when left unattended. Review of facility policy on Resident Rights Privacy and Confidentiality read, Purpose, each resident has the right to privacy and confidentiality of personal care and medical records. Policy, the facility will respect the resident's right to personal privacy and the right to secure and confidential personal and medical records .

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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. 43245 Based on observation, interview, and record review, the facility failed to ensure appropriate protective and preventive measures for communicable diseases and infections. This is evidenced by the facility failing to ensure staff followed standard precautions by performing hand hygiene, implemented enhanced barrier precautions when appropriate, and sanitized shared medical equipment after each use. 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) On 07/16/24 at 10:15 AM, an observation was done of Registered Nurse (RN)16 changing the dressing on the gastric tube insertion site for Resident (R)199. RN16 was wearing gloves and a procedure mask, but no gown. Once the dressing was completed, observed RN16 change her gloves with no hand hygiene in between. She then administered a nasal spray to R199, after which he requested some oral medication. Observed RN16 doff her gloves right before leaving the room but performed no hand hygiene after that. On 07/16/24 at 10:31 AM, an interview was done with RN16 in front of the medication cart on Unit 2. When asked about hand hygiene between glove changes, RN16 stated she does not usually do hand hygiene between glove changes because the sink is not accessible at the bedside. When asked if the facility provided staff with alcohol-based hand rub (ABHR) that could be carried into the room and used for hand hygiene at the bedside, RN16 responded no. RN16 acknowledged that facility policy is to perform hand hygiene between glove changes and after doffing gloves and agreed that she should have done it. When asked about enhanced barrier precautions (EBP) while doing the dressing change for R199's gastric tube, RN16 agreed that she should have implemented EBP and donned a gown in addition to her gloves and mask for the dressing change. 43414 2) On 07/17/24 at 08:40 AM, during observation of R180, R180 began moaning and groaning, and stated he cannot breathe, observed his nasal cannula out of his nose. This surveyor requested Unit Manager (UM) 4 to assist R180. UM4 quickly went into R180's room without performing hand hygiene and adjusted R180's nasal canula. 47783 3) On 07/15/24 at 12:25 PM, observed Certified Nurse Aide (CNA) 12 passing meal trays in Unit 4. CNA12 was coming out of resident (R)49's room when she stopped to check on R44 who was up in her wheelchair in the hallway. CNA12 readjusted R44's mask, repositioned the blanket covering her lap then went back in the room to check on R183. When CNA12 got to R183's bedside, she repositioned the meal tray on the bedside table, pulled her blanket up then proceeded to check on R49. CNA12 moved R49's table closer and repositioned the meal tray to the middle of the table. CNA12 then exited the room and proceeded to R215's room and assisted her with her meal. CNA12 did not perform hand hygiene when moving from one resident to another. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hale Nani Rehabilitation and Nursing Center	1677 Pensacola Street Honolulu, HI 96822

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) On 07/17/24 at 08:27 AM, observed Registered Nurse (RN) 5 as she was passing medications at Unit 4. RN5 placed the medications to be administered to R11 in a plastic tray and entered room without performing hand hygiene. RN5 then placed the tray on R11's bedside table, removed 2 cups from the table, donned a pair of gloves, gave the inhaler (device used to deliver medication through the mouth directly into the lungs), then handed R11 a cup of water and asked him to rinse his mouth. RN5 then administered R11's insulin (diabetes medication) injection to his right arm, removed her gloves, discarded the cup used to rinse his mouth and exited the room. RN5 went back to her medication cart, donned new gloves, and wiped the medication tray with disinfecting wipes. RN5 did not perform hand hygiene between glove changes. 5) On 07/17/24 at 08:54 AM, observed CNA13 enter a room where four residents were lying in their beds. CNA13 brought a shared equipment used to check the resident's blood pressure. When CNA13 came out of the room, she performed hand hygiene using the alcohol-based hand rub (ABHR) dispenser mounted on the wall outside the room and entered the blood pressure readings on a tablet. Asked CNA13 if she disinfected the shared blood pressure cuff. CNA13 said she did not but knows she was supposed to. On 07/18/24 at 11:17 AM, an interview was conducted with the Director of Nursing (DON) in the conference room. DON confirmed that staff are supposed to perform hand hygiene before they enter and when exiting a resident's room, between glove changes, and when moving from one resident to another. DON also confirmed that the blood pressure cuff needs to be cleaned with disinfecting wipes immediately after use and before being used on another resident. Review of the facility policy Infection Prevention and Control Program (IPCP) stated, . Staff will perform hand hygiene, even if gloves are used . Before and after contact with the resident. After removing PPE (personal protective equipment which includes gloves) . multi-use equipment and supplies . will be de-contaminated prior to re-use.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 39754 Based on record review, staff interview and review of policy, the facility did not document the refusal of an influenza vaccine for one Resident (R)63 out of five residents sampled. As a result of this deficiency, there was a risk for miscommunication and misadministration of the influenza vaccine. Findings include: Record review for R63 showed no documentation of influenza vaccination administration or refusal for the last immunization time period '23-'24. During staff interview with the Infection Preventionist (IP) on 07/18/24 at 10:20 AM, IP said that R63's representative consented to the influenza vaccination and later R63 refused but that was not recorded in the Electronic Health Record. Review of policy on Infection Prevention and Control Influenza and Pneumococcal Immunizations read, Purpose, to minimize the risk of residents acquiring, transmitting or experiencing complications from influenza and pneumococcal disease. Policy, the facility will provide influenza and pneumococcal immunizations to minimize the risk of residents acquiring, transmitting or experiencing complications from influenza and pneumococcal disease. Residents and/or resident representatives will receive information related to the risks and benefits of immunizations. Immunizations will be administered according to the recommendations of The Advisory Committee on Immunization Practices unless medically contraindicated, refused or if the resident has previously been immunized. Administration of these vaccinations will occur based on this policy, specific physician orders are not needed prior to administration. Guidelines; Influenza, . 7. The resident record will reflect the provision of education and the administration or refusal of the immunization, or non-administration due to medical contraindication, precaution or other reason for non-administration of the vaccine .