STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125013	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maunalani Nursing and Rehabilitation Center	5113 Maunalani Circle Honolulu, HI 96816

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** 39754 Based on resident interview, family interviews, record review and staff interview, the facility failed to care for two Residents (R) 46 and 188 of eight residents reviewed, with respect and dignity. As a result of this deficiency, R46 and R188 were not given their right to the maintenance and/or enhancement of their quality of life. Findings include: 1) During an interview with R46's family (FAM) on 08/26/24 at 12:00 PM, FAM was concerned about several issues related to care and quality of life. FAM said that the showering was not being done three times a week as ordered. FAM said they would notice dirt or fecal like matter on the hands or fingernails after the supposed showering. FAM said they have not had any follow up from the physician about medications related to low blood pressure. During activities, FAM said that staff would speak loudly and scare R46. Review of Electronic Health Record (EHR) showed R46 was admitted on [DATE] with diagnosis including Cerebral Infarction (Stroke), Difficulty Walking, Muscle Weakness, Hypertension, High Cholesterol . Task; bed bath/shower 3x/wk., MWF mornings. 2) Interview on 08/27/24 at 10:45 AM, R188 said that staff took a long time to respond when he/she activated the call bell. After staff assisted R188 to the bathroom, they did not return to assist back to bed. R188 said that he/she made it back to the bed by self without any assistance. Review of EHR showed R188 was admitted on [DATE] with diagnosis including Post Knee Joint Replacement Surgery, High Cholesterol . Care Plan; Toilet use, I need substantial /maximum assist during toileting transfer, I need substantial /maximum assist to dependent assist during toileting hygiene. Staff interview on 08/29/24 at 11:00 AM, Director of Nursing (DON) acknowledged the care concerns previously mentioned. DON said that the facility was already aware of some of the concerns and would continue to work with the residents to resolve the care concerns.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 38870 Based on record review and interview, the facility failed to accurately assess one Resident (R) 2 of three in the sample who had two pressure ulcer's that were acquired in the facility. The resident assessment coded one stage three pressure injury as present on admission. The deficient practice potentially affects the care plan which implements the goals and treatment outcomes. All residents in the facility may be affected. Findings include: Cross Reference to F696. Electronic Health Record (EHR) review of the Minimum Data Set (MDS) Annual assessment date 02/27/2024. R2 did not have any unhealed pressure ulcers. RR of MDS change of status assessment date 04/11/2024. R2 has a stage three pressure ulcer that was coded as present on admission. Review of the Minimum Data Set (MDS) quarterly review 07/12/24. R2 is cognitively intact with impairment on bilateral upper and lower extremities and dependent on staff for self-care and mobility. R2 is coded with having a stage three pressure ulcer that was present on admission. Interview and concurrent record review with the Director of Nursing (DON) on 08/29/24 at 12:58 PM. The DON confirmed that R2's pressure ulcers were facility acquired and said that the coding in the MDS is incorrect and will need to be updated.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38870 Based on observation, interview, and record review, the facility failed to provide care consistent with professional standards of practice to prevent the development of two stage three (full thickness skin loss) pressure ulcers (a localized damage to the skin and/or underlying tissue, as a result of intense pressure in combination with shear) while in the facility for one resident (R) 2 of three in the sample. The facility staff failed to turn and reposition R2 every 1-2 hours. The deficient practice placed the resident at an increased risk of infection and poor health outcomes. All residents who require assistance from staff for mobility are at risk. Findings include: R2 is a [AGE] year-old female. Primary diagnoses includes other neurological conditions, and coronary artery disease. R2 was readmitted to the facility after being discharged to the hospital on 12/29/2023 per Electronic Health Record (EHR) review of the census and face sheet. Review of the facility matrix revealed that R2 had a stage three pressure ulcer not present on admission. Observation and interview with R2 on 08/26/24 at 09:00 AM. Observed R2 lying on her back center, the head of her bed up at a 45-degree angle working on a word search tablet. When asked if she likes to get up and go to activities, she stated, only Bingo on Tuesdays. I prefer to stay in my room. EHR review of the following Minimum Data Set's (MDS): Annual assessment date 02/27/2024; Change of status assessment date 04/11/2024, and Quarterly review dated 07/12/2024, cross reference to F641. EHR review of orders and wound care notes dated 08/22/24. Resident with stage three ulcer to right buttocks. Orders to turn and reposition every (Q) hour. Orders to sit no longer than 30 minutes. Observed R2 in her room in her bed on 08/26/24 at 11:15 AM. Her eyes were closed, lying on her back center with the head of bed up at 45-degree angle. Observation and interview with R2 in her room on 08/27/24 at 09:42 AM. Head of bed is up at a 45-degree angle, and she is on her back center. When asked if R2 has a sore on her back or her bottom, she said, something is there. When asked if she has a wound or a dressing, she said yes, they are taking care of it. The nurses are coming in to do change it. Observed R2 in the activity room on 08/27/24 at 03:30 PM Sitting up in her wheelchair with a Bingo card on the table with pieces on it. 08/28/24 11:31 AM observed sleeping in her bed with the head of bed up 45 degrees. She was laying on her back center. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and concurrent record review with Licensed Practice Nurse (LPN)25. On 08/29/24 at 11:20 AM on the unit near R2's room. The surveyor asked LPN25 where the ulcers are located and are they healing? She now has two ulcers on her buttocks. The left buttock was moisture associated skin damage (MASD) on 04/02/24, and now it's a stage three. The right buttock started in 05/2024 as a round open area. Now it is a stage three. We get her up for only 30 minutes when she attends Bingo once a week every Tuesday only for 30 minutes. The orders vary if it changes. She is being turned every two hours. Interview and concurrent record review with the Director of Nursing (DON) during the Quality Assurance Performance Improvement (QAPI) meeting in the Administrators office on 08/29/24 at 12:58 PM. The surveyor asked the DON to verify in the record when the resident received the pressure ulcers and if they were acquired in the facility after admission. The DON confirmed that R2's pressure ulcers were acquired in April and May 2024 after the admission and progressed to a stage three. The DON added that the coding in the MDS will need to reflect two stage three facility acquired pressure ulcers. Mauna [NAME] Nursing and Rehabilitation Center Policy for Pressure Injury 08/14/2024 revised reviewed. A. Minimize pressure, friction, and shearing .Limit amount of time resident may be in one position without moving in bed or chair by repositioning resident during a purposeful rounding or more frequently depending upon the resident's condition and specific needs .