STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yukio Okutsu State Veterans Home	1180 Waianuenue Avenue Hilo, HI 96720

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 42160 Based on observations and interviews, the facility failed to ensure the resident's right to a dignified existence and is treated with respect and dignity for one resident (Resident (R)36) sampled. Registered Nurse (RN)6 referred to resident's who require assistance with meals as feeders in front of R36, who requires assistance with meals. As a result of this deficient practice, residents are at a potential risk of psychosocial harm. Findings include: On 11/12/24 at 12:09 PM, while conducting an interview with R36 in the resident's room, RN6 entered the room, stood next to the resident, and informed this surveyor, The unit has two other feeders, and the aide will be over to assist the resident (R36 with lunch) when they (aides) are done. After RN6 left the room, R36 stated, I guess I'm a feeder. and reported it did not feel good to hear staff refer to him as a feeder. RN6 returned to R36's room a short time later to assist the resident with lunch and R36 refused the meal. Review of R36's Electronic Health Record (EHR) documented the resident's most recent annual Minimum Data Set (MDS), Section C. Cognitive Patterns, Brief Interview for Mental Status (BIMS) score was 15, indicating R36's cognition is intact. A significant change in status MDS with an Assessment Reference Date (ARD) of 07/23/24, documented R36's BIMS score was 14, and his cognition was intact. On 11/13/24 at 03:15 PM, while conducting an interview with the Director of Nursing (DON) in her office, DON confirmed staff should not call or refer to residents as feeder.

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 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. 42160 Based on observation and interview, the facility failed to facilitate a resident's self-determination through support of the resident's choice of food preferences for one resident (Resident (R)58) sampled. R58's reported he informed the facility of his food preferences and still receives foods that he informed the facility he does not like, for example milk and fish. During lunch observation on 11/12/24, the resident was served salmon for lunch and the resident's meal ticket documented R58 dislikes fish. As a result of this deficient practice, residents are at risk for more than minimal physical and/or psychosocial harm. Findings include: On 11/12/24 at 10:55 AM, conducted an interview with R58. During the interview, R58 reported the food is not so good and he receives foods that he has told staff he dislikes or has stopped eating/drinking. Asked R58 for an example of an event he experienced. R58 reported since last week, he has had diarrhea and, in an attempt, to minimize the incident of having diarrhea, he told staff that he does not want any milk or dairy products, with the thought that the lactose in the milk is potentially a cause or is contributing to the diarrhea. However, for breakfast, he is brought cereal and milk. The resident has his own refrigerator, with R58's permission, the refrigerator was inspected and noted there were 6 containers of milk stored. R58 stated that those are the milks he received with his meals after informing the facility staff that he did not want milk with his meals. On 11/12/25 at 12:15 PM, conducted a lunch dining observation for R58. R58 stated, Look they gave me fish and I don't eat fish. It's on my paper, dislikes fish. Reviewed R58's lunch meal ticket which documented, Dislikes: Fish. R58 reported, this is not the first time I have received something I told them I do not want. On 11/15/24 at 09:05 AM, conducted an interview with the Dietitian (D)1. D1 confirmed R58 received fish for lunch on 11/12/24 despite his meal ticket documenting that he dislikes fish and confirmed kitchen staff made a mistake. On 11/15/24 at 09:10 AM, the Director of Nursing (DON) was informed of R58's food preferences were not being honored. DON confirmed R58 should not have been served fish for lunch.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42160 Based on interview and record review, the facility failed to ensure the resident or their representative was given written notice of transfer or discharge from the facility and that a copy of the notice was sent to a representative of the Office of the State Long-Term Care Ombudsman for two residents (Resident (R)7 and R43) sampled. This deficient practice has the potential to affect all the residents who are transferred or discharged from the facility. Findings include: 1) Review of R7's Electronic Health Record (EHR) documented R7 was sent to an acute hospital on 07/09/24 due to difficulty breathing. On 11/15/24 at 09:18 AM, conducted an interview and concurrent review of R7's Transfer/Discharge Notice (which was provided by the facility) with Social Service staff (SS)2. Inquired if a copy of R7's Transfer/Discharge Notice for 07/09/24 was sent to a representative of the Office of the State Long-Term Care Ombudsman and requested for SS2 to provide a confirmation of the date and time the notice was sent. SS2 confirmed R7's Notice of Transfer/Discharge for 07/09/24 was not sent to a representative of the Office of the State Long-Term Care Ombudsman but should have been. 48351 2) R43 is a [AGE] year-old male admitted to the facility on [DATE]. On 10/17/24, R43 fell out of his wheelchair and was transferred to the hospital. A review of the R43's EHR was conducted on 11/13/24. R43's EHR did not contain any documentation that the facility had provided R43 and his representative a written notification for his transfer to the hospital. Interview was conducted with the facility Administrator on 11/13/24 at 04:49 PM. Administrator confirmed that no written notification was given to R43 or R43's family member. A review of the facility policy titled, Discharge/Transfer Notice, with a last revised date of 03/2024 was conducted. The policy noted, . Before the facility transfers or discharges a resident, the facility must make the following notifications-notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand .

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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** 42160 Based on record review and interview, the facility failed to develop a comprehensive person-centered care plan (CP) for pain which included non-pharmacological interventions for one of five residents (Resident (R)16) sampled for unnecessary medication. Review of R16's CP for pain did not include non-pharmacological interventions as a standard of practice of multimodal approaches for pain relief according to the American Nurses Association (ANA). As a result of this deficient practice, resident is at risk for potential harm by potentially receiving unnecessary medications, which could include opioids, prior to implementing other effective modalities of pain relief (cold, heat, repositioning, exercise, stretching etc.). Findings include: Review of R16's Electronic Health Record (EHR) documented R16 was admitted to the facility on [DATE] with diagnosis which included low back pain and has a current diagnosis of cellulitis to both lower limbs, and gangrene. R16 was admitted to hospice on 10/31/24. R16's physician's orders which included Oxycodone HCl 5 mg as needed for pain give 5 mg (milligrams) by mouth every 4 hours as needed for pain level 4-7/10 and give 10 mg by mouth every 4 hours as needed for pain level of 8-10/10 ; Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML, give 0.25 ml by mouth every 1 hours as needed for pain 1-3/10 not to exceed 20 mg per hour. May give sublingual (under the tongue) if unable to swallow and give 0.5 ml by mouth every 1 hours as needed for pain 4-6/10 not to exceed 20 mg per hour. May give sublingual if unable to swallow and give 1 ml by mouth every 1 hours as needed for Pain 7-10/10 not to exceed 20 mg per hour. May give SL if unable to swallow and give 0.25 ml by mouth every 1 hours as needed for SOB (shortness of breath) not to exceed 20 mg per hour. May give sublingual if unable to swallow; Methadone HCl Oral Tablet 5 mg, give 0.5 tablet by mouth one time a day for pain and give 1 tablet by mouth at bedtime for pain. Review of R16's November 2024 Medication Administration Record (MAR) documented the resident received Oxycodone 5 mg on 11/01/24 at 12:05 AM and 09:30 PM, 11/02/24 at 05:25 AM, 11/03/24 at 04:37 PM, 11/05/24 at 12:40 AM, 11/06/24 at 07:46 AM, 11/07/24 at 05:06 AM, and 11/10/24 at 09:10 PM. R16 also received Morphine on 11/07/24 at 05:45 AM. On 11/13/24 at 03:45 PM, conducted a concurrent interview and record review of R16's EHR with the Director of Nursing (DON) in her office. After reviewing R16's physician orders and CP, DON confirmed non-pharmacological interventions should be implemented prior to administering medications as a standard of practice for implementing least invasive interventions first and R16's CP does not include non-pharmacological interventions but should have included any effective non-pharmacological interventions. DON reviewed R16's chart and could not provide documentation confirming the facility is currently implementing other modalities of treating R16's pain besides medication.

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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** 42160 Based on observation, interviews, and record review, the facility failed to provide appropriate medical care for one resident (R)58. The facility failed to manage R58's bowel regimen and manage the resident's diarrhea. This deficient practice has the potential to result in more than minimal psychosocial and physical harm. Findings include: On 11/12/24 at 10:52 AM, entered R58's room and conducted an interview with R58 and R58's Family Member (FM)1. R58 reported having diarrhea since last week Thursday (11/07/24). R58 expressed concerns about having diarrhea for the past six (6) days and felt that the facility has not been managing his condition according to professional standards of medical care. R58 reported to date, the facility has not taken a stool sample to ensure he does not have C. difficile (a germ bacterium that causes diarrhea and inflammation of the colon and can be life threatening) or a similar condition; administered medication that is an osmotic laxative (MiraLAX, which draws water into the colon) while having soft/loose stools which worsened his condition; R58 reported having to ask the nurses for medication to treat the symptoms of diarrhea and stop attempting to give him a laxative; experiencing pain to an area where the skin was starting to breakdown on his bottom area; no nursing interventions were implemented to mediate R58's condition so he started to elevate his legs to alleviate the pain and pressure on the area where his skin was hurting; reduced the amount he ate and drank to reduce the incidence of having diarrhea and started to feel weak as a result. R58 informed staff that he was no longer eating/drinking dairy products to see if that was the cause of his condition but still received milk and cereal for breakfast. Inquired if Attending Physician (AP)1 had been in to assess or address his condition. R58 confirmed AP1 has not assessed him and added that he only sees AP1 approximately once a month when he must certify that his condition qualifies him to be in the facility and the visits with AP1 are minimal lasting less than several minutes. R58 shared that he does not feel he is receiving person-centered care from AP1, and the facility is not doing all they can to immediately address the issue before it affects him to the point that he must go to the hospital. Asked R58 how he was currently feeling. R58 reported feeling weak due to dehydration and minimizing his intake to avoid having diarrhea. Also, R58 shared that he was feeling emotionally down due to lack of attention to his concerns and lack of confidence in the facility's ability to provide quality care. While in the resident's room, inspected his personal refrigerator and observed approximately six (6) containers of milk. R58 confirmed those were the milk which came on his meal trays after he told staff that he did not want milk or dairy due to this condition. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	While conducting the interview with R58, AP1 entered the resident's room, walked pass this surveyor and up to R58's bedside. AP1 asked R58 about his breathing and if he had any pain. R58 confirmed he did not have any difficulty breathing or pain. AP1 put on his stethoscope placed it over R58's heart, then removed his stethoscope. R58 was telling AP1 about having diarrhea and AP1 did not ask any clarifying questions. After the third time, R58 reported he had pain in his stomach. AP1 moved to R58's abdomen area and made contact with this surveyor. I identified myself as a nurse surveyor with the Department of Health (DOH), held up my identification badge, and was wearing a shirt with the Department of Health logo. AP1 smiled and nodded, then turned to R58 and quickly palpated his stomach. R58 informed AP1 that he's been having diarrhea for several days and he was surprised that AP1 did not order a stool sample or some sort of diagnostic test to figure out what is going on. AP1 responded and told R58 that they could get a stool sample, then left the room shortly after. AP1 interaction and assessment of R58 took approximately five (5) minutes or less. AP1 did not auscultate R58's stomach area and did not give any orders to this surveyor. Reviewed of R58's Electronic Health Record (EHR) documented R58 was admitted to the facility on [DATE] and diagnosis included acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, heart failure, type 2 diabetes mellitus, hypertension, and atrial fibrillation. Review of R58's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/23/24, Section C. Cognitive Patterns, Brief Interview for Mental Status (BIMS) score was 14, indicating the resident's cognition is intact. Review of R58's Bowel Elimination Task monitoring form documented R58 was consistently incontinent of bowels, had not had an event of loose stools or diarrhea from 10/15/24 to 11/06/24 (timeframe of monitoring form is 30 days). Documentation of the size and consistency of R58's bowel movements were: Day 1: 11/07/24 at 11:15 AM- Large Putty- like 11/07/24 at 12:23 PM- Medium Putty- like 11/07/24 at 01:23 PM- Large Putty- like 11/07/24 at 06:51 PM- Medium Loose/Diarrhea 11/07/24 at 09:21 PM- Medium Loose/Diarrhea Day 2: 11/08/24 at 01:27 AM- Medium Loose/Diarrhea 11/08/24 at 12:38 PM- Small Loose/Diarrhea 11/08/24 at 06:39 PM- Medium Formed 11/08/24 at 08:18 PM- Small Loose/Diarrhea (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/08/24 at 09:38 PM- Small Loose/Diarrhea Day 3: 11/09/24 at 01:46 AM- Medium Formed 11/09/24 at 05:10 AM- Medium Formed 11/09/24 at 07:14 AM- Medium Putty- like 11/09/24 at 09:14 AM- Medium Putty- like Day 4: 11/10/24 at 01:30 AM- Large Loose/Diarrhea 11/10/24 at 05:40 AM- Large Loose/Diarrhea 11/10/24 at 09:25 AM- Small Loose/Diarrhea Day 5: 11/11/24 at 04:02 AM- Large (consistency not documented) 11/11/24 at 11:50 PM- Large Putty- like 11/11/24 at 11:50 PM- Medium Putty- like Day 6: 11/12/24 at 01:52 PM- Medium Putty-like 11/12/24 at 06:16 PM- Small Putty-like Review of R58's physician orders documented an order of MiraLAX 1 scoop by mouth in the afternoon for constipation. Hold for loose BM (bowel movement) at 04:00 PM daily and Loperamide HCl Capsule 2 mg (milligram), Give 1 capsule by mouth every 6 hours as needed (PRN) for loose stool after each loose stool (ordered on 11/08/24). Loperamide is administered to control and relieve symptoms of acute diarrhea by slowing down intestinal movement. AP1 ordered the stool sample on 11/13/24, a day after AP1 informed R58 a stool sample would be done. Also, contact precautions for R58's loose stool was not implemented until 11/13/24, six days after the onset of symptoms. Review of R58's Medication Administration Record (MAR) for MiraLAX documented nursing staff attempted to administer the laxative when R58 was actively having stool with the consistency of putty-like and loose/diarrhea of two occasions: 11/07/24- R58 refused (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/08/24- R58 refused 11/09/24- R58 was administered MiraLAX 11/10/24- MiraLAX was held (not administered) 11/11/24- MiraLAX was placed on hold Review of R58's MAR for Loperamide HCl 2 mg documented: 11/08/24- ordered and administered twice 11/09/24- administered once 11/10/24- administered three times 11/11/24- administered once 11/12/24- administered twice. R58 continued to have putty-like and loose/diarrhea after the implementation of Loperamide HCl 2 mg and the consistency of the resident's BM continued be mostly putty-like and loose/diarrhea. Review of R58's comprehensive person-centered care plan confirmed a care plan was not developed to address R58's bowel management and infection prevention goals and interventions, until 11/13/24. Review of R58's progress notes documented: 11/08/24 at 12:37 PM, . Resident requested if he could have an order of Loperamide 2 mg every 6 hours as needed for loose stool . Confirmed the resident was actively advocating for himself. 11/09/24- No progress notes documented in R58's EHR 11/10/24 at 10:46 PM, Resident had x1 episode of mucous in stool with a scant amount of blood . 11/12/24 at 11:20 AM, a progress not written by AP1 documented, . Stool studies ordered and pending . Abd (abdomen): flat, non tender, no mass, bowel sounds present . However, this surveyor did not observe AP1 listen to R58's abdomen/stomach area during his assessment of R58. In a follow-up with R58, the resident confirmed AP1 did not conduct any additional assessments on 11/12/24 and this surveyor was present during the only assessment AP1 conducted on him at the time of the recertification survey. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 03:24 PM, conducted a concurrent interview and record review of R58's EHR with the Director of Nursing (DON). DON navigated R58's EHR and confirmed according to professional standard of practice, R58 should not have been offered or administered MiraLAX due to having multiple episodes of loose stools; as a result of on-going loose stool, a stool sample should have been taken sooner and the resident should have been placed on contact precautions sooner and until the facility could rule out the cause of his condition was not due to a potentially contagious bacterial or viral infection; and the care plan was not developed for bowel management. Also, DON confirmed the collection of R58's stool was delayed because the collection and test was not ordered until the following day. DON stated on follow-up with AP1 regarding the day delay in the order, AP1 stated he gave a verbal order to the new nurse in the room. Informed DON the only people in the room when AP1 was conducting his assessment was R58, FM1, and this surveyor. AP1 did not address me or verbalize any orders and the only mention of a stool sample was AP1 telling R58 that they (the facility) could get a stool sample. AP1 did not give any orders to this surveyor and this surveyor did not accept any orders from AP1 according to professional standards of practice which would include directly addressing staff with the resident's information and parameters of the order with a verbal read back to the physician. Also, as professional standards of practice, if the physician is onsite, verbal order should not be given to licensed staff and the physician should directly input orders into the ordering system. On 11/15/214 at 10:11 AM, conducted a telephone interview with AP1. Inquired about the nature and reason of AP1 visit with R58 on 11/12/24. AP1 stated the visit was a regular recertification visit and during the visit R58 reported having diarrhea. AP1 confirmed there was a delay in ordering the stool culture and testing.AP1 said he gave the order to the nurse in the room. Informed AP1 there was a total of four (4) people in the room: AP1, R58, FM1, and this surveyor. Inquired if AP1 recalls this surveyor introducing and identifying herself as a nurse surveyor with the DOH. AP1 replied that he must have missed that and did not recall this surveyor identifying herself, did not notice the DOH logo on my shirt and did not notice that I was not wearing scrubs.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47783 Based on observations, interviews and record review, the facility failed to provide care consistent with professional standards of practice for the resident (Resident (R)25) who received hemodialysis (treatment to remove waste and excess fluids from the blood) treatments. Specifically, the facility did not ensure fluid restrictions were followed as ordered by the attending physician. This deficient practice could result in preventable adverse health conditions like fluid overload and congestive heart failure for residents with end stage renal disease. Findings include: R25 was admitted to the facility on [DATE] for short-term rehabilitation services. Diagnoses included but not limited to End Stage Renal Disease (ESRD) and dependence on renal dialysis. During an interview with R25 on 11/13/24 at 09:25 AM, R25 said he has been on hemodialysis for over [AGE] years. Asked R25 if he has had any complications during his treatments. R25 said his blood pressure drops during treatments when the weight gains between treatments are high. Asked R25 if the staff limit his fluid intake. R25 nodded Yes and said I don't drink much. Review of R25's Electronic Health Records (EHR) revealed that the fluid restriction ordered by the physician was 1,200 milliliters (ml) per day. On the following dates for November, R25's recorded fluid intake was above 1,200 ml: 11/03/24 was 1,680 ml; 11/07/24 was 1,680 ml, 11/08/24 was 3,360 ml, 11/10/24 was 1,338 ml and 11/11/24 was 1,318 ml. On 11/14/24 at 11:12 AM, a concurrent interview and record review was conducted with Registered Nurse (RN)6 at the second-floor nurse's station. Asked RN6 how they monitor and ensure R25's fluid restriction is followed. RN6 said they coordinate with the CNAs (Certified Nurse Aide) on the amount of fluid given to R25 every shift. RN6 added that the night shift nurse will add up all the documented fluids given to R25 at the end of the day and enter that amount in the monitoring log. Reviewed fluid intake log with RN6, acknowledged that ordered fluid restrictions were not followed for the five days listed above. Asked RN6 if the resident was able to get his own water or other fluids to drink. RN6 said, No, fluids are provided by the staff. The family also come to visit and we would not know if they also give him anything to drink. Asked RN6 why it is important to follow the fluid restrictions for R25. RN6 said, it was because the resident is on hemodialysis, he is not able to remove excess fluid from his body and added they have to follow the restrictions as ordered.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 47783 Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5%, as evidenced by two medication errors observed out of 30 opportunities, for an error rate of 6. 67%. Safe and timely medication administration practices are essential for the health and well-being of the residents. As a result of this deficient practice, two residents (Resident (R)56 and 52) were placed at risk of negative outcomes due to medication errors. This deficient practice has the potential to affect all residents in the facility taking medications. Findings include: 1) On 11/14/24 at 08:14 AM, observed Licensed Practical Nurse (LPN)2 administer medications on the second floor. One of the medications administered to R56 was Mucinex Extended Release, 600 mg (milligrams). LPN2 cut the tablet into two pieces prior to giving it to R56. 2) On 11/14/24 at 08:31 AM, LPN2 administered Flonase nasal spray to R52. LPN2 inserted the applicator into R52's nostril and administered two sprays into each nostril as ordered. LPN2 then replaced the applicator cover and did not give any instructions to R52 while administering the nasal spray. On 11/14/24 at 01:31 PM, a concurrent interview and record review was conducted with LPN2 by the nurses' station. Asked LPN2 if there was an order to cut the Mucinex Extended Release tablet into two for R56. LPN2 reviewed the orders in the Electronic Heath Records (EHR) and said she could not find an order. Reviewed package instructions for the medication with LPN2 that stated, . Do not crush, chew or break tablet . LPN2 confirmed that she should not have cut the tablet into two pieces unless it was ordered by the physician. Surveyor then asked LPN2 if there was a package insert for the Flonase nasal spray in the box. LPN2 checked the box and pulled out the package insert. Reviewed administration directions with LPN2 that stated, . Blow your nose to clear your nostrils . Close 1 nostril. Tilt your head forward slightly . insert the nasal applicator into the other nostril . Start to breathe in through your nose . press firmly . Breathe out through your mouth . wipe the nasal applicator with a clean tissue and replace the dust cap . LPN2 confirmed that she did not follow the manufacturer's directions for administering the nasal spray and thanked the surveyor for sharing the information in the package insert.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yukio Okutsu State Veterans Home	1180 Waianuenue Avenue Hilo, HI 96720

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48351 Based on observations and interviews, the facility failed to clean and maintain food serving equipment, dishes, and utensils in a sanitary condition. This deficient practice places the residents at risk for food borne illness and has the potential to affect all the residents who have meals served by the facility. Findings Include: 1) Concurrent observation and interview were conducted on [DATE] at 09:31 AM. Observation was made of a food warmer that contained an uncovered container of soup. The top of the food warmer had a worn down rubber seal and a buildup of dust and lint. The dust and lint were directly above the uncovered soup. Both the cook and the Dietitian (D)1 were shown the dirty warmer and the uncovered soup. D1 confirmed that the container of soup should have been covered and the food warmer should be cleaned. 2) Concurrent observation and interview were conducted on [DATE] at 09:43 AM. Dietary Assistant (DA)1 was observed testing the dishwasher solution. After the solution was tested , observation of the test strip bottle showed that the container had an expiration date of [DATE]. Both DA1 and D1 were shown the bottle of strips. DA1 and D1 confirmed that the bottle of strips were expired and should not have been used to test the dishwasher sanitizing solution. A review of the facility policy titled, Cleaning and Sanitation of Dining and Food Service Area, with a revised date of ,d+[DATE], was conducted. The policy noted, The food service staff will maintain the cleanliness and sanitation of the dining and food service areas .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 47783 Based on record review and interview, the facility failed to ensure the Binding Arbitration Agreements (BAA) followed all the requirements as specified in the regulations. Specifically, the agreements residents were asked to enter into, did not explicitly grant the residents or their representatives the right to rescind the agreement within 30 calendar days of them signing it. Findings include: On 11/14/24 at 10:00 AM, review of resident (R)25's Electronic Health Record (EHR) was conducted. Review of the document titled Patient and Facility Arbitration Agreement revealed that it did not include language that the resident or their representative have the right to rescind the agreement within 30 calendar days of signing it. Review of the list of residents that have entered into a BAA showed 42 of the 60 residents have agreed to it. On 11/15/24 at 10:32 AM, a concurrent interview and record review was conducted with the Administrator in her office. Administrator reviewed the BAA and acknowledged the agreement did not explicitly grant the residents or their representatives the right to rescind the agreement withing 30 days of signing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 42160 Based on interviews and record review, the facility failed to ensure a resident's medical record included documentation that indicated the resident did not receive the influenza immunizations for one of five residents (Resident (R)46) sampled for immunizations. R46 signed a consent form to receive the influenza immunization. However, R46 did not receive the influenza immunization and the resident's refusal and education regarding the benefits of the vaccination was not documented in his medical record. As a result of this deficient practice, R46 was placed at risk for more than minimal harm. Findings include: On 11/14/24 at 03:04 PM, conducted an interview and concurrent record review with the Director of Nursing (DON), in her office regarding the facility's infection control program. Reviewed the immunization status of five (5) preselected residents. R46 did not receive the influenza immunization but had signed a consent form to receive it. Provided an opportunity for DON to provide an attestation or other documentation of R46's refusal and education the facility provided to the resident on the risks and benefits of receiving the influenza immunization. DON reviewed R46's Electronic Health Record (EHR) and could not find the requested documentation in his chart. DON inquired with Registered Nurse (RN)99 who was responsible for obtaining consents and refusal forms. RN99 recalled R46 initially signed the consent to receive the influenza immunization, but when staff was administering the immunization, R46 changed his mind and refused it. Provided an opportunity for NS99 and DON to provide any form of documentation of R46's refusal and of the education provided to the resident upon his refusal. On 11/15/24 at 09:52 AM, checked back in with DON regarding the requested documentation. DON confirmed the facility did not document the R46's refusal and education provided at the time of refusal in the medical chart or EHR. Review of R46's EHR documented a progress note (11/14/2024 at 06:32 PM) Fluzone administered to L (left) deltoid. Placed on alert to monitor for adverse effects x 72. R46 received the immunization.