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	02/06/2025

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on observation, interview, and record review (RR), the facility failed to identify and support the bathing schedule preference of 1 of 2 residents (R) sampled for Self-Determination. As a result of this deficient practice, R32 did not have his needs met and was hindered from attaining his highest practicable well-being. This deficient practice has the potential to affect all the residents at the facility. Findings include: Cross-reference to F684 Quality of Care. Despite identifying and documenting an ongoing pruritic (itching) skin condition since September 2024, the facility failed to adequately address and provide relief for Resident (R)32's itching. Resident (R)32 is a [AGE] year-old male admitted to the facility on [DATE] for long-term care. A review of R32's Minimum Data Set (MDS) Admission Assessment with an Assessment Reference Date (ARD) of 07/11/24 notes that his admitting diagnoses include, but are not limited to, heart failure, high blood pressure, diabetes, and end-stage renal disease (on dialysis). The Admission Assessment also documents R32 with a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating that he is cognitively intact. On 02/03/25 at 09:29 AM, observations and an interview were done with R32 at the bedside. R32 was observed continuously scratching all along his right arm. Noted on his right forearm were multiple tiny scratches with blood. Also noted were many pinpoint areas of dried blood on R32's white pillowcase. No rash or redness was grossly visible to R32's right arm, but when asked, R32 stated that his arms and back were always itchy. On 02/03/25 at 03:49 PM, a follow-up interview was done with R32 at the bedside. R32 clarified that he has itchy areas all over body, but his arms and back bother him the most. When asked if anything makes the itching better, R32 responded that he usually feels better after a shower. R32 also stated that he would like to shower daily because of the itching, but they won't let me, reporting that he is only allowed to shower twice a week. When asked if staff have anything for him to apply to his skin for the itching, R32 reported that there is a lotion that staff will apply for him, but that it does not help. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R32's comprehensive care plan noted that his ADL (activities of daily living) care plan and his Activities care plan do not include his shower preferences or documentation of any identified skin issues. On 02/06/25 at 10:20 AM, an interview was done with Unit Manager (UM)1 in her office. When asked about shower preferences, UM1 stated that all residents are assessed upon admission regarding shower frequency. Asked her to provide documentation that this was assessed as a review of R32's MDS Admission Assessment, his admitting progress note, and his comprehensive care plan, does not indicate that this specific question was asked. This requested documentation was never provided. During a concurrent record review, UM1 confirmed that R32 was on a twice a week shower schedule. On 02/06/25 at 02:00 PM, an interview was done with Certified Nurse Aide (CNA)5 who stated that she is familiar with R32's care. When asked about R32's shower frequency, CNA5 stated that R32 is scheduled to shower on the evening shift, but when she works in his area, even if she is on the day shift, she will shower him daily because he likes to shower. CNA5 reported that she is unsure how often R32 gets showered on the evening shift but states she is aware that he wants to shower more than twice a week.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 51870 Based on observation and staff interviews, the facility failed to have maintain a sanitary and clean shower room for two of the four shower rooms observed. This deficient practice could affect all residents at the facility if appropriate cleaning of the showers are not done. Findings include: On 02/03/25 at 09:00 AM, a walkthrough of the 2nd floor [NAME] Wing shower room noted black substance on the left bottom corner caulking through the bottom middle caulking, extending to the right corner side caulking of the shower stall. The Ewa Wing shower room also noted black substance on the bottom right corner caulking of the shower stall. On 02/05/25 at 09:20 AM, interviewed Certified Nurses Aid (CNA) 15 and identified that the black substance was mold and wasn't sure how housekeeping cleaned it. At 09:30 am, during an interview with Housekeeper (H)1 and H2, they housekeepers acknowledged the black substance and noted that they didn't know what it was and have tried to remove it by scrubbing it. On 02/05/25 at 12:40 PM, met with Maintenance Director (MD), MD accompanied surveyors to observe the Ewa Wing shower room and noted that he already removed the black substance after surveyors brought it up to housekeeping staffs' attention. He initially stated the black substance was black caulking that was applied by previous maintenance worker, but when asked why would the maintenance worker mix black and white caulking between the tiles, MD then stated the black substance was dirt. MD confirmed he used tools to scrape the caulking earlier today and applied grout. He acknowledged the black subtance should've been taken cared of sooner.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 51869 Based on record review and interview, the facility failed to provide documentation that written notice of transfer or discharge was provided to the resident and resident's representative(s), and that a copy of the notice was sent to a representative of the Office of the State Long-Term Care Ombudsman for one of five resident samples. This deficient practice has the potential to affect resident or resident's representative(s) right to appeal the discharge. Findings include: Resident (R) 69 was sent to the Emergency Department and admitted to the hospital on 01/02/25. Record review was done on 02/05/25 at 12:26 PM for two forms titled, Discharge/Transfer Notice and [Provider] Notice of Discharge. Information for R69 was noted on both forms, but no documentation was found that it was sent to the resident's representative or Long-Term Care Ombudsman. The Social Services Director (SSD) was interviewed, in her office, on 02/25/25 at 12:33 PM, and stated that there is nothing documented that the written discharge/transfer notification was sent to the resident's representative. In addition, the SSD was not able to provide a copy of any fax confirmation notice.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 51869 Based on record review and interview, the facility failed to provide documentation that written notice of bed-hold policy was provided to the resident or resident's representative within 24 hours of emergency transfer for one of one resident (Resident (R) 69) reviewed for closed record. This deficient practice does not ensure the resident's right to have a place to return and does not provide continuity of care. Findings include: Resident (R) 69 was sent to the Emergency Department and admitted to the hospital on 01/02/25. Record review was done on 02/05/25 at 12:26 PM for two forms titled, Resident Progress Notes and [Provider] Bed Hold Agreement At Time of Transfer/Discharge. The Resident Progress Note entry dated 01/02/25 noted, SS [Social Services) received call from sister/POA [Power of Attorney] informing facility that resident/family unable to pay to hold the bed for the resident . The bed-hold agreement noted oral notification was provided by the facility, but the section titled, Written Notification was not completed. The Social Services Director (SSD) was interviewed in her office on 02/05/25 at 12:33 PM, and stated that the bed-hold agreement was mailed to the resident's representative who did not send it back. SSD confirmed that documentation of written notification sent should be in the progress notes but was not done.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37954 Based on observation, interview and record review errors on Minimum Data Set (MDS) Quarterly Assessments were found for two of 18 residents sampled, Resident (R)20 and R21. Error for R20 was made under section I. Active Diagnoses and error for R21 was made under section M. Skin Conditions. Findings Include: 1) Cross Reference to F656 (Comprehensive Care Plan). On 02/03/25 at 10:50 AM R20 was observed lying in his bed and surveyor noticed he had a contracture to his left hand. Asked R20 if he can open or close his hand and he reported it is not so well, resident was not able to do this. During record review of R20's Electronic Health Record (EHR) found he has an active diagnosis of Contracture of muscle, left upper arm dated 02/15/24. On 02/06/25 at 09:48 AM interviewed Director of Nursing (DON) and asked if R20's MDS Quarterly assessment dated [DATE] had the active diagnosis, Contracture of muscle, left upper arm, and she stated she was not able to find it. Inquired if this should have been included and she confirmed it should have been included. 2) Cross Reference to F656 (Comprehensive Care Plan). During record review of R21's Electronic Health Record (EHR) found he was sent to and admitted to the hospital on 11/29/24 for rectal bleeding. R21 was discharged from the hospital on 12/13/24 and returned to the facility. Review of discharge summary from the hospital revealed he was admitted to the hospital with pressure ulcers (PUs) to bilateral heels and discharged with PUs to his heels. Review of R21's skin assessments upon return to the facility did not include documentation of PUs to R21's heels. Review of R21's MDS Quarterly Review dated 12/16/24 did not include PUs to R21's heels. On 02/06/25 at 12:47 PM interviewed Minimum Data Set Coordinator (MDSC) 2. Reviewed discharge paperwork with MDSC2 who confirmed the discharge summary from the hospital stated resident was admitted and discharged with pressure ulcers to his heels. Inquired if staff completed a skin assessment upon R21's return to the facility and DON and MDSC2 were unable to provide one that included documentation of R21's PUs to his heels. DON confirmed this information should have been included on the admission skin assessment. Inquired of MDSC2 if the PUs to R21's heels should have been included in his 12/16/24 MDS Quarterly Review under skin conditions and she confirmed this should have been included.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37954 Based on observation, interview, and record review, the facility failed to develop and implement a resident-centered Comprehensive Care Plan (CP) for 8 of 18 residents (R) sampled (R20, R21, R55, R37, R32, R24, R27, and R56). As a result of this deficient practice, these residents were placed at risk for a decline in their quality of life and were prevented from attaining their highest practicable well-being. This deficient practice has the potential to affect all the residents at the facility. Findings Include: 1) Cross-reference to F641 Accuracy of Assessments for R20. The facility failed to include R20's active diagnosis Contracture of muscle, left upper arm, in his Minimum Data Set (MDS) Quarterly Assessment. The facility failed to develop and implement a care plan to address R20's limited ROM needs of his left arm. 2) Cross-reference to F641 Accuracy of Assessments for R21. The facility failed to identify pressure ulcers (PUs) to bilateral heels on R21's Minimum Data Set (MDS) Quarterly Assessment after R21 returned to the facility from being hospitalized . The facility failed to develop and implement a care plan to provide treatment and monitoring of R21's PUs on his heels. 3) Cross-reference to F676 Activities of Daily Living (ADLs)/Maintain Abilities Despite identifying upon admission R55's primary language is Cantonese and that he needs or wants an interpreter to communicate with a doctor or health care staff the facility failed to develop and implement a Communication/Language Barrier care plan for R55. 43245 4) Cross-reference to F684 Quality of Care for R37. Despite identifying that he was at risk for dehydration, the facility failed to develop and implement a dehydration care plan. Cross-reference to F676 Activities of Daily Living (ADLs)/Maintain Abilities Despite identifying upon admission that his primary language was not English, the facility failed to develop and implement a Communication/Language Barrier care plan for R37. 5) Cross-reference to F684 Quality of Care for R32 despite identifying and documenting an ongoing pruritic skin condition since September 2024, the facility failed to develop and implement a care plan that effectively monitored and addressed R32's itching. 6) Cross-reference to F676 Activities of Daily Living (ADLs)/Maintain Abilities. Despite identifying upon admission that her primary language was not English, the facility failed to develop and implement a Communication/Language Barrier care plan for R24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7) Cross-reference to F688 Maintain/Prevent Decline in Range of Motion for R27. Despite identifying a left-hand contracture, the facility failed to develop and implement a care plan to address R27's limited ROM needs. 43414 8) Cross Reference to F688. The facility failed to ensure R56 with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion, and ensure treatment provided was evaluated by therapy, physician ordered, and/or care planned. R56 was admitted to the facility on [DATE] with diagnoses, not limited to, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, vascular dementia, history of occlusion and stenosis of unspecified cerebral artery, muscle weakness, and contracture of muscle right upper arm and right lower leg. Review of R56's quarterly admission Minimum Data Set (MDS) with assessment reference date of 01/06/25 found in Section GG. Functional Abilities and Goals, R56 is dependent in self-care and has impairment on one side for upper and lower extremity range of motion. Review of R56's CP reviewed/revised on 01/25/25 documented R56 .has impaired range of motion to right arm and right leg r/t [related to] previous stroke and contractures .will have no unaddressed complications related to limited range of motion through the review, .Monitor for presence of pain, intolerance, or muscle spasm during range of motion .OT/PT [Occupational Therapy/Physical Therapy] to eval [evaluation] and treat as indicated. Encourage to follow guidelines set from therapy. Multiple observations of R56 in bed were done on 02/03/25 at 08:41 AM and 11:35 AM, 02/04/25 at 08:05 AM, and 02/05/25 at 08:41 AM and 12:59 PM. R56's arms were observed to be bent to chest with closed fists holding rolled hand towels in both hands. Right leg was bent, knee toward stomach and left leg was positioned straight. Review of R56's Electronic Health Record (EHR) found no documentation that range of motion was done including monitoring for pain, intolerance, or muscle spam during range of motion as indicated in the CP. Documentation for hand towels on both hands recommended and assessed by therapy, physician ordered, and in CP was not found. On 02/05/25 at 02:11 PM, an interview with Director of Nursing (DON) was done. DON reported the facility does not have a Rehabilitation Nursing Aide (RNA) program so the Certified Nurse Aids (CNA) are encouraged to do passive range of motion (PROM) for residents. DON confirmed there was no documentation in R56's EHR because there is no place for the CNAs to document and do not have a way to keep track of residents receiving PROM services. Inquired if R56 was assessed to use hand rolls, if it was physician ordered, and care planned, DON stated she did not see the treatment in R56's EHR.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37954 Based on observations, record reviews, and interviews, the facility failed to ensure the comprehensive person-centered care plan (CP) was reviewed and/or revised by the interdisciplinary team for four of 18 residents (Resident (R) 29, R55, R38, and R54) sampled for care plans. As a result of this deficit practice, R29's need for assistance with meals was not care planned for which was something new with the resident, R55's range of motion (ROM) was not addressed as recommended by physical therapy to prevent further contractures, R38's respiratory care was not person-centered and/or revised to appropriately reflect her status, and R54's pressure ulcer status was not updated to a Stage 4 with person-centered interventions. Findings include: 1) During record review of R29's Electronic Health Record (EHR) found she was hospitalized on ce in December 2024 and she returned to the facility on [DATE]. On 12/15/2024 at 14:37 the Minimum Data Set Coordinator (MDSC)1 documented R29 had a significant change for The assessment was originally scheduled due to new indwelling Foley catheter. However, Foley catheter was discontinued and resident successfully completed voiding trial. On the other hand, IDT (Interdiisciplinary Team) reported that resident has declined in her ability to feed herself from setup help to dependent. For this reason, will continue to complete significant change assessment. On 02/06/25 at 09:59 AM interviewed Unit Manager (UM)1. Inquired if R29 requires assistance with meals and UM1 confirmed this. Inquired about significant change R29 had and UM1 confirmed R29's significant change was for the decline with her Activities of Daily Living (ADLS) with requiring assistance with her meals. At this time reviewed R29's Care Plan (CP) with UM1 and found there were no interventions to address resident's decline and the need for assisitance with her meals. Inquired of UM1 if R29's CP should have been updated to reflect this significant change and UM1 confirmed it should have been updated with R29's significant change for requiring assistance with her meals. 2) On 02/03/25 at 02:29 PM a family interview was conducted with R55's family member. Inquired if R55 had full range of motion (ROM) of his arms and family member stated he is able to lift up his cup to his mouth and they were unsure if he has higher ROM with his arms. During record review of R55's Electronic Health Record (EHR) found resident has a CP that states [Name of R55] is quadriplegic and contractures to bilateral legs related to this. His L (left) hand fingers, and R (right) index finger are contracted. Elbows and shoulders ROM are still WNL (within normal limits). R hand ROM slightly weak. with a Long Term Goal Target Date: 04/27/2025 Name of R55 will participate in self care activities at highest level of independence. with an Approach Start Date: 02/15/2024 OT/PT to eval and treat per MD orders as needed for ROM. On 02/06/25 at 10:28 AM interviewed Physical Therapy Assistant (PTA)1. Inquired if R55 had Physical Therapy (PT) and PTA1 stated resident has finished with PT. PTA provided documentation that resident refused PT each time they asked. PTA1 provided a copy of the directions for ROM for R55 and his preferences. Inquired if this was shared with nursing and PTA1 confirmed it was. PT's recommendation for facility staff was to perform passive range of motion (PROM) exercises in bed 2-3 times a week. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/06/25 at 10:42 AM inquired of Director of Nursing (DON) if resident has recommendation listed on his CP from PT Continue PROM exercises in bed 2-3 times a week. DON confirmed it did not include the information provided by the PT department for R55's PROM exercises. DON confirmed this should have been included on resident's CP. 43414 3) R38 was admitted to the facility on [DATE] with diagnoses, not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, hyperlipidemia, hypertension, and hypoxemia. Review of R38's physician orders for oxygen (O2) included, continuous O2 at two liters per minute (LPM) via face mask, may titrate flow to keep saturation (SATS) greater than (>) 90 percent (%) and O2 at 0-5 LPM via nasal cannula or face mask (per resident preference) as needed, may titrate flow to keep SATS > 90%. Observations of R38 in her room on 02/03/25 at 09:47 AM, 12:40 PM, and 02:26 PM, 02/04/25 at 08:25 AM, 02/05/25 at 08:01 AM and 11:06 AM and on 02/06/25 at 08:01 AM and 10:13 AM, found R38's O2 face mask not covering her mouth or nose to provide continuous oxygen, but located on the side of her face. The O2 concentrator was running at two LPM. On 02/03/25 at 09:47 AM, interview with R38 was done. R38 reported her O2 is on the whole day but she puts on her face mask herself when needed. R38 stated she does not need to inform nursing staff when she used or needs O2. A second interview with R38 was done on 02/05/25 at 08:01 AM, R38 reported when she needs O2 she will put the mask on herself and if she doesn't, she takes it off. When inquired how often does she need to utilize O2 she stated all day and all night. R38 was not using her O2 mask at this time, and although the O2 concentrator was running, the tubing connecting the face mask to the concentrator was not connected. On 02/06/25 at 10:14 AM, an interview with Registered Nurse (RN) 5 was done. RN5 reported R38 puts on and off her own face mask for O2 because R38 wanted the O2 on all the time. RN5 clarified and stated R38 does not necessarily need the O2 concentrator to be on continuously but more so wants it on continuously. On 02/06/25 at 10:37 AM, an interview and concurrent record review with Unit Manager (UM) 1 was done. UM1 reported R38 does not use O2 all the time but likes to have it on continuously for comfort. R38 takes on and off her face mask on her own. Inquired if R38's CP reflected R38's preference to have the O2 run continuously for comfort and was educated and assessed to independently remove and put on her mask on her own, UM1 confirmed it did not. Documentation for hand towels on both hands recommended and assessed by therapy, physician ordered, and in CP was not found by UM1. Review of the facility's policy and procedure Oxygen Administration reviewed/revised on 06/2023 documented, The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) Cross Reference to F686. The facility failed to provide R54 necessary treatment, consistent with professional standards of practice to promote healing of a stage 4 pressure injury. R54 was admitted to the facility on [DATE]. R54's diagnoses include, not limited to, stage 4 pressure ulcer of sacral region, posterior reversible encephalopathy syndrome, local infection of the skin and subcutaneous tissue, type 2 diabetes mellitus with other skin complications peripheral vascular disease, acquired absence of right leg above knee, type 2 diabetes mellitus with hyperglycemia, non-pressure chronic ulcer of other part of right lower leg with necrosis of bone, pain, and infection of amputation stump of right and left lower extremity. Review of R54's quarterly Minimum Data Set (MDS) with assessment reference date of 12/17/24 found R54's Brief Interview for Mental Status (BIMS) scored a 15 (cognitively intact). In Section GG. Functional Abilities and Goals, under Mobility, R54 needs substantial/maximal assistance to roll left and right, is dependent sit to lying and lying to sitting on the side of bed. On 02/03/25 at 08:59 AM, observation and interview with R54 was done. R54 reported she has a pressure injury on her coccyx and had it for a while. The wound team reportedly informed her on their last visit that the wound was getting bigger. R54 expressed that she was frustrated because she tries to do the turning and positioning herself by using the bed rails to hold on to and offload but cannot do it for long because it is sore and becomes more painful. R54 stated she must ask staff to be repositioned but if she doesn't ask, they do not help or reposition her. Observed resident attempt to reposition herself by using her arm strength and holding on to the bed rail lifting herself up, for less than thirty seconds, before going back to a flat on her back position. No pillows or wedges were observed to be used to help reposition her. During a second observation and interview with R54, on 02/04/25 at 08:36 AM, R54 was observed lying flat on her back and stated her arm was sore when turning herself. Inquired if the facility offered a wedge to help reposition so she does not have to hold on to the bed rail and lift herself up, R54 reported she has a wedge, but it is a hard foam and every time they put it behind her back it is uncomfortable, so she takes it off. R54 reportedly requested for pillows instead to reposition, and staff tell her they will look but never come back with pillows. On 02/06/25 at 03:28 PM, concurrent record review and interview with UM1 and Infection Preventionist (IP) was done. Concurrent review of R54's EHR documented R54 has a stage 4 pressure injury. UM1 stated residents with pressure injuries or are at risk and are not able to turn themselves should be turned every two hours and may use a wedge to assist residents in repositioning. IP reported R54 uses her arm to turn herself and has a wedge and pressure mattress but R54 refuses the wedge because it is too hard. Staff had offered covering the wedge with a blanket. UM1 stated if a resident refuses treatment, nursing staff should educate and reapproach or offer different interventions as well as education of risk and benefits. Refusals should be documented in the progress notes. UM1 confirmed refusals were not documented. Review of R54's CP, UM1 confirmed the resident's CP was not updated to reflect R54's pressure injury status, did not include person-centered intervention, to aid with turning and positioning every two hours and to use pillows/wedges or other devices to assist with turning and positioning and should have been care planned. (continued on next page)

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	125024	A. Building B. Wing	02/06/2025

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Nuuanu Hale	2900 Pali Highway Honolulu, HI 96817

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy and procedure (P&P) Pressure Injury Prevention and Management reviewed/revised on 06/2023 documented under intervention for prevention and to promote healing of a pressure injury, The goals and preferences of the resident .will be included in the plan of care .Interventions will be documented in the care plan and communicated to all relevant staff .Compliance with interventions will be documented in the weekly summary charting. The P&P included when modifications of interventions are needed, Interventions on a resident's plan of care will be modified as needed. Considerations for needed modifications include .Changes in resident's degree of risk for developing a pressure injury .Resident non-compliance. Review of the facility's P&P Comprehensive Care Plans reviewed/revised 06/2023 documented the CP will describe, at a minimum, The services that are to be furnished to attain or maintain the residents highest practical physical, mental, and psychosocial well-being .Any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment .Resident specific interventions that reflect the resident's needs and preferences that align with the resident's cultural identity, as indicated. The P&P further documented The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment .objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed and the resident will be informed of .risks and benefits of proposed care, of treatment, and treatment alternatives/options. The facility will attempt alternate methods for refusal or treatment and services document such attempts in the clinical record, including discussions with the resident .

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on observations, interviews, and record reviews, the facility failed to provide the proper care and treatment, including assistive devices/tools, to improve and promote the communication abilities of 3 of 3 residents (R) sampled for Language/Communication. Despite identifying upon admission that their primary language was not English, the facility failed to implement the use of alternative communication methods, such as a communication board, non-verbal pain assessment tools, or commonly used phrases in their primary language, or an interpreter for Residents (R)37, R24 and R55. As a result of this deficient practice, the residents are at an increased risk of not having their needs met and experiencing a decline in their physical well-being, psychosocial well-being, and quality of life. This deficient practice has the potential to affect all residents at the facility with communication needs. Findings include: 1) Cross Reference to F656 (Comprehensive Care Plan) Resident (R)37 is a [AGE] year-old male admitted to the facility on [DATE] for long-term care. A review of R37's Minimum Data Set (MDS) Admission Assessment with an Assessment Reference Date (ARD) of 12/09/24 notes that it identifies R37 as English/Chuukese speaking, and as answering Yes to the question, Do you need or want an interpreter to communicate with a doctor or health care staff? A review of his admission progress note dated 12/05/24 at 01:49 PM noted Registered Nurse (RN)11 documenting the following: Primary language is Chukees [sic] . On 02/03/25 at 01:42 PM, observations and interview were done with R37 at the bedside. No communication tools were observed at the bedside or on the walls surrounding his bed. While interviewing R37, noted that while he understood limited English, conducting a thorough assessment of his physical and psychosocial needs was challenging without an interpreter. When asked how he communicates with staff when he has a question or a concern, R37 stated that his brother visits and translates for him but could not state how often his brother comes to visit. On 02/05/25 at 08:22 AM, a review of R37's comprehensive care plan (CP) was done. For his Activities care plan, the following was noted in the problem section: He is able to understand very little English. However, the Approach section did not contain any interventions to address the language barrier. Further review of his CP noted no Communication or Language Barrier care plan and his ADLs [activities of daily living] Functional Status/Rehabilitation Potential care plan did not identify a communication need. On 02/05/25 at 09:56 AM, an interview was done with the Director of Nursing (DON) in her office. DON confirmed that for residents identified as non-English speakers, a communication care plan should be developed as a part of their CP. When asked for examples of what approaches/interventions should be included in a communication care plan, DON stated it should include a communication board and non-verbal/picture assessment aids at the bedside, and phone interpreter services. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure, Communicating with Persons with Limited English Proficiency, last reviewed/revised 06/2023, revealed the following: Facility staff will identify the language and communication needs of the LEP [limited English proficiency] person . All interpreters, translators, and other aids needed by the resident and/or representative will be provided . 2) Cross Reference F656 (Comprehensive Care Plan) Resident (R)24 is an [AGE] year-old female admitted to the facility on [DATE]. A review of R24's MDS Admission Assessment with an ARD of 01/24/25 notes that she is identified as Korean speaking, and as answering Yes to the question, Do you need or want an interpreter to communicate with a doctor or health care staff? A review of an admission progress note dated 01/18/25 at 06:44 PM noted Unit Manager (UM)2 documenting the following: . her primary language is Korean . On 02/04/25 at 09:08 AM, observations were done of R24 at the bedside. No communication tools or aids were observed at the bedside or on the walls surrounding her bed. On 02/04/25 at 01:50 PM, a review of R24's CP revealed no indications that the communication need had been identified. As a result, the language barrier was not listed in any of her care plans, and no interventions had been developed. On 02/05/25 at 02:45 PM, a phone interview was done with MDS Coordinator (MDSC)1. MDSC1 agreed that if English is not a resident's primary language and the resident requests interpreter services, the identified need should be care planned under Communication/Language Barrier. In addition, MDSC1 stated that communication/language barrier interventions may also be added to the ADLs or Activities care plans. When asked what type of interventions would be included in a Communication/Language Barrier care plan, MDSC1 gave the following examples: have an interpreter, ask for assistance from family, use interpreter services, communication board at the bedside, pictures/common phrases at the bedside, and use gestures and/or facial expressions to communicate. 37954 3) Cross Reference to F656 (Comprehensive Care Plan) On 02/03/25 at 02:00 PM a family interview was conducted with R55's family member. Inquired if English is a second language for R55 and R55's family member stated he speaks Cantonese and they think that he might not understand what staff are saying to him and they think staff are not using an interpreter when they communicate with him when family are not there. On 02/05/25 at 01:00 PM interviewed Registered Nurse (RN)11. Inquired if R55 needs an interpreter and RN11 stated resident can speak English and have basic needs met. RN11 stated facility has interpreter services and was able to show surveyor where the contact number and languages that are offered at the nurse's station. During survey no staff were observed using an interpreter when communicating with R55. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R55's MDS Quarterly Review dated 09/16/24 identifies resident's language as Cantonese and Yes was checked off that he needs or wants an interpreter to communicate with a doctor or health care staff. Review of R55's CP did not include use of interpreter services when communicating with a doctor or health care staff. On 02/06/25 at 09:02 AM an interview was done with the DON. Inquired of DON if R55's need for an interpreter should have been included on his care plan and she confirmed resident should have had a CP for an interpreter.

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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 addressed the needs of 1 of 2 residents sampled for Activities. Despite identifying that he had a visual deficit, the facility failed to implement activities Resident (R)37 could perform. As a result of this deficient practice, R37 was placed at risk of a decline in his psychosocial well-being. This deficient practice has the potential to affect all residents at the facility. Findings include: Resident (R)37 is a [AGE] year-old male admitted to the facility on [DATE] for long-term care. A review of R37's Minimum Data Set (MDS) Admission Assessment with an Assessment Reference Date (ARD) of 12/09/24 notes that R37 had been identified as Vision Impaired - sees large print, but not regular print in newspapers/books. On 02/03/25 at 01:35 PM, concurrent observations and interview were done with R37 at the bedside. R37 stated he had reading glasses at home in Chuuk but did not bring it with him when he moved. Observed a regular-print Word Search book on his bedside table, sitting untouched. When asked about it, R37 stated he enjoys word search puzzles but cannot see them without reading glasses. A review of R37's Comprehensive Care Plan (CP) noted that although his visual deficit had been identified in his ADLs (activities of daily living) Functional Status/Rehabilitation Potential CP, there were no interventions (such as provide reading glasses) planned to address it beyond the following: Monitor for changes in vision as it affects ADLs functioning. Update MD [Physician] as necessary. A review of R37's Activities CP noted that it did not identify his visual deficit and only had the following intervention: Activities to encourage participation, support and engage socially, provide adaptations (if needed), and encourage positive coping strategies. On 02/06/25 at 12:30 PM, an interview was done with the Activities Director (as listed by the facility on their Staff List) in the Activities Room. The Activities Director (AD) stated that she was no longer the AD and that the position was currently unfilled. Reported there currently was an Activities Aide (AA) however she was out sick. When asked about R37, AD stated she was aware of his visual deficit and that he could not see small (or regular) print. A concurrent review of his Activities CP was done, and AD agreed that his visual deficit should have been identified and addressed. When asked about resident-specific interventions based on activity needs, AD seemed unclear what the State Agency (SA) meant. Asked if it was normal to have only one generalized intervention in the Activities CP, AD responded yes, all residents' activity care plans usually just have the one intervention.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on observation, interview, and record review, the facility failed to implement a hydration program that recognizes, evaluates, and addresses the hydration needs of 1 of 2 residents (Resident 37) sampled for hydration. Individuals who do not receive adequate fluids are more susceptible to urinary tract infections, pneumonia, pressure injuries, skin infections, confusion, and disorientation. In addition, despite identifying and documenting an ongoing pruritic (itchy) skin condition for 1 of 5 residents (Resident 32) sampled for non-pressure related skin conditions, the facility failed to adequately address and provide relief for his itching, impacting his comfort and psychosocial well-being. These deficient practices have the potential to affect all residents at the facility. Findings include: 1) Cross Reference to F656 (Comprehensive Care Plan) Resident (R)37 is a [AGE] year-old male admitted to the facility on [DATE] for long-term care. A review of R37's electronic health record (EHR) notes that he was admitted with diagnoses that include, but are not limited to, congestive heart failure (a disorder that impairs ventricular (a chamber in the heart) filling or ejection of blood to the systemic circulation), type 2 diabetes, and constipation. Further review of his EHR confirmed that despite his chronic congestive heart failure (CHF), R37 was not on any fluid restrictions. A review of R37's medication list noted the following routine medications: Furosemide 40 milligrams (mg) daily (a diuretic, which is a substance that promotes the increased production of urine). Spironolactone 25 mg daily (a diuretic) Jardiance 10 mg daily (an antidiabetic) A review of the manufacturer's Warnings and Precautions for the Jardiance (found on the package insert) revealed the following: Volume Depletion: . can cause intravascular (situated in, occurring in, or administered by entry into a blood vessel) volume depletion . After initiating, monitor for signs and symptoms of volume depletion . A review of the manufacturer's Drug Interactions for the Jardiance (found on the package insert) revealed the following: Diuretics: Coadministration with diuretics may enhance the potential for volume depletion. Monitor for signs and symptoms. On 02/03/25 at 09:36 AM, observation was made at R37's bedside that there was no water pitcher, bottles, or cups of water at his bedside. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/04/25 at 09:20 AM, observation was made at R37's bedside that there was no water pitcher, bottles, or cups of water at his bedside. When asked, R37 stated that he is not offered fresh water or fluids outside of what comes on his meal trays. On 02/05/25 at 07:47 AM, observed R37 lying in bed stating that he was feeling nauseous and had vomited that morning. Also observed that there was no water pitcher, bottles, or cups of water at his bedside. A review of his Comprehensive Care Plan (CP) noted that R37 had two care plans that identified his increased risk for dehydration due to the medications he was taking but had no intervention to ensure to provide adequate fluids. R37's Edema (swelling)/Diuretic CP had the following interventions: Assess/report dehydration . Monitor blood pressure. Report signs of hypotension [low blood pressure] and/or hypovolemia [low fluid volume]. R37's Nutritional Status CP identified that R37 was at risk for nutritional and fluid deficits R/T [related to] . use of diuretics, but again had no intervention to ensure to provide adequate fluids. Review of R37's EHR revealed that since admission, his diuretics and blood pressure medications were consistently held 3-7 times a week because his blood pressure was too low, however he consistently received the Jardiance every day. In addition, it was noted that R37 would consistently be given as needed Milk of Magnesia and Bisacodyl for constipation (often a sign of low fluid volume). Review of R37's nurse progress notes revealed no documentation that anyone had identified his consistently low blood pressures and constipation as potential signs of a fluid deficit and informed the Physician. On 02/05/25 at 10:03 AM, an interview was done with the Director of Nursing (DON) in her office. DON stated that upon admission, someone should have put an order in for monitoring for signs of dehydration so that there would be an actual log. DON stated she was surprised no one, including the pharmacist, had noticed, and questioned if the low blood pressures might be a sign of dehydration. In addition, DON stated R37 should have a water pitcher at his bedside and be offered fresh water daily. After a concurrent review of his EHR, DON confirmed that R37's fluid intake was not being monitored/logged for adequacy. Review of the facility policy and procedure Hydration Maintenance, last revised 10/10/17 revealed the following: 1. Appropriate residents able to self-serve, will be provided with water pitchers at their bedside and refilled as appropriate, and at a minimum twice a shift. 4. Daily fluid intake will be documented for each resident and an average daily intake will be calculated on a weekly basis. All information will be documented in the electronic medical record. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Residents who do not drink an average of 1000cc/day will be placed on a weekly Hydration List and reviewed by Nurse Manager or RN and/or dietitian. 6. The Hydration List will be available at the nurse's station and residents on the Hydration List will be identified on the CNA communication book. All staff will make an effort to increase the fluid intake of these residents. 7. Resident's care plan will be updated to reflect the need for increased hydration with appropriate interventions identified and indicated. A review of R37's fluid intake for the month of January 2025 revealed the following for his average daily intake calculated on a weekly basis: Week 1- 626ml Week 2- 685ml Week 3- 668ml Week 4- 654ml Week 5- 684ml On 02/06/25 at 10:13 AM, an interview was done with Unit Manager (UM)1 in her office. UM1 confirmed that R37 was not on any fluid intake monitoring and was not on the Hydration List. 2) Cross Reference to F656 (Comprehensive Care Plan) Resident (R)32 is a [AGE] year-old male admitted to the facility on [DATE] for long-term care. A review of R32's Minimum Data Set (MDS) Admission Assessment with an Assessment Reference Date (ARD) of 07/11/24 notes that his admitting diagnoses include, but are not limited to, heart failure, high blood pressure, diabetes, and end-stage renal disease (on dialysis). The Admission Assessment also documents R32 with a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating that he is cognitively intact. On 02/03/25 at 09:29 AM, observations and an interview were done with R32 at the bedside. R32 was observed continuously scratching all along his right arm. Noted on his right forearm were multiple tiny scratches with blood. Also noted were many pinpoint areas of dried blood on R32's white pillowcase. No rash or redness was grossly visible to R32's right arm, but when asked, R32 stated that his arms and back were always itchy. On 02/03/25 at 03:49 PM, a follow-up interview was done with R32 at the bedside. R32 clarified that he has itchy areas all over body, but his arms and back bother him the most. When asked if anything makes the itching better, R32 responded that he usually feels better after a shower. R32 also stated that he would like to shower daily because of the itching, but they won't let me, reporting that he is only allowed to shower twice a week. When asked if staff have anything for him to apply to his skin for the itching, R32 reported that there is a lotion that staff will apply for him, but that it does not help. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R32's CP noted that although R32 did have a Skin Integrity CP, it did not identify his pruritic skin condition, and only documented/addressed the following: . at risk for alteration to skin integrity secondary to incontinent episodes, requires assistance with toileting hygiene/transfers, DM [diabetes], hx [history] CVA [stroke], hx left great toe amputation. Review of R32's Weekly Skin Assessments noted they do not accurately represent/reflect/document the multiple tiny bleeding lesions observed on his right arm. Review of R32's provider orders noted Camphor-Menthol lotion ordered on 10/11/24, Apply a thin layer to BUE [bilateral upper extremities] and back for Pruritis, however, no documentation was found of any skin monitoring to measure its effectiveness. On 02/06/25 at 10:22 AM, an interview was done with UM1 in her office. UM1 confirmed that the different interventions the facility has used to address R32's pruritis (including the Camphor-Menthol lotion) should have been added to his CP since his pruritis has been an issue since admission. During a concurrent review of his CP, UM1 validated that R32's CP did not include these resident-centered interventions. On 02/06/25 at 01:29 PM, an interview was done with Certified Nurse Aide (CNA)6 outside of room [ROOM NUMBER]. CNA6 confirmed that he is familiar with R32's care and has noticed R32 is frequently itchy and scratching his arms, stating, oh yeah, [he scratches] all the time. CNA6 also confirmed that he has frequently observed spots of blood on R32's linen and reported that he has observed multiple bleeding areas on both R32's arms and back. CNA6 stated that R32 complains about the itchiness a lot, which CNA6 consistently reports to the nurse.

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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** 43414 Based on observation, interview, and record review, the facility failed to provide necessary treatment, consistent with professional standards of practice, to promote healing of a stage 4 pressure injury for one of five residents (Resident (R) 54) sampled for pressure injuries. R54 did not get the support she needed to turn and reposition every two hours causing discomfort. This deficient practice put R54 at risk for failed progress toward healing. Findings include: R54 was admitted to the facility on [DATE]. R54's diagnoses include, not limited to, stage 4 pressure ulcer of sacral region, posterior reversible encephalopathy syndrome, local infection of the skin and subcutaneous tissue, type 2 diabetes mellitus with other skin complications peripheral vascular disease, acquired absence of right leg above knee, type 2 diabetes mellitus with hyperglycemia, non-pressure chronic ulcer of other part of right lower leg with necrosis of bone, pain, and infection of amputation stump of right and left lower extremity. Review of R54's quarterly Minimum Data Set (MDS) with assessment reference date of 12/17/24 found R54's Brief Interview for Mental Status (BIMS) score a 15 (cognitively intact). In Section GG. Functional Abilities and Goals, under Mobility, R54 needs substantial/maximal assistance to roll left and right, is dependent sit to lying and lying to sitting on the side of bed. On 02/03/25 at 08:59 AM, observation and interview with R54 was done. R54 reported she has a pressure injury on her coccyx and had it for a while. The wound team reportedly informed her their last visit that the wound was getting bigger. R54 expressed that she was frustrated because she tried to do the turning and positioning herself by using the bed rails to hold on to and offload but cannot do it for long because it is sore and becomes more painful. R54's pressure injury causes her pain and discomfort. R54 stated she must ask staff to be repositioned but if she doesn't ask, they do not help or reposition her. R54 is not assisted in turning or repositioning every two hours. Observed resident attempt to reposition herself by using her arm strength and holding on to the bed rail lifting herself up, for less than thirty seconds, before going back to a flat on her back position. No pillows or wedges were observed to be used to help reposition her. During a second observation and interview with R54, on 02/04/25 at 08:36 AM, R54 was observed lying flat on her back and stated her arm was sore when attempting to relieve the pressure from her coccyx. Inquired if the facility offered a wedge to help reposition so she does not have to hold on to the bed rail and lift herself up, R54 reported she has a wedge, but it is a hard foam and every time they put it behind her back it is uncomfortable, so she takes it off. R54 reportedly requested for pillows instead to reposition, and staff tell her they will look but never come back with pillows. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/06/25 at 03:28 PM, concurrent record review and interview with UM1 and Infection Preventionist (IP) was done. Concurrent review of R54's Electronic Health Record (EHR) documented R54 has a stage 4 pressure injury. UM1 stated residents with pressure injuries or are at risk and are not able to turn themselves should be turned every two hours and may use a wedge to assist residents in repositioning. IP reported R54 uses her arm to turn herself and has a wedge and pressure mattress but R54 refuses the wedge because it is too hard. Staff had offered covering the wedge with a blanket. UM1 stated if a resident refuses treatment, nursing staff should educate and reapproach or offer different interventions as well as education of risk and benefits. Refusals should be documented in the progress notes. UM1 confirmed refusals and turning and repositioning every two hours were not documented in the EHR. Review of Pressure Injury Prevention Guidelines provided by the facility documented Routine repositioning schedule: every two hours, using both side-lying and back positions. Reposition in bed, and out of bed.

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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 three of six residents (Residents 27, 20, and 56) sampled for limited range of motion (ROM) received the appropriate treatment, equipment, and services to maintain or prevent a decline in their ROM. Resident (R)27 did not have the splint for his left hand applied or monitored for application, R20 did not have physician ordered treatment to prevent worsening of resident's contracture, and R56 was provided treatment that was not evaluated by therapy or physician ordered and did not receive recommended passive ROM (PROM) and services. As a result of this deficient practice, these residents were placed at risk of a decline in their range of motion and a potential loss of function. Findings include: 1) Cross Reference F656 (Comprehensive Care Plan) Resident (R)27 is a [AGE] year-old male readmitted to the facility on [DATE] for long-term care. A review of R27's Minimum Data Set (MDS) Admission Assessment with an Assessment Reference Date (ARD) of 12/06/24 notes that his admitting diagnoses include, but are not limited to, left-sided weakness and paralysis following a stroke, pain, and contracture (a shortening and hardening of muscles, tendons, or other tissue, often leading to a deformity and rigidity of joints) of his left hand. On 02/03/25 at 01:59 PM, observations and interview were done with R27 at his bedside. Observed (and confirmed by interview) that R27 could not open his left hand as all his fingers were contracted. There were no braces or splints grossly visible at the bedside, and when asked, R27 stated that he did not have any orthotic devices for his left hand. State Agency (SA) then made observation of a hand splint buried under R27's belongings in a box on his bedside table. After additional questioning, R27 eventually acknowledged that the splint was for his left hand but stated that he had not worn it in a long time. A review of R27's Comprehensive Care Plan (CP) revealed that although the CP identified his left-hand contracture in several areas, there were no interventions that included use of his left-hand splint to prevent a decline in ROM. In addition, a review of his physician orders revealed no orders that addressed his left-hand contracture. On 02/06/25 at 09:50 AM, an interview was done with the Director of Nursing (DON) in her office. DON agreed that if there is a hand splint at the bedside, the expectation would be that there would be some documentation about it either in the physician orders or CP. A concurrent review of R27's electronic health record (EHR) confirmed that R27 had no CP, no orders, and did not have a signed refusal on file for the hand splint. DON was asked to provide documentation of how the facility was addressing the limited ROM of R27's left hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/06/25 at 11:20 AM, DON provided SA with a Therapy Communication To Nursing form dated 02/23/21 that documented [NAME] [put on] L [left] Palm Protector Splint daily, after L hand is cleaned & dried thoroughly between fingers. Provide skin checks daily. DON stated she had found the form posted in R27's closet which is where the facility used to put the form a long time ago. Currently, the form should be kept in the CNA (Certified Nurse Aide) Communication Binder at the Nurses' station. DON confirmed that someone should have removed R27's form from his closet and placed it in the binder but had not. DON could find no documentation to indicate when the splint had last been applied. 37954 2) On 02/03/25 at 10:50 AM observed R20 in his room in bed. Observed resident with contracture to his left hand and inquired if he could open and close his hand and R20 reported it is not so well. Asked resident if staff put a splint on his hand or a rolled up wash cloth and he denied this. At this time neither were observed in/on R20's left hand. Record review of R20's Electronic Health Record found he has a diagnosis that include and is not limited to quadriplegia, unspecified (Primary, Admission), central cord syndrome at unspecified level of cervical spinal cord, subsequent encounter and contracture of muscle, left upper arm. Review of R20's CP found Resident's name is quadriplegic and has left arm and hand contractures related to this. R20's long term goal (LTG) date of 04/27/25 and LTG stating Resident's name will not exhibit signs of autonomic dysreflexia (life threatening syndrome with sudden and severe rise in blood pressure and other symptoms) or other complications related to quadriplegia and contractures through the review. On 02/06/25 at 09:27 AM interviewed Unit Manager (UM)1. Inquired if R20 receives passive range of motion (PROM). UM1 stated residents are provided care, the Certified Nurse Aides (CNAs) do the best that they can and sometimes resident does not want to be touched and refuses care. At this time reviewed CP with UM1 who confirmed there are no interventions listed to prevent worsening of contractures or to prevent contractures in R20's other limbs. Review of physician orders did not find any treatments ordered for care of R20's left hand and arm. 02/06/25 09:28 AM interviewed DON and asked if facility has a Restorative Nursing Assistant (RNA) program and she said no, they have tried to convert some of their CNAs to RNAs but they are short staffed. They tried hiring but no one has applied. 43414 3) Cross Reference to F656 (Comprehensive Care Plan) R56 was admitted to the facility on [DATE] with diagnoses, not limited to, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, vascular dementia, history of occlusion and stenosis of unspecified cerebral artery, muscle weakness, and contracture of muscle right upper arm and right lower leg. Review of R56's quarterly admission Minimum Data Set (MDS) with assessment reference date of 01/06/25 found in Section GG. Functional Abilities and Goals, R56 is dependent in self-care and has impairment on one side for upper and lower extremity range of motion. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R56's care plan reviewed/revised on 01/25/25 documented R56 .has impaired range of motion to right arm and right leg r/t [related to] previous stroke and contractures .will have no unaddressed complications related to limited range of motion through the review, .Monitor for presence of pain, intolerance, or muscle spasm during range of motion .OT/PT [Occupational Therapy/Physical Therapy] to eval [evaluation] and treat as indicated. Encourage to follow guidelines set from therapy. Multiple observations of R56 in bed were done on 02/03/25 at 08:41 AM and 11:35 AM, 02/04/25 at 08:05 AM, and 02/05/25 at 08:41 AM and 12:59 PM. R56's arms were observed to be bent to chest with closed fists holding rolled hand towels in both hands. Right leg was bent, knee toward stomach and left leg was positioned straight. Review of R56's Electronic Health Record (EHR) found no documentation that range of motion was done including monitoring for pain, intolerance, or muscle spasm during range of motion as indicated in the CP. Documentation for hand towels on both hands recommended and assessed by therapy, physician ordered, and in CP was not found. On 02/05/25 at 12:41 PM, interview and concurrent record review with Physical Therapy Assistant (PTA) 1 and Occupational Therapy Assistant (OTA) 2 was done. PTA1 reported R56 was last seen on 12/08/23 by physical therapy (PT) and OTA2 reported she was not seen by occupational therapy (OT). Concurrent review of R56's 12/08/23 PT Discharge Summary, documented R56 was discharged from PT with right hip flexion of 50 percent (%) degrees and discharged with generalized muscle weakness. PT recommended assistance with a functional maintenance program and concluded R56's prognosis to maintain current level of function if staff are consistent with follow-through. Review of R56's Therapy Communication to Nursing dated 12/13/23 including nursing staff signatures with comments to continue perform bed exercises (PROM) to optimize joint mobility. PTA1 reported nursing staff and residents are trained on PROM exercises when recommended. OTA2 reported if a resident had contractures, it would be noted by the therapist in the notes and discharge summary. PTA1 confirmed contractures was not included in the discharge summary diagnoses. OTA2 stated if a resident developed contractures nursing staff would usually make a referral to therapy. Inquired if nursing staff used hand rolls should that be assessed by therapy, OTA2 stated if there were contractures to the hands nursing staff would make a referral to OT and OT would assess and make treatment recommendations. For hand rolls the treatment would include what time and how long it is to be used, and nursing staff should monitor for redness or complications. OTA2 confirmed therapy did not assess or recommend hand rolls for R56. Referrals from nursing staff to assess R56 after discharge on 12/08/23 was not done. On 02/05/25 at 02:11 PM, an interview with Director of Nursing (DON) was done. DON reported the facility does not have a Rehabilitation Nursing Aide (RNA) program so the Certified Nurse Aids (CNA) are encouraged to do passive range of motion (PROM) for residents. DON confirmed there was no documentation in R56's EHR because there is no place for the CNAs to document and do not have a way to keep track of residents receiving PROM services. DON was not able to provide documentation that the CNA's were providing PROM services for R56. Inquired if R56 was assessed to use hand rolls, if it was physician ordered, and care planned, DON stated she did not see the treatment in R56's EHR. DON confirmed hand rolls should not be used since R56 was not assessed to use hand rolls by therapy or ordered by the physician.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43414 Based on observation, interview, and record review, the facility failed to ensure a resident's oxygen (O2) tubing was connected to the O2 concentrator consistent with professional standards of practice for one of one resident sampled (Resident (R) 38) for respiratory care. As a result, R38 was not receiving continuous O2 as physician ordered. This failure placed R38 at risk for respiratory distress. Findings include: R38 was admitted to the facility on [DATE] with diagnoses, not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, hyperlipidemia, hypertension, and hypoxemia. Review of R38's physician orders for O2 included, continuous O2 at two liters per minute (LPM) via face mask, may titrate flow to keep saturation (SATS) greater than (>) 90 percent (%) and O2 at 0-5 LPM via nasal cannula or face mask (per resident preference) as needed, may titrate flow to keep SATS > 90%. On 02/06/25 at 08:01 AM observed R38 in her room, R38's O2 face mask was not covering her mouth or nose but located on the side of her face. The tubing connecting the O2 face mask to the O2 concentrator was not connected, and the connection end of the tubing was touching the floor. The O2 concentrator was on and running. R38 reported she needs to utilize O2 treatment all day and night. On 02/06/25 at 10:14 AM, a concurrent observation and interview with Registered Nurse (RN) 5 was done. RN5 reported R38 puts on and off her own face mask for O2 because R38 wanted the O2 on all the time. RN5 clarified and stated R38 does not necessarily need the O2 concentrator to be on continuously but more so wants it on continuously. Concurrent observation of R38's O2 tubing from the face mask to the concentrator was not connected while the concentrator was on. RN5 confirmed it should have been connected. Review of the facility's policy and procedure Oxygen Administration reviewed/revised on 06/2023 documented, Oxygen is administered under orders of a physician .Staff shall monitor for complications associated with the use of oxygen and take precautions to prevent them.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 51869 Based on interview and record review, the facility failed to manage and monitor the medication regimen for one of five residents sampled for unnecessary medications, by not implementing a physician ordered gradual dose reduction (GDR) for an antidepressant. This deficient practice does not protect residents from the possible side effects of overmedication and has the potential to affect other residents prescribed with psychotropic medications. Findings include: On 02/06/25 at 01:45 PM, a review of the Medication Regimen Review (MRR) for Resident (R) 18, dated 09/25/24, and done by the Consultant Pharmacist, recommended that R18's Citalopram 10mg be reviewed for an annual GDR versus clinical contraindication. On the same form, R18's physician (MD) 1 marked the option titled, Condition stable: Attempt dose reduction to and handwrote in 5 QD [milligrams daily]. The bottom of the form contained his signature and date of 9/27/24. Upon review of R18's September and October 2024 physician orders, no order change for Citalopram 10mg to 5mg was noted. There was also no indication of a Citalopram order change noted in the progress notes dated from 09/25/24 to the end of October 2024. R18's current Citalopram order, dated 01/26/24, noted 10mg. On 02/06/25 at 01:45 PM, an interview was conducted with the Director of Nursing (DON). The DON validated that MD1's notation of 5 QD on the MRR meant to reduce the Citalopram dosage to 5mg daily. The DON also confirmed that MD1's written date at the bottom of the MRR was 09/27/24. The DON stated that the facility receives the MRRs monthly, and a review is done by the DON, Unit Manager and clinical team. When MD1 visits the facility on Tuesday and Fridays, orders are obtained, documented in the progress notes, and carried out. The DON then confirmed that R18's Citalopram order for dose reduction was not carried out.

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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** 51869 Based on observation, interview, and record review, the facility failed to ensure all medications administered were stored, labeled, and administered according to professional standards. Proper labeling and administration practices of medications are necessary to decrease the risk of medication errors. This deficient practice has the potential to affect all residents in the facility. Findings include: 1) On [DATE] at 07:56 AM, Medication pass observations were done with Registered Nurse (RN) 12. For Resident (R) 10, the Carvedilol 25mg order on the Medication Administration Record (MAR) was listed to be given twice a day at (08:00 AM and 05:00 PM). The label on the medication blister pack noted Carvedilol to be given every 12 hours. A review of the physician orders was done on [DATE] at 11:15 AM for R10's Carvedilol. The current physician order for R10's Carvedilol, dated [DATE], stated it to be given 25mg twice a day. An interview was done with RN12 on [DATE] at 11:30 AM. RN12 confirmed that R10's Carvedilol order on the MAR and the medication label on the blister pack did not match. RN12 then proceeded to bring out a full Carvedilol 25mg blister pack, obtained from the bottom drawer of the medication cart, with the label matching the MAR. RN12 stated that R10 went to the hospital on [DATE] and returned to the facility on [DATE]. Upon return, RN12 transcribed the Carvedilol 25mg order to be given twice a day. However, the blister pack, with the label stating Carvedilol 25mg to be given every 12 hours, was kept in the medication cart and was being used. RN12 confirmed that blister pack should have been discarded. 43245 2) On [DATE] at 12:49 PM, while inspecting the Right-Wing medication cart with the Director of Nursing, noted a Lantus insulin pen for Resident (R)37 that had been labeled as opened [DATE] with a discard date of [DATE]. DON confirmed the insulin pen was expired and should have been wasted.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51869 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program to ensure a safe, sanitary and comfortable environment to prevent the development and transmission of communicable diseases and infections. The facility failed to: 1) ensure a pill cutter, used for multiple residents, was cleaned between patient use, observed from one of three medication carts; 2) ensure staff perform hand hygiene after discarding dirty gloves before assisting resident (R) 123 with her meal, one unsampled resident; 3) ensure clean medical supplies to be used are kept on clean surfaces and follow standard precautions by performing hand hygiene between glove change for one of five residents (Resident (R) 54) sampled for wound care; 4) ensure a nursing staff member providing care used appropriate Personal Protective Equipment and performed hand hygiene between gloves for one of six residents (R68) sampled with Enhanced Barrier Precautions (EBP); 5) ensure a lancet, a needle used to puncture the fingertip, was properly discarded for one of two residents (R54) sampled with Transmission Based Precautions (TBP); and 6) ensure a urinary catheter bag was not left on the floor for one of one resident (R68) sampled for urinary catheters. These deficient practices could put residents at risk of contamination that receive medication(s) being cut by the pill cutter, puts R123, R54 and R68 at risk of infection, and puts residents, visitors, and staff members at risk for infection and blood-borne pathogen transmission. Findings include: 1) During inspection of the facility's second floor Ewa medication cart on 02/05/25 at 08:17 AM, a pill cutter, located in the top drawer of the medication cart, was observed to have large amounts of white/brown sediments in the interior portion of the cutter. The Registered Nurse (RN) 12 administering medications from this cart was concurrently interviewed. RN12 confirmed seeing the white and brown sediments in the pill cutter and stated it could be from not cleaning it. RN12 also stated that the cutter should be cleaned after each use. 37954 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) On 02/03/25 at 11:30 AM observed Certified Nurse Assistant (CNA)11 deliver a lunch tray to R123 in her room. CNA11 had performed hand hygiene by applying hand sanitizer to her hands before picking up the lunch tray from the cart. CNA11 delivered the lunch tray and then put on clean gloves to re-position R123 in her bed. CNA11 used the draw sheet to raise R123 up in her bed. CNA11 disposed of the dirty gloves and then used the bed control to raise resident's head of bed so R123 was sitting up for her meal. CNA11 then proceeded to assist R123 with her lunch by sitting at the bedside and fed R123. CNA11 did not do hand hygiene after disposing of the dirty gloves or before feeding R123. On 02/03/25 at 11:45 AM interviewed CNA12 and asked what staff are expected to do after wearing gloves to position a resident and disposing of gloves, he stated sanitize hands. On 02/05/25 at 10:39 AM interviewed Director of Nursing (DON). Inquired what staff are expected to do when they take off dirty gloves and she stated staff are supposed to perform hand hygiene. Explained observation that occurred with CNA11 to DON who confirmed best practice is to wash hands if they are soiled and hand sanitize if not. 3) On 02/04/25 at 01:40 PM observed Registered Nurse (RN)12 do dressing change for resident (R)54. RN12 brought in supplies to the resident's room, used proper personal protective equipment (PPE) as resident is on contact precautions. RN12 was observed placing clean gauze on resident's bed side table. Bed side table was not wiped down prior to nurse placing dressing change supplies directly onto the table, such as the clean gauze. RN12 cleaned R54's pressure ulcer (PU) as ordered by the physician. Afterwards RN12 took off her dirty gloves and put on clean gloves. No hand hygiene was observed prior to RN12 putting on clean gloves. After dressing change interviewed RN12 and asked if it was ok to put clean gauze on resident's dirty bed side table. RN12 confirmed it was dirty and asked if surveyor had any recommendations. RN12 was also told she was seen putting on clean gloves after taking off dirty gloves. Asked her if she is supposed to do anything before putting on clean gloves and she stated wash hands. Inquired with RN12 if she had training on hand hygiene and she said not in a while. Surveyor asked RN12 when she started working at facility and she said about six months ago. Asked if she had training at that time and she confirmed that she had. On 02/04/25 at 02:03 PM interviewed DON who confirmed staff have had training on hand hygiene during orientation, as needed and annually and she reported they do audits. DON explained audits consist of watching to see if staff sanitize their hands before they go into the room or if hands are soiled. DON explained wound nurse or Infection Preventionist nurse does audits as well of wound dressing changes. DON stated she will look into getting small chux that nurses can use for barriers. DON also stated they have trays, I don't know why she didn't use it. On 02/04/25 at 02:10 PM interviewed education nurse who confirmed they do training with staff on hand hygiene and dressing change during orientation and annually. She confirmed nurse should have sanitized hands after taking off dirty gloves before putting on clean gloves. 43414 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) On 02/04/25 at 08:10 AM, observed RN12 respond to R68 when yelling for help because she made a bowel movement (BM). Prior to entering R68's room, a sign outside the door indicated she was under EBP, gloves and gown are needed when providing contact care. RN12 observed at bedside wearing gloves and wiping R68's hands. RN12 was not wearing a gown. R68 complained to RN12 that her stomach was sore and RN12 was observed to assess and touch R68's stomach. RN12 then took off her gloves and grabbed a new pair without hand washing in between glove use and adjusted R68 oxygen tubing. RN12 informed R68 someone will be coming to change and clean her BM. RN12 reported she was wiping R68's hands because she was touching the BM stains on her incontinence under pads. RN12 confirmed R68 is under EBP and should have worn a gown when providing direct care and hand sanitize between gloves. On 02/06/25 at 11:35 AM, an interview with Infection Preventionist (IP) was done. IP stated nursing staff are to wear gown and gloves while providing high contact care to residents with EBP to prevent infections or multidrug-resistant organism (MDRO). Residents with certain medical devices are prone to more infections. IP confirmed nursing staff should hand wash or sanitize between glove use. 5) On 02/04/25 at 08:36 AM, during an interview with R54 observed an opened lancet on the foot of R54's bed and the cover on R54's bedside table. On 02/04/25 at 08:41 AM, an interview with RN12 was done. RN12 confirmed the item on R54's bed was an opened lancet and was used to puncture a finger to test blood sugar levels. RN12 reported used lancets are discarded in a sharps container (a container used to prevent injuries and spread of infections from sharp objects.) On 02/06/25 at 11:35 AM, an interview with IP was done. IP confirmed lancets are to be discarded in a sharps container because it could potentially prick someone else and puts others at risk of blood-borne pathogen contamination. 51870 6) R68 is a [AGE] year-old resident who was admitted to the facility on [DATE] for hospice services. Review of the electronic health record (EHR) , R68 has an indwelling catheter. On 02/05/25 at 08:05 AM, observed R68's catheter bag on the floor. Noted a basin adjacent to the catheter bag. On 02/05/25 at 08:45 AM, Certified Nurses Aid (CNA) 5 verified that catheter bag should be off the floor and in the basin. CNA5 noted that they use the basin as a barrier. Observed CNA5 place catheter bag in basin. Staff interview on 02/05/25 at 11:50 AM, Director of Nursing stated that CNAs are supposed to clean catheters from top to bottom, reporting any signs/symptoms of foul-smelling odor, color of the urine, bag secured to their leg and that there should be a barrier between the catheter bag and the floor. Staff interview on 02/06/25 at 12:40 PM, IP stated that catheters should be hung on the bed, should be off the floor, and basin used as a barrier. She stated that this was to prevent contamination. (continued on next page)

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	02/06/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's catheter policy dated 07/2021 and revised on 01/11/24, Catheter care will be performed every shift and as needed by nursing personnel and catheter drainage bags will be positioned below bladder level, clear from the floor and will not be level with resident in while resident is in bed.