STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl City Nursing Home	919 Lehua Avenue Pearl City, HI 96782

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38870 Based on interview, record review and document review, the facility failed to ensure that one resident (R) 25 of three in the sample received care and services to prevent a urinary tract infection (UTI). The resident's indwelling foley catheter was not removed as ordered upon admission to the facility until [DATE] and the resident developed a UTI. The Resident declined and was hospitalized on [DATE] for a serious illness. Findings include: Cross reference to F692 Reviewed intake ID11269. Resident's family member (F)1 filed a complaint to the state agency regarding care at the facility from [DATE] to [DATE]. F1 interviewed by telephone on [DATE] at 3:00 PM. F1 confirmed the concerns noted in the intake and emphasized that she was aware of the discharge instructions to remove R25s indwelling catheter, and that she asked the nursing staff repeatedly when the foley catheter was going to be removed. F1 was very worried that R25 would develop a UTI and did test positive on [DATE]. F1 stated that her mother also lost 20 pounds (lbs.) during the time she resided in the facility. F1 stated that R25 was in the hospital until [DATE], and was discharged home on hospice. On [DATE], R25 died . Onsite survey conducted on [DATE]. Electronic Medical Record (EMR) reviewed. R25 is a [AGE] year-old female admitted to the facility on [DATE], with a primary diagnosis of rhabdomyolysis, a breakdown of skeletal muscle due to muscle injury, and generalized muscle weakness. (Per review of the admission record), [DATE]. Discharge instructions dated [DATE] from Acute care hospital reviewed. Cardiac diet . Rehab .Voiding trial at skilled nursing facility (SNF) for foley removal . Minimum data set (MDS) admission five-day assessment dated [DATE] reviewed. Resident has an indwelling foley catheter at the time of assessment. No trial of a toileting program attempted on admission/entry or reentry. (continued on next page)

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care plan reviewed. Focus: The resident has indwelling catheter due to urinary retension (sic). Monitor to the Medical Doctor (MD) for signs and symptoms (s/sx) UTI: pain, burning .altered mental status, change in behavior, change in eating patterns. Progress notes reviewed. Removed indwelling foley catheter at 3:00 PM. [DATE]. 3:12 PM resident is confused, F1 came and also notice that R25 is confused, called MD to made aware and ordered Urinalysis (UA). Straight Cath done and noted cloudy urine 350 cubic centimeters (cc) out. [DATE] 02:05 AM. 2:35 PM. F1 called about R25's UA. Informed her that report status pending. MD is aware but will wait for the final result. [DATE] 3:40 PM MD ordered Cipro (antibiotic) 250 milligrams (mg) by mouth (PO) x five days. [DATE] 11:45 Final UA culture & sensitivity (C&S) result showing Extended Spectrum Beta Lactamases (ESBL), a type of enzyme or chemical produced by some bacteria that are resistant to common antibiotics. Relayed to MD. Received order to complete 14 days treatment of Cipro. [DATE] 11:42 AM. Mental Status: Resident is confused. [DATE] 3:54 PM. F1 requested transfer to Emergency Department (ED). MD made aware of patient's decline. Ambulance arrived at facility at 1:30 PM to take R25 to ED. [DATE] at 09:01 AM. Confirmed patient arrived at ED at 2:34 PM. Resident admitted at 9:53 PM with an admitting diagnosis of Metabolic encephalopathy, a brain dysfunction caused by systemic illness. Interview with Director of Nursing (DON), Nursing Supervisor (NS)1, and Registered dietician, (RD)1. On [DATE] at 12:24 PM in the Administrators office. The surveyor asked the DON and NS1 when did the hospitalization for R25 occur and what was the cause. They looked in the EMR and said she was sent to ED for weakness, poor po intake and weight loss of 20 pounds. The DON added that the resident's dehydration status would have affected the UTI and confirmed that the indwelling catheter had not been removed as ordered in the admission orders. Urinary Tract Infections (Catheter-Associated), Guidelines for preventing Level III 2001 MED-PASS, Inc. reviewed. The purpose of this procedure is to provide guidelines for the prevention of catheter-associated urinary tract infections (CAUTIs) .Be able to identify and report the clinical signs and symptoms of a urinary tract infection (with or without catheter), including: .Confusion and/or functional decline .General Guidelines . It is the responsibility of the interdisciplinary team to maintain vigilant practices to prevent CAUTIs and to recognize and report early indications that a CAUTI may be developing .Leave catheters in place only as long as needed. Conduct ongoing assessment and monitoring of residents with indwelling catheters to establish continued need .Initiate steps to discontinue order and remove catheter if criteria is no longer met . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hospital medical record dated [DATE] to [DATE] reviewed. Principal diagnosis: UTI .Secondary diagnoses include .Acute-subacute metabolic encephalopathy, multifactorial, resolving. Chief issue on admission, significantly worsening confusion at her SNF .On this admission initial UA was from Old foley, but on repeat urine culture still grew ESBL E coli resistant to multiple agents .Treated 7-day course of Ertapenem . discharged home on hospice.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38870 Based on interview, record review and document review, the facility failed to Recognize, evaluate, and address the needs of one resident of three in the sample who was at risk for adequate hydration and nutrition status. This deficient practice may have resulted in decline, weight loss, and an unplanned hospitalization with severe illness. Findings include: Cross reference to F690. Resident (R)25 is a [AGE] year-old female admitted to the facility on [DATE], with a primary diagnosis of rhabdomyolysis a breakdown of skeletal muscle due to muscle injury, and generalized muscle weakness. (Per review of the admission record), 06/24/24. Hospital (H) discharge summary dated 06/24/24 reviewed. Principal diagnosis: rhabdomyolysis, (when muscles are severely injured or inflamed) and multiple medical diagnoses. Admission orders reviewed. Take resident weight everyday x three days of admission, weekly for four weeks then monthly thereafter unless otherwise notified by Registered Dietician (RD)/Medical Doctor (MD) 06/25/24. Weights reviewed from 06/25/24 to 07/16/24: 06/25/24 1:07 PM, 181.6 Lbs. in wheelchair; 06/28/24 10:04 AM 177.0 lbs. in wheelchair; 07/01/24 2:08 PM 176.8 lbs. in wheelchair. Next weight documented on 07/16/24 2:02 PM 160.8 lbs. in wheelchair. Noted 11.5 percent (%) decrease in weight since admission on 06/25/24. No weights documented between 07/01/24 to 07/16/24. Fluid and nutrition intake from 07/05/24 to 07/19/24 reviewed. Average fluid intake was 274 cubic centimeters (cc) per day. Average nutrition intake documented was 0-25%. Skilled nursing notes reviewed from 06/25/24 to 07/18/24. Skilled nursing evaluation notes state Taking nutrition and hydration orally, no complaints of thirst . No documentation of the resident with poor oral intake noted. Interview with the Director of Nursing (DON), Nursing Manager (NM)1 and Registered Dietician (RD) on 11/07/2024 at 12:24 PM in the Administrators office. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Surveyor asked the RD when was the weight loss identified and what interventions were put in place? Who was notified and when? The RD looked into the EMR and stated, R25's oral (PO) intake was documented between 0-50% during the week of 07/07 to 07/13. The diet was liberalized from Cardiac to regular. Snacks and supplements were offered with our alternative menu. The resident was offered assistance with her meals, and she would say that she didn't need help, but she really did need help to eat and drink. The surveyor asked why there weren't any orders for supplements? The DON and NM1 looked in the medical record and stated, R25 declined the supplements and snacks. The MD was updated on R25's weight loss on 07/17/24. The surveyor asked the RD if weights were taken between 07/01 and 07/16. The RD looked into the record and confirmed there were no weights documented during that time and on 07/16/24 the resident was identified with an 11percent % weight loss. Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol 2001 MED-PASS, Inc. reviewed. 1. The nursing staff will monitor and document the weight and dietary intake of residents in a format which permits comparisons over time .4. The staff will report to the physician significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake .For individuals with recent or rapid weight gain or loss .the staff and will review for possible fluid and electrolyte imbalance as a cause .The physician and staff will monitor nutritional status, an individual's response to interventions, and possible complications of such interventions (for example, additional weight gain or loss, nausea, or vomiting) . Hospital medical record dated 07/19/2024 to 08/04/2024 reviewed. Principal diagnosis: UTI .Secondary diagnoses include .unintentional/ rapid weight loss .Robust appetite was noted (both in chart and by F1 when she discharged from Hospital eating plateful meals three times/day; standing weight on 06/24/24 was 180 lbs. Developed poor PO intake/appetite at SNF. Admission weight on 07/19/24 bed scale was 159 lb. F1 and R25 report intermittent discomfort with swallowing, while overall swallow mechanics appear intact, he struggles with even simple foods - her dentures no longer fit due to the rapid weight loss .