STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125024	A. Building B. Wing	03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nuuanu Hale	2900 Pali Highway Honolulu, HI 96817

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 observation, interviews, and record review, the facility failed to ensure the resident's right to a dignified existence for one of three residents (R)8 sampled. R8 is dependent on staff for toileting needs. R8 removed a soiled incontinent brief which staff removed from the room and did not apply another incontinent brief for the resident. R8 was found on the ground, naked, tangled in cords, calling out for help, in full view of the resident's roommate. As a result of this deficient practice, all residents dependent on care from staff are at risk of potential for physical and psychosocial harm. Findings include: On 03/07/24 at 01:45 AM, review of R8's electronic health record (EHR) documented R8 was admitted to the facility on [DATE]. R8's diagnosis included myocardial infarction (heart attack), Dementia with behavioral disturbances, spinal stenosis (narrowing of spaces in the spinal canal), dry eye syndrome, ocular laceration, and rupture with prolapse/loss of intraocular tissue (ruptured eye which causes permanent blindness), high blood pressure, sleep apnea, and anxiety disorder. Review of R8's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 02/12/24, Section C. Cognitive Patterns documented R8's Brief Interview for Mental Status (BIMS) score was 13, indicating R8's cognition is intact. Section GG. Functional Abilities and Goals documented R8 has impairment to upper and lower extremities and is dependent on staff for toileting and transfer (requires 2 or more staff and use of a Hoyer lift for transfers). Reviewed R8's care plan which addressed behavioral symptoms of disrobing in public/room with approaches to redress R8, provide privacy if in the room, or move the resident to the room (if in public). There was an approach (intervention) for staff to frequently check on the resident when the resident was on the floor mattress. During a telephone interview with registered nurse (RN)21, it was reported that facility staff would leave R8 on the floor with no clothes or brief, in puddles of urine on the night shift (11 PM to 7 AM). (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cross reference to F689- Accident Hazard- While conducting observations of the Ewa unit on 03/08/24 at 04:55 AM, heard a resident calling out for Help multiple times and identified a resident in room [ROOM NUMBER] was calling out for staff. The closest staff to room [ROOM NUMBER] was Certified nurse aide (CNA)3, who actively providing care to a resident in room [ROOM NUMBER] and was unable to hear the calls for help. Upon entering room [ROOM NUMBER], observed R8 lying on the floor naked, on his stomach, two pillows under the resident's upper torso, in-between two floor mattresses, and the resident's genitalia was in direct contact with the ground. The oxygen concentrator humidifying solution bottle was under R8's shins and calves were tangled in the nasal tubing which bottle. R8's feet were tangled in the call light cord which was wrapped around the bed rail and connected to the wall and the cord of the oxygen concentrator machine which was also plugged into the wall. Observed two large bandages on R8's shins (both dated 03/07), redness on both knees and feet, multiple skin tears/small wounds both feet and legs, a scabbed cut (approximately 2-3 inches long) on the resident's right upper back, and two straight line cuts on the left calf. The privacy curtain located between R8 and the roommate, was open which left R8 in full view of R8's awake roommate. Surveyor provided a blanket to cover-up himself in a dignified manner and asked why he did not have any clothes or brief on. R8 stated he had a brief on but, .it was soaked, so I took it off and they didn't put another one on. They left me like this. Inquired how the resident alerts staff if he needs help. R8 reported he calls out for help because his call light does not work and even if it did work, he's blind and cannot see where staff put the call light. Activated the call light and certified nurse aide (CNA)3 responded several minutes later. CNA3 came into the room, looked at the resident, then stated she was going to get supplies and another staff to help assist with R8's care. CNA3 returned approximately seven minutes later with RN2. Conducted an interview with RN2 at 05:14 AM, during the interview RN2 stated it was R8's preferences to be on the floor mattresses, but the two floor mattresses had slid apart as it was not secure. RN2 confirmed R8's environment was not safe which resulted in the resident tangled in cords and after seeing R8 tangled in the cords, confirmed wounds on R8's legs resulted from the resident being on the floor (witnessed resident banging feet on oxygen concentrator machine when attempting to roll over, legs caught in cords, and the bottle with tubing under the resident's lower leg). At 05:38 AM, conducted an interview with CNA3 in the resident's room. Requested for CNA3 to locate the soiled brief R8 removed. CNA3 confirmed the soiled brief was discarded outside of the room and did not put another brief onto the resident because he requires at least two staff. CNA3 also confirmed the resident did not refuse application of a clean brief. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/08/24 at 08:58 AM, conducted a concurrent review of R8's EHR and interview with the director of nursing (DON) regarding the observations of R8 at 04:55 AM. Reviewed R8's care plan, DON confirmed the facility used to document frequent checks for the resident in a logbook, but no longer does and was unable to confirm if staff are completing frequent checks on R8. Inquired for the DON to provide documentation of when staff had assisted R8 with toileting on the 03/07/24 night shift (11 AM- 7PM). DON revealed on the vital tab CNA3 documented R8 had episodes of large urine on 03/08/24 at 11:29 PM; 02:15 AM and 04:30 AM. DON stated there was no documentation to support R8 refused a clean brief after he removed the soiled brief. DON determined R8 was left naked for a minimum of 30 minutes before being found by this surveyor. DON stated the curtain between the resident and roommate should have been closed when staff became aware that R8 was naked and while staff provided care to the resident. DON confirmed this surveyor's observation of R8 was not dignified. The DON and surveyor visited the resident in his room. DON confirmed environmental hazards do exist while R8 is on the floor and the resident is also at risk of infection due to the resident being in direct contact with the floor.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42160 Based on observations, interviews, and record review, the facility failed to ensure the resident's environment remains free of accident hazards for one resident (R)8 sampled. The facility implemented interventions to allow the resident to self-transfer from the bed to the floor mattress, but did not evaluate, analyze, identify, or address any environmental hazards which existed once R8 self-transferred to the floor mattress prior to implementing this intervention. Also, after implementing the did not monitor the effectiveness or safety for the floor mattress. As a result of this deficient practice, R8 sustained multiple skin tears, bruising, and wounds on both lower legs. Findings include: According to Definitions 483.25 (d) an Avoidable Accident means that an accident occurred because the facility failed to: - Identify environmental hazards and/or access individual resident risk of an accident, including the need for supervision and/or assistive devices; and/or - Evaluate and analyze the hazard and risks and eliminate them, if possible, or if not possible, identify and implement measures to reduce the hazards/risk as much as possible; and/or - Implement interventions, which include adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan, and current professional standard of practice in order to eliminate the risk, if possible, and if not, reduce the risk of an accident; and/or - Monitor the effectiveness of the interventions and modify the care plan as necessary, in accordance with current professional standards of practice. Cross reference to F550- Resident Rights. During a telephone interview with RN21, it was reported that facility staff would leave R8 on the floor with no clothes or brief, in puddles of urine on the night shift (11 PM to 7 AM). (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 0689 Level of Harm - Actual harm Residents Affected - Few	On 03/07/24 at 01:45 AM, conducted a review of R8's EHR. R8 was admitted to the facility on [DATE] with diagnosis which included a myocardial infarction (heart attack), Dementia with behavioral disturbances, spinal stenosis (narrowing of spaces in the spinal canal), dry eye syndrome, ocular laceration, and rupture with prolapse/loss of intraocular tissue (ruptured eye which causes permanent blindness), high blood pressure, sleep apnea, and anxiety disorder. Review of R8's quarterly MDS with an ARD of 02/12/24, Section C. Cognitive Patterns documented R8's BIMS score was 13, indicating R8's cognition is intact. Section GG. Functional Abilities and Goals documented R8 has impairment to upper and lower extremities and is dependent on staff for toileting and transfer (requires 2 or more staff and use of a Hoyer lift for transfers). Reviewed R8's care plan which documented an approach (intervention) (started on 08/11/22): 08/11/22: Bed against wall and standard mattress to left side of bed at all times. Bed in lowest position due to POA's, request to allow R8 to self-transfer to mattress. POA prefers to keep bed rails between resident bed and floor mattress to assist in bed mobility and independence with self-transfer to floor mattress. POA aware of risk and benefits, verbal consent obtained by DON and UM. Bed rail does not prevent resident from self-transferring to floor mattress. Nursing staff will reposition R8 when he self-transfers to standard mattress as indicated and tolerated by resident. On 08/07/22 an approach for staff to do frequent visual check while R8 is in bed and encourage the resident to call for assistance with repositioning and to ensure the call light is in reach at all times. On 03/08/24 at 04:55 AM, while conducting observations on the Ewa unit, heard a resident calling out for Help multiple times and identified a resident in room [ROOM NUMBER] was calling out for staff. The closest staff to room [ROOM NUMBER] was Certified nurse aide (CNA)3, who actively providing care to a resident in room [ROOM NUMBER] and was unable to hear the calls for help. Upon entering room [ROOM NUMBER], observed R8 lying on the floor naked, on his stomach, two pillows under the resident's upper torso, in-between two floor mattresses, and the resident's genitalia was in direct contact with the ground. The oxygen concentrator humidifying solution bottle was under R8's shins and calves were tangled in the nasal tubing which bottle. R8's feet were tangled in the call light cord which was wrapped around the bed rail and connected to the wall and the cord of the oxygen concentrator machine which was also plugged into the wall. After applying the blanket, R8 while attempting to roll onto his back and began kicking his feet to try and untangle his feet from the cords, despite his attempt, R8 was unable to free his feet from the cords. Surveyor assisted the resident with detangling from the cords, then R8 grabbed onto the bed sheet (on the framed bed mattress) for help with turning back onto his stomach during and the resident's feet were forcefully hitting the oxygen concentrator machine. Surveyor encouraged R8 to not turn and wait for staff assistance. Asked R8 how he alerts staff when he needs help/assistance. R8 responded he calls out for help until staff come. Inquired if he can use the call light. R8 stated, I'm blind, I cannot see where the call light is and even if I did use the call light, my light is broken because they said I need too much help and they have to take care of other residents. Informed R8 that the call light was wrapped around the bed rail and was going to activate it. R8 reported, They [staff] put it far away from me so I can't use it. The call light was activated and certified nurse aide (CNA)3 responded within five minutes. CNA3 assessed the resident then stated she was going to get supplies and another staff to help with R8's care. Observed two large bandages on R8's shins (both dated 03/07), redness on both knees and feet, multiple skin tears/small wounds both feet and legs, a scabbed cut (approximately 2-3 inches long) on the resident's right upper back, and two straight line cuts on the left calf. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 03/08/24 at 08:58 AM, conducted a concurrent review of R8's EHR and interview with the director of nursing (DON) regarding the observations of R8 at 04:55 AM. DON reported R8 received a new bariatric bed during the recent recertification survey (January 22-26, 2024), it is the preference of R8 to self-transfer from the bed to a mattress on the floor, R8's power of attorney (POA) is aware of this and signed a consent for to implement bedrails to assist R8 with self-transfers. DON revealed it is R8's preference to rest on the floor mattress, it helps him feel safe because he is blind. Reviewed R8's care plan. Although the facility obtained a signed consent for the use of bedrails and verbal consent from R8's POA allowing the resident to transfer from the bed to the floor, the consent do not eliminate the facility's responsibility to protect the resident from avoidable accidents, nor does it relieve the provider of its responsibility to assure the safety health, safety, and welfare of its residents. DON confirmed the only relevant approaches does not address R8's safety while on the floor mattress and the DON was unaware that two mattresses were being used on the floor. Inquired if the facility completed any assessment(s) of R8's room/floor space to ensure the resident was free of potential accident hazards and how the facility monitors R8 while on the floor. DON confirmed assessments of R8's room/floor space was not assessed for potential/actual accident hazards, the facility did not evaluate R8's floor mattress for accident/hazards, direct care staff did not report any concerns so there was no follow-up for appropriateness of the intervention. DON reported the facility did have a logbook for checking on resident every 2 hours and used a logbook to document the checks. Requested to review the logbook, DON stated staff used the logbook for one month then discontinued it. DON reviewed R'8 entire care plan and confirmed there were no care plan area or approach which address R8's safety while on the floor. Inquired about the bandages on R8's shins. DON reviewed progress notes and reported on 03/05/24 the resident got two skin tears while self-transferring from the bed to the floor. The DON and surveyor conducted a concurrent observation of R8 during which the resident was in the bed. While in R8's room, DON confirmed because of not assessing for potential environmental hazards and risk of area R8's mattress is on the ground, the facility did not identify, evaluate, or analyze the safety of the interventions (approaches) implemented for R8 and after implementing the intervention, the facility did not monitor intervention even after the resident sustained skin tears on both shins while self-transferring.