STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125048	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ann Pearl Nursing Facility	45-181 Waikalua Road Kaneohe, HI 96744

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853 Based on interviews, document and record review (RR), the facility failed to provide one Resident (R)1 the right to equal access of quality care. Specifically, R1's primary language was Korean and the facility did not have an effective process in place to access interpreters. Due to this deficiency, staff were unable to communicate and understand R1's needs to provide her the quality of care she had the right to. This deficiency has the potential to affect any resident whose primary language is not English. Without appropriate communication, the resident's may not meet their highest level of physical and psychosocial well-being. Findings include: 1) R1 was an [AGE] year female admitted to the facility on [DATE], for short term physical and occupational therapy after a brief hospitalization for generalized weakness. Her primary language was Korean, she used hearing aides, and had mild cognitive impairment. R1's medical history included but not limited to anemia, chronic kidney disease, and Type 2 Diabetes on insulin. She required assist of one to transfer from wheelchair to bed. On 05/16/2024, R1 was transferred to the Emergency Department for psychiatric evaluation after she attempted self harm. She was readmitted to the facility the next day, and then discharged home on 06/16/2024. 2) Record review revealed the following nursing notes: 05/15/2024, 01:55 PM: Resident admitted at 11:30 AM from hospital.Mild cognitive impairment. Resident is alert and oriented 2-3 (alert and oriented to person, place and time, but not situation) ., Korean speaking primarily. Resident had hearing aids .Resident denies any pain at this time. 05/15/2024, 10:58 PM: .Resident is hard of hearing and Korean speaking. Resident is noted with difficulty understanding English and communicating with staff. At 1700 (05:00 PM) is noted with multiple attempts to stand from bed and self transfer. Resident noted with lower extremity weakness and trouble bearing weight. Resident transferred with wheelchair and with periods of agitation about wanting to go home. 1:1 supervision provided. Daughter updated and willing to drive to facility to attempt to calm Resident. Daughter on site for a few minutes then states she is leaving because she can not help Resident. She (R1) does not recognize her voice and unwilling to listen.Resident with ongoing agitation.Resident noted to purposely sit on ground from recliner and scoot to the door.Resident stated, I don't want to be here. I am going home.NP (Nurse practitioner) updated .with orders for PRN (as needed) Melatonin (for sleep).Resident continues with restlessness with constant 1:1 provided. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/16/2024, 01:06 AM: NP notified for residents continued attempts to slide down/off wheelchair, lay on floor. Resident refused assistance to get back into wheelchair, or allow staff to assist into sitting position. Order to use GERI CHAIR (padded recliner, reduces fall and other injury risks) this shift.MD updated. Resident at this time is with CN (Charge Nurse) 1:1 Supervision, no behaviors, no attempts to get out of chair, resting with eyes closed. PRN melatonin given . 05/16/2024, 06:02 AM: Tolerated sitting in Geri chair during night, multiple attempts to continue to get out of chair. Resident given continuous 1:1 entire shift, .Resident cooperative with getting into wheelchair this morning. 05/16/2024 at 09:11 AM, entry by Resident Care Manager (RCM): Resident needing 1:1 assistance this morning. Per CN-resident with attempts to self harm with call light cord, bed remote and personal nail clippers. Items removed and safety ensured of resident.Resident primarily Korean speaking, but able to speak/understand some English words. Resident requesting to speak with Korean person via telephone. Provided assistance for resident. Resident wanting door and curtain closed for privacy.Resident prefers Korean foods. 05/16/2024, 01:50 PM: Spoke with NP and Physician (MD1) .MD1 requesting to have resident sent out 911 to hospital for further eval (evaluation). 05/17/2024, 01:30 PM: .Spoke with RN (Registered Nurse (at Hospital emergency room)) .No admission will be done, resident treated for UTI (urinary tract infection).No ETA (estimated time of arrival) on return back to facility . 05/17/2024, 06:12 PM: Late entry for 5/16/24 14:28 (02:28 PM). Noted with attempts to harm self. Using nail file on nail clippers repeatedly jabbing and poking at right wrist causing bleeding. Opening to skin is superficial.Resident assisted to bed and monitored with one to one.On call MD updated with self harm and refusal behaviors . 05/17/2024, 06:15 PM: Returned to facility in stable condition. Resident in no distress, calm and cooperative with care . 3) On 07/10/24 at 09:00 AM conducted a telephone interview with Licensed Practical Nurse (LPN), who admitted R1 on 05/15/2024. She said she received a telephone report from the hospital nurse and there was nothing out of the ordinary. She said when R1 arrived, she was kind of sleepy but was cooperative during the initial assessment and interactions that day. LPN said the report provided by the hospital appeared to be accurate and reflected how R1 presented. She went on to say she had been in orientation that day as a new LPN, so had a preceptor. She said she was still working as a CNA some shifts at the facility, and she came back the next day as a CNA. That morning, RN4 told her R1 had been 1:1 the previous shift. Asked her the process to obtain a translator, and she said she had not really encountered the situation and recalled having a pad to contact someone a few years ago. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/09/2024 at 05:00 PM, during an interview with RN2, the evening CN, he said R1 was restless and wanting to go home. RN2 said her daughter came in for a short period of time, but was unable to calm her. He said when he left that evening, R1 was still restless. RN2 said he called the DON (Director of Nursing) to update her on the situation, and confirmed there was a language barrier. He said they didn't have a translator that shift, but often use staff if on duty and translation apps (applications on the phone). RN2 said they really didn't know R1's baseline cognitive status because it was her first shift at the facility. On 07/10/2024 at 10:30 AM, conducted a telephone interview with RN3, the night nurse. She said at shift change, the evening charge nurse, said R1 kept forcefully sliding herself out of the wheelchair onto floor. They didn't want her to injure herself or fall, so let her lie on the floor. RN3 said she didn't want to leave her on the floor, so called the provider and got an order for the geri chair and kept her within eye sight. RN3 said she sat next to R1 to calm her when she was weeping, crying, a heartfelt cry. She (R1) kept repeating the same sentence and speaking Korean. I didn't know what she was saying. I didn't know what her story was, couldn't translate anything, and couldn't access anyone to translate. RN3 said R1 had her purse with her and wouldn't give it up, so couldn't inventory belongings in the bag. She said R1 was adamant she was not supposed to be there. Google translate was not working. I sat, she was talking, but no idea what she was trying to say. I wanted her to know we cared, so showed her I was actively listening. It seemed to calm her. She was needing to get what ever she had to say out. RN3 said she tried calling R1's daughter, but unable to reach her. Inquired what resources the facility had for interpreters, and she said they really didn't have anything place. RN3 went on to say she had worked in facilities that had access to a 1-800 interpreter service. I don't have a resource if someone comes in and there is a language barrier. There is no one to call. Common sense is to use Google translate when nothing else is available. RN3 said she had an orientee with her that night, who asked her about interpreters. On 07/09/2024 at 03:30 PM, interviewed the day Charge Nurse (RN4) on duty 05/16/2024. Her recall was the incident of self harm took place early AM, shortly after she arrived. She said R1 was lying in the hallway with her head on her purse. The off going RN (RN3) reported R1 had been agitated, didn't want to give up her purse or sleep in bed and had been monitored 1:1 all night. RN4 said R1 was at peace lying on the floor. She went on to say, later the CNA came to me and said R1 had a nail clippers and had self inflicted scratches on her arm. RN4 reviewed her progress note for that shift and confirmed it was a late entry and documented the day after the event occurred. RN4 said she had not cared for R1 before, so thought R1 may have had some behavioral problems and may even sleep on the floor at home. RN4 said she thought when R1 was admitted , someone was able to reach the daughter who provided all the information. She said if they couldn't find someone to speak the resident's language, they would go to management, or can do Google translate. On 07/10/2024 at 08:30 AM, interviewed the Unit Clerk (UC) assigned to monitor R1 after the incident of self harm. She said when putting R1 in bed, R1 kept grabbing at other objects or striking the rail to harm herself. UC said I kept telling R1, please don't do that, and R1 replied If not today, tomorrow. The UC interpreted this as R1 wanted to hurt herself. When asked the UC what resources the facility had for interpreters, she replied I know we do have something, but would have to ask. I would continue to ask until someone could assist me. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/09/2024 at 03:00 PM, during an interview with the RCM, she said if someone had a communication barrier, they would try to locate a translator and there is a bilingual access line. Inquired if any nurse could access the bilingual services, and she said I believe so, but was not sure of the specific guidelines. The RCM said she sat with R1 awhile after the incident, and during that time, R1 asked to talk to someone in Korean. She said at that time, she didn't know about the bilingual access line, couldn't reach the daughter, and ended up contacting one of her own family members, who speaks fluent Korean. The RCM went on to say she couldn't understand all that was said, but from what she understood, R1 didn't know why she was at the facility, seemed very confused and thought her daughter was coming back with food. She wanted the door closed and had Asian food preferences. Inquired how many Residents the facility had that did not have English as primary language, and she said a good handful. The RCM said when R1 was admitted , the daughter was not there, but believed the staff talked to her on the phone. On 07/10/2024 at 09:30 AM, conducted an interview with Social Services (SS). She explained she meets with all new admissions, and if the Resident is unable to communicate due to condition or language barrier, she will contact family to assist. SS said she was made aware of R1's intent to self harm on 05/16/2024, but had been off. The weekend was the 17th and 18th and her first day back, 05/19/2024 she saw R1. The intent of that first visit was to do the SS admission assessment as well as to follow up after the incident. SS said R1 could understand hand gestures and she said would repeatedly respond to questions by saying her daughter's name. Inquired if SS talked with R1 about the incident to assess her mental and emotional status, and she said she was calm and cooperative, and thought R1 understood what she was saying. SS said R1 kept saying I'm OK now, and Little pieces of English. Inquired what her practice was to complete assessments if residents primary language is not English, and she said in this case, the daughter was contacted and assisted in completion of the assessment. When asked if she used interpreter services for admissions, she said most times it is the family. SS said if she needed an interpreter, she would try to find someone in the facility. She said she had not used other (external) interpreter services while employed at the facility. On 07/10/2024 at 11:35 AM, conducted a second interview with SS and reviewed the 5 day MDS assessment. She confirmed the documentation on 05/19/2024, which indicated Section C (cognitive) and D (mood) were not completed, because R1 wouldn't answer questions. SS confirmed the PHQ9 (instrument for screening of depression and presence of suicide ideation), also was not completed. She said the only interpreter she used to communicate with R1 was her daughter. On 07/10/2024 01:11 PM, during an interview with the Administrator (ADM), she said Human Resources maintains a list of staff that speak other languages, and they try to utilize staff first for interpreting. If unable to find staff, the process would be to use the Bilingual access line. The ADM was unsure if the access line was available 24/7. 4) Reviewed the facility policy titled Resident Rights, original effective date 05/01/2022, last revised 10/01/2022. The purpose of the policy included To ensure that resident rights are respected, protected and promoted. The policy also included 1. The resident has the right to exercise his /her rights as a resident of the facility and as a citizen or resident of the United States.23. The resident has the right to be fully informed in language that he/she can understand of his/her total health status, including but not limited to his/her medical condition. Reviewed the facility policy titled Limited English Proficiency (LEP), effective date 11/17/2015. The policy included the following: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: [NAME] Pearl Rehab and Nursing will take reasonable steps to ensure that persons with Limited English Proficiency (LEP) have meaningful access and an equal opportunity to participate in our services, activities, programs and other benefits. The policy .to ensure meaningful communication with LEP patients/clients and their authorized representatives involving their medical conditions and treatment. The policy also provides for communication of information contained in vital documents, including but not limited to, waivers of rights, consent to treatment .etc.Language assistance will be provided through the use of competent bilingual staff, staff interpreters, contracts or formal arrangements with local organizations providing interpretation or translation services, or technology and telephonic interpretation services. All staff will be provided notice of this policy and procedure, and staff that may have direct contact with LEP individuals will be trained in effective communication techniques, including the effective us of an interpreter. [NAME] Pearl Rehab and Nursing will conduct regular review of the language access needs of our patient population, as well as update and monitor the implementation of this policy and those procedures, as necessary. Procedures: 1.will promptly identify the language and communication needs of the LEP person. 2. Administrator and/or designee at [PHONE NUMBER] is/are responsible for: (a) maintaining an accurate and current list showing the name, language, phone number and hours of availability of bilingual staff; (b) Contacting the appropriate bilingual staff member to interpret, in the event that an interpreter is needed, if an employee who speaks the . (c) Obtaining an outside interpreter if a bilingual staff or staff interpreter is not available or does not speak the needed language. Helping Hands Hawaii Bilingual Access Line has agreed to provide qualified interpreter services.Some LEP persons may prefer or request to use a family member or friend as an interpreter. However family members or friends of the LEP person will not be used as interpreters unless specifically requested by that individual and after the LEP person had understood that an offer of an interpreter at no charge to the person had been made by the facility. Such an offer of an interpreter and response will be documented in the person's file. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpreting, confidentiality, privacy, and conflict of interest will be considered.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853 Based on interviews, document review and medical record review (RR), the facility failed to ensure a person-centered comprehensive care plan (CP) was developed to address one resident's (R)1 needs of a sample size of three. R1 had significant hearing impairment, but the CP did not include this barrier to communication. As a result of this deficiency, the care team may not have been aware of her hearing impairment when interacting with her. There is a potential any resident may not reach their highest practical physical and psychosocial potential if their needs are not identified and addressed in the CP. Findings include: 1) R1 was an [AGE] year female admitted to the facility on [DATE], for short term physical and occupational therapy after a brief hospitalization for generalized weakness. Her primary language was Korean, she used hearing aides, and had mild cognitive impairment. On 05/16/2024, R1 was transferred to the Emergency Department for psychiatric evaluation after she attempted self harm. She was readmitted to the facility the next day, and then discharged home on 06/16/2024. 2) RR revealed the following progress note entries: 05/15/2024 at 01:55 PM, Nursing Progress New Admit note: .Resident is alert and oriented 2-3 (oriented to person, place and time), can response [sic], Korean speaking primarily. Resident has hearing aids . 05/15/2024 at 10:58 PM, Nursing Progress note: . Resident is hard of hearing and Korean speaking. Resident is noted with difficulty understanding English and communicating with staff. 05/24/2024 at 03:43 PM Social Services Progress note: . R1 is primarily Korean speaking, hard of hearing but uses hearing aids, . Reviewed R1's baseline care plan and comprehensive care plans, which included the following: Baseline CP dated 05/16/2024: .I communicate verbal. My preferred language is Korean. My hearing is adequate I need nothing to improve my hearing. Comprehensive CP included: - Resident does not speak in the dominant language of the facility. Primary language of resident-Korean. - Long term Goal .Resident will establish a reliable means of communication with staff. - Approach .Encourage resident to use gestures, communication board when expressing self. There were no updates or revisions throughout R1's stay regarding her hearing impairment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reviewed the Minimum Data Set assessment dated [DATE], which documented in Section B-Hearing, Speech and Vision, R1 had minimal difficulty, for ability to hear, and that she used hearing aid or other hearing appliance. Review of the Emergency Department Provider notes from R1's visit on 05/16/24 revealed the following entries: .History is mostly from EMS (Emergency Medical Services) as the patient is Korean speaking only and is very hard of hearing.We did get the Korean translator system but she states that she cannot hear the Korean translator.Patient sent from rehab due to thoughts of harming self and potential aggression toward staff. She is calm here but there is a significant barrier due to her not having her hearing aids. We will try translator services and try to contact the care facility for hearing aid batteries. 3) Reviewed the facility policy titled Comprehensive Care plans, last revision date 05/23/2023. The policy included the following: Policy statement: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframe to meet a resident's medical, nursing and psychosocial needs that are identified in the comprehensive assessment. Definitions: Person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their lives. Policy: 1. The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided ., as outlined by the comprehensive care plan, shall be culturally-competent and trauma informed. 3. The comprehensive care plan will describe at a minimum the following: . f. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identify, as indicated.