

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
NAME OF PROVIDER OR SUPPLIER Islands Skilled Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1205 Alexander Street Honolulu, HI 96826	

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)
<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853</p> <p>Based on interviews, record and document reviews, the facility violated federal regulations when they initiated a discharge that did not originate through the Resident's (R)1's Representative's verbal or written request, and was not in alignment with R1's goals for care and preferences. R1 was transferred to an acute care hospital for a medical condition requiring higher level of care. It was R1's Representative's intent to have him return to the facility post hospitalization . Although the facility had the capacity and capability to provide the respiratory specialty services needed, the facility inappropriately made the decision, to deny him the right to return. In addition, the medical record did not contain documentation of the required elements of this discharge. As a result of this deficient practice, R1's Representative was not given the appropriate notification of facility initiated discharge and was unable to appeal the appropriateness of discharge and R1 was denied the right to return to the facility.</p> <p>Findings include:</p> <p>1) R1 is a [AGE] year old male with a history of hypertension, quadriplegia with tracheostomy and gastrostomy tube (tube placed through the abdomen in the stomach) for nutrition after a hemorrhagic stroke. He is nonverbal at baseline. R1 has had multiple episodes of pneumonia. He was admitted to the facility on [DATE], specifically for the specialty respiratory services they provide. R1's Power of Attorney is his mother and his insurance is Medicaid. On 05/31/2024 R1's had a rapid heart rate on and off all day with behavioral changes of agitation and hallucinations. The facility initiated a transfer to the hospital due to his medical condition, where he was admitted for further treatment. R1's POA expected him to return to the facility post hospitalization , but when his condition stabilized, the hospital Social Service department was informed they would not allow him to return due to issues with the parents behavior.</p> <p>2) Review of the R1's medical record revealed the Emergency Department Physician notes dated 5/31/2024 revealed the following entries:</p> <p>Altered Mental Status (.Normally can blink eyes for yes or no questions, but today unable to do so.</p> <p>Upon my evaluation, this patient (R1) had a high probability of imminent or life-threatening deterioration due to acute hypoxic respiratory failure, which required my direct attention, intervention, and personal management.</p> <p>(continued on next page)</p>

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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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The was no documentation in R1's medical record by a provider regarding the transfer on 05/31/2024. In addition, there was no discharge summary documented after the facility decided not to allow R1 to return.</p> <p>3) On 07/17/2024 at 10:30 AM, interviewed the Admissions Director (AD). She said when a referral for admission comes in, she screens the profiles electronically. The AD said the facility specializes in ventilators and tracheotomies. She went on to say she works with the team and runs any questions by the Director of Nursing (DON). The AD went on to say, if they don't accept someone, she will document the reason in CareLink (electronic referral system), but cannot recover that data. The AD said R1 was at the facility a couple of years ago and then went back to the hospital right away due to an issue with his medications. At that time, he did not come back. She said when he was hospitalized in March 2024, the Community Liaison from the facility went to screen R1 in the hospital. The DON and Administrator (ADM) made the decision to admit him, and he came to the facility on [DATE]. The AD said she was aware there was an issue between staff and the mother (POA) the day R1 was transferred to the hospital (05/31/2024), and upper management spoke with staff about their concerns. She said they made the call that R1 could not return, and she informed Social Service staff at the hospital. When asked if the facility had beds at that time and she replied yes.</p> <p>On 07/17/2024 at 09:45 AM, conducted an interview with Respiratory Therapy (RT)1. Inquired if the facility had the ability to care for R1's respiratory issues, and she Yes. She went on to say sometimes his secretion management was an issue, and hard to keep up with, but most of the issues were with the parents.</p> <p>4) Reviewed the facility policy titled Transfer and Discharge (including AMA) last reviewed/revised 06/30/2024. The policy included the following:</p> <p>It is the policy of this facility to permit each resident to remain in the facility, and not initiate transfer or discharge for the resident from the facility, except in limited circumstances.</p> <p>Transfer refers to the movement of a resident from a bed in one certified facility to another certified facility when the resident expects to return to the original facility.</p> <p>Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or location in the community, when return to the original facility is not expected.</p> <p>Facility-initiated transfer or discharge: is a transfer or discharge which the resident objects to, or did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences.</p> <p>Policy explanation and Compliance guidelines:</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>12. Emergency Transfers/Discharges- .i. The resident will be permitted to return to the facility upon discharge from the acute care setting after facility evaluates and determines if the resident's clinical or behavioral status (or condition) can be met by facility prior to return/re-admission.I. The resident has the right to return to the facility pending an appeal of any facility-initiated discharge unless the return would endanger the health or safety of the resident or other individuals in the facility. The facility will document the danger that the failure to transfer or discharge would pose.</p> <p>In a situation where the facility initiates discharge while the resident is in the hospital following emergency transfer, the facility must have evidence that the resident's status at the time the resident seeks to return to the facility (not at the time the resident was transferred for acute care) meets one of the criteria at S483.15(c)(1)(i)(A) through (D). Additionally, the resident has the right to return to the facility pending an appeal of any facility-initiated discharge unless the return would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that the failure to transfer or discharge would pose. (S483.15(c)(1)(ii)).</p> <p>5) Cross Reference F623: Notice requirements before transfer/discharge</p> <p>While R1 was hospitalized after a facility initiated transfer, the facility made the decision to refuse to allow him to return, the facility failed to provide the Representative or Ombudsman the required written notice of the facility initiated discharge. The notice should have included the date and specific reasons for the discharge.</p> <p>6) Cross Reference F626: Permitting Residents to Return To Facility</p> <p>The facility had an established transfer/discharge policy, but failed to follow and implement that policy and did not comply with regulations when R1 was ready to return to the facility post hospitalization .</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853</p> <p>Based on interviews, record and document reviews, the facility did not provide the required notification of transfer/discharge to one Resident's (R)1's representative out of a sample size of four. When R1 was transferred to the hospital for a higher level of care and admitted , it R1's Representatives expectation R1 would be returning to the facility when discharged . While R1 was hospitalized , the facility made the decision to not readmit. The facility failed to provide the Representative or Ombudsman written notice of the facility initiated discharge. As a result of this deficient practice R1's Representative did not have the information needed to exercise their rights to appeal the appropriateness of the facility initiated discharge.</p> <p>Findings include:</p> <p>1) R1 is a [AGE] year old male with a history of hypertension, quadriplegia with tracheostomy and gastrostomy tube (tube placed through the abdomen in the stomach) for nutrition after a hemorrhagic stroke. He is nonverbal at baseline. R1 has had multiple episodes of pneumonia. He was admitted to the facility on [DATE], specifically for the specialty respiratory services they provide. On 05/31/2024 the facility initiated a transfer to the hospital due to his medical condition, where he was admitted for further care.</p> <p>2) Reviewed the facility Notices of Transfer/ Discharge, completed by the Social Worker (SW) on 06/05/2024. The form included:</p> <p>Date Resident/Representative Initially Notified: 05/31/2024 (date of transfer to hospital).</p> <p>Date Resident/Representative Notified: 06/05/2024.</p> <p>Reason(s) for transfer was checked: 1.) The resident's welfare cannot be met in this facility.</p> <p>E. BED HOLD POLICY Islands Skilled Nursing and Rehabilitation will hold a Resident's bed during a temporary hospitalization .in accordance with federal and state regulations. Islands Skilled Nursing and Rehabilitation shall document in the Resident's record that it offered this Bed Hold Policy to the resident, whether the Resident or Resident Representative declined or agreed to pay to hold the Resident's bed. If the Resident required a transfer to a hospital, Islands .will hold the resident's bed if Resident pays Islands . to hold the Resident's bed and all fees owing Islands .are paid in full. In such case, the Resident shall have the right to his or her bed immediately after hospital stay. Medicare does not pay for bed holds; and the State of Hawaii does not authorize payment for such a bed-hold under Medicaid.</p> <p>BED HOLD Policy (cont.) In order for Islands . to hold the Resident's bed, the Resident must pay the full basic daily fee for the type of bed being held. If the Resident does not pay for a bed in accordance with this bed hold policy, and the Resident wishes to be readmitted to the Islands . , the Islands . will readmit the Resident to his/her prior room if it is still available, or immediately upon the first available bed, AND if Islands is able to care for the resident.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>You have the right to file an appeal in either writing or by contacting the following:</p> <p>A. State of Hawaii Department of Health Office of Health Care Assurance .</p> <p>B. State of Hawaii Department of Health executive Office on Aging Hawaii Long-Term Care Ombudsman Program .</p> <p>C. For those with developmental disabilities and/or mental illness, .by writing or contacting the following: Hawaii Disability Rights.</p> <p>D. If you intend to file an appeal of this transfer/discharge, it is recommended that you do so at your earliest convenience after receiving this notice. The decision regarding an appeal typically will be made within 30 days from the date you were formally notified. However, the ability of the Department of Health to render a decision may be jeopardized if the appeal is not submitted in a timely manner. You may represent yourself or have legal counsel, a relative, friend, or other spokesperson. Please ask the respective entity in which you file the transfer/discharge appeal for more information on your rights.</p> <p>E. Please note that the facility may proceed with the transfer/discharge an [sic] the end of the thirty (30) days, even if a decision on the appeal has not been made. The facility reserves the right to determine whether or not to permit yo to stay until such is determined.</p> <p>F. Please be aware that the decision to transfer/discharge may be upheld and that you should prepare to be transferred/discharge at the end of the thirty (30) days from the date you were formally notified.</p> <p>3. The facility checked Yes that education and a copy of Bed hold Policy was provided in writing to resident/resident representative. It also checked Yes that information was provided for the appeal process.</p> <p>4. The Resident/Representative Signature section documented Sent via text. Copy left at bedside w/belongings.</p> <p>5. The section titled Exception for Thirty (30) day notice was marked Resident's medical needs/welfare requires more immediate transfer/discharge.</p> <p>This notice was provided specifically to address the transfer for higher level of care on 05/31/2024.</p> <p>A notice was sent to the Hawaii State Long Term Care Ombudsman at the end of the month, which is the facility practice with transfers. The notice documented the reason for Discharge was Sent out via 9-1-1 for acute care services. Resident agrees to discharge was checked Yes. Family agrees to Discharge was checked Yes. The area on the form for additional details documented: Sent out and admitted on [DATE].</p> <p>The facility did not give a formal notice of decision not to readmit/discharge to the Representative or Ombudsman (required at the same time). The facility initiated notice must include the date of discharge,when they made the decision to not readmit and reasons why.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3) Reviewed the facility policy titled Transfer and Discharge (including AMA) last reviewed/revised 06/30/2024. The policy included, but limited to the following:</p> <p>It is the policy of this facility to permit each resident to remain in the facility, and not initiate transfer or discharge for the resident from the facility, except in limited circumstances.</p> <p>Facility-initiated transfer or discharge: is a transfer or discharge which the resident objects to, or did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences.</p> <p>4. The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand. the notice will include all of the following at the time it is provided:</p> <ul style="list-style-type: none"> a. The specific reason and basis for the transfer or discharge. b. The effective date of transfer or discharge. d. An explanation of the right to appeal the transfer or discharge to the State. e. The name, address (mailing and email) and telephone number of the State entity which receives such appeal hearing requests. f. Information on how to obtain an appeal form. g. Information on obtaining assistance in completing and submitting the appeal hearing request. h. The name, address .of the State Long-Term Care Ombudsman. <p>12. In a situation where the facility initiates discharge while the resident is in the hospital following an emergency transfer, the facility will have evidence that the resident's status at the time the resident seeks to return to the facility meets one of the specified exemptions. k. In situations where the facility has decided to discharge the resident while the resident is still hospitalized , the facility will send a notice of discharge, and must also send a copy of the discharge notice to a representative of the Office of the State Long-Term Care Ombudsman. Notice to the Ombudsman will occur at the same time the notice of discharge is provided to the resident and resident representative, .</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4) On 07/17/2024 at 11:51 AM, interviewed the SW in the conference room. Discussed her role in the transfer/discharge process. The SW said We are changing the process since he (R1) was transferred. When he is transferred, the process was I would notify the family and give them a copy of the notice. We are changing to have nursing do that. SW went on to say R1 was transferred out 05/31/2025, which was a Friday. She was off the weekend and made aware of the transfer when she returned. She said she did a screen shot of the notice and sent a PDF copy by text to the mother and left a hard copy at bedside. She said there was no discussion at that time about return and it was her assumption that he would be coming back. She went on to say the appeal process was on the form. The SW agreed that although the form says Transfer/discharge, the language on the form and intent was to address the transfer on 05/31/2024. She explained when a resident is transferred, they are discharged from the electronic system,so it was her understanding that a transfer is a discharge.</p> <p>On 07/18/2024 at 10:00 AM, a second interview was conducted with the SW regarding the transfer/discharge notice. At that time she confirmed the notice sent to ombudsman was sent on 06/01/2024 and batched with the other transfers for the month. The SW said there was not another notice sent to the Representative and Ombudsman to inform them of the facility initiated discharge and they would not allow R1 to return. She repeated her understanding that when a resident is transferred, they are discharged .</p> <p>On 07/17/2024 at 10:30 AM, interviewed the Admissions Director (AD), who screens Residents for admission. She said she receives requests for a bed electronically, and if there is a question, she would send it to the Director of Nursing, Respiratory Director or the Administrator. The AD said R1's return was discussed by the team and they made the decision not to allow him to come back. She said she spoke with the Social Service department at the hospital and informed them of the decision.</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p>39853</p> <p>Based on interviews, document review and record review, the facility had an established transfer/discharge policy, but failed to follow and implement that policy and did not comply with regulations that apply to discharges. Specifically, R1 was sent to the Emergency Department (ED) and hospitalized for further care. His Representative had the expectation R1 would return to the facility, but when he was ready for discharge, the facility refused to let him return and resume residence.</p> <p>Findings include:</p> <p>1) R1 had been a resident at the facility since 03/07/2024. On 05/31/2024, he was transferred to the Emergency Department for a higher level of care. When his condition was stable, the hospital Social Service department contacted the facility Admissions Director to arrange for R1 to return to the facility. The facility informed the hospital they would not let R1 return due to concerns they had with the mother's behavior.</p> <p>2) On 07/17/2024 at 10:30 AM. during an interview with the Admissions Director (AD), she said initially she assumed R1 would be returning to the facility. She confirmed that when the hospital contacted the facility to send R1 back, they had an open bed. She went on to say the facility gets referrals (bed request) from the hospitals electronically in a system called Carelink. She said they can decline the admission and note the reason in the system, but that information is not retrievable. The AD said R1 had been at the facility once before, a couple years ago for only one day and had to return to the hospital. She said there had been some discussion about the interactions with the mother from that admission prior to accepting him on 03/07/2024. The AD said she was aware there were some issues during this stay and on the day R1 was transferred to the hospital, so she spoke with the team, the Administrator and Director of Nursing, before accepting him back and they made the decision not to let R1 return. The AD said she communicated the refusal to the hospital Social Service Department.</p> <p>On 07/18/2024 at approximately 01:00 PM, during an interview with the Administrator (ADM), he said prior to R1's admission on 03/07/2024, he went to the hospital with the Community Liaison, who will sometimes go to the hospital to screen a ventilator or trach patient for admission, but did not go inside the room, or participate in the conversation. He confirmed the facility had the capacity and capability to care for R1 when the hospital wanted to discharge him, but after investigating some concerns and spoke with the staff, they made the decision not to allow R1 to return. The ADM said he spoke briefly with the mother the day after the transfer, just to let her know he was aware there had been an issue with staff at the time of the transfer, but had not spoken to her again. He said they did not arrange a conference or work with the parents regarding the facilities concerns, or how they could work them out. The ADM confirmed the refusal was not based on R1's behavior or medical condition.</p> <p>3) Cross Reference 623 Notice Requirements before Transfer/discharge.</p> <p>The facility failed to provide R1's Representative or Ombudsman written notice of the facility initiated discharge.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853</p> <p>Based on interviews and record review, the facility failed to update one Resident's (R)1 care plan (CP) of a sample size of four. R1's representative had specific requests/preferences regarding his care, which were not included in the CP. As a result of this deficiency, the CP was not comprehensive or individualized to include agreed upon interventions. This deficient practice could affect all residents and be a barrier to meeting their highest practicable psychological and physical well-being</p> <p>Findings include:</p> <p>1) R1 is a [AGE] year old male with a past medical history includes cerebral hemorrhage with quadriplegia, chronic respiratory failure with tracheostomy, hypertension, dysphasia (difficulty swallowing), and gastrostomy tube dependent for nutrition. At his baseline, he does not require oxygen and is alert and oriented 1x-2x (person and place). He requires extensive assistance for all activities of daily living, can only make some needs known with expression, nodding head and gestures, and totally dependant on staff. R1's mother is his power of attorney (POA). His family cared for him at home prior to R1 living in nursing facilities, so the parents know his needs and actively advocate for him. R1 was admitted to the facility from an acute care hospital on 03/07/2024 for skilled nursing and respiratory care.</p> <p>2) Reviewed R1 medical records, which revealed notes of interventions for care and preferences agreed upon by the facility and of R1's POA. These were documented on the first page/screen when opening the medical record The entries read: Special instructions: REMINDERS: Routine Facetime with family/kids Q (every) Wed & Sun at 8 PM.Pressure boots on at all times & Call light by right hand. OOB (out of bed) Schedule every T-TH-S- Shave every Monday or PRN (as needed): Ask resident first-Family requests that pt (R1) wears gloves to avoid scratches on face & keep res (R1) warm. Turn off AC (air conditioner), et- 5/29 Per family, do NOT use Kleenex to wipe resident eyes, only use gauze.</p> <p>Reviewed R1's active CP, last review date 04/01/2024. The CP included the facetime call with his family under psychosocial well-being, but did not include any of the other important information documented in the Special instructions. Interventions that should have been included in the CP include the pressure boots, Call light placement, gloves to avoid scratches, preference of gauze to wipe eyes, and temperature control (people with stroke quadriplegia often experience challenges with temperature regulation).</p> <p>3) On 07/18/2024 at approximately 02:15 PM, during an interview with the Director of Nursing (DON), reviewed R1's CP and special instructions. She said the special instructions were documented specifically in that chart location as it would be visible to staff when they open R1's record. The DON said these things were very important to the POA and was a way to ensure all staff were aware of them. She agreed the CP should have been revised to include several of the items and that the special instructions would reinforce, but should not replace the CP.</p>		

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<p>F 0713</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or arrange emergency care by a doctor 24 hours a day.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853</p> <p>Based on interviews, document review and medical record review, the facility failed to provide availability of physician services 24 hours a day. On 05/31/2024, the nursing staff was unable to reach a physician/provider to discuss a Resident's (R)1 condition. This deficient practice puts any resident requiring emergency physician services at risk of delay in care, which could result in harm or death.</p> <p>Findings include:</p> <p>1) R1 is a [AGE] year old male with a past medical history of cerebral hemorrhage, chronic respiratory failure with tracheostomy, dysphasia (difficulty swallowing), gastrostomy tube for nutrition and is alert and oriented 1x-2x (person and place).He requires extensive assistance for all activities of daily living and totally dependant on staff. He was to the facility from an acute care hospital on 03/07/2024. On 05/31/2024, R1 had an increased heart rate (HR) and behavioral changes, and then developed a temperature. His condition required notification of a provider (Physician or Advanced Practice Registered Nurse (APRN). The nursing staff were unable to access physician services prior to transferring R1 to the Emergency Department.</p> <p>2) Reviewed Progress notes, which included the following:</p> <p>05/31/2024 at 07:49 PM, Respiratory Therapist note: . Throughout the shift, Resident's HR high, up and down all day between 110-160. Suspected hallucinations/anxiety from scopolamine patch. Patch taken off this morning. Resident very combative and did not rest all day.RN aware .Waited for on call APRN to call back, they were paged 3 times throughout the day, could not get a hold of them.RT was in room at least every 20 minutes and continuously monitored. Resident left via EMS (Emergency Medical Services) around 18:48 (06:48 PM).</p> <p>05/31/2024 at 07:44 PM Nursing note: Pts mother (POA) arrived at the facility this evening .Mother became very agitated and said the nurse should call 911 . RN told mother the the on call provider for Physician (MD)1, APRN, was paged and RN awaiting call back for orders.</p> <p>3) Reviewed the facility policy titled Notification of Changes last reviewed/revised 02/2024. The policy included:</p> <p>- The purpose of the policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notified, consistent with his or her authority, the resident's representative when there is a change of condition.</p> <p>-Definition: Need to alter treatment significantly means a need to stop a from of treatment because of adverse consequences (such as adverse drug reaction), or commence a new form of treatment to deal with a problem.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Islands Skilled Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1205 Alexander Street Honolulu, HI 96826	

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<p>F 0713</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4) On 07/18/2024 at approximately 02:15 PM, during an interview with the Director of Nursing (DON), she said if nursing is unable to reach the Resident's Physician, or covering Provider, the process would be to notify the person on call for nursing who could facilitate obtaining physician services by contacting the Medical Director. The DON confirmed there was no documentation when the phone calls were made to the covering APRN.</p> <p>On 07/17/2024 at 09:45 AM interviewed Respiratory Therapist (RT)1 on duty the day R1 was transferred to the hospital. Reviewed the progress note dated 05/31/2024. She confirmed she cared for R1 that day and they suspected his hallucinations/anxiety was from the scopolamine patch, so it was taken off this morning. The RT confirmed the RN paged the APRN throughout the day, and did not get a response. Paged at least three times, wanted to get OK to send to hospital.</p>

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<p>F 0726</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853</p> <p>Based on interviews, document and record review, the facility nursing staff did not demonstrate the competency and skill set to provide one Resident (R)1 the services needed to safely care for him. Specifically, when R1 had ongoing symptoms that were not his baseline requiring additional intervention, they did not implement the process to obtain emergency physician services when unable to reach the on call provider. In addition, nursing applied a scopolamine patch (used to control secretions) on R1, that was not ordered by the physician. The patch may have resulted in significant side effects. As a result of these deficiencies, R1 suffered harm and experienced hallucinations, and increased heart rate. He as ultimately transferred to acute care facility, where he was admitted .</p> <p>Findings include:</p> <p>1) R1 is a [AGE] year old male with a past medical history includes cerebral hemorrhage with quadriplegia, chronic respiratory failure with tracheostomy, hypertension, dysphasia (difficulty swallowing), and gastrostomy tube dependent for nutrition. At his baseline, he does not require oxygen and is alert and oriented 1x-2x (person and place). He requires extensive assistance for all activities of daily living, can only make some needs known with expression, nodding head and gestures, and totally dependant on staff. He was admitted to the facility from an acute care hospital on 03/07/2024 for skilled nursing and respiratory care. On 05/31/2024, R1 was transferred to the hospital due a rapid heart rate, fever and changes in his behavior. His physician (MD)1 was notified in the AM, and ordered the scopolamine patch be removed. When R1's symptoms continued, the nursing staff were unable to reach a provider in a timely manner, but did not go through the chain of command for assistance, until R1's mother arrived and was upset he had not been transferred to the Emergency Department.</p> <p>2) Record review revealed the following Progress notes:</p> <p>Nursing Notes: 05/29/2024 at 02:52 PM: O2 97% .Resident with pain this shift. Administered Tylenol @1504, had HR (heart rate) over 100's and was making a lot more movement, .</p> <p>05/31/2024 04:54 AM: Noted resident HR fluctuating 100s-115 and restless and combative during brief change.</p> <p>05/31/2024 at 10:56 AM: Resident is combative and HR goes up to the 140's. Will not shake head yes or no when asked if in pain.</p> <p>05/31/2024 at 12:00 PM: Resident is combative and HR is in the 130's. Will continue to monitor</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>05/31/2024 at 12:10 PM: Resident with pain this shift. Suspected pain d/t (due to) HR in 130's and intermittent spikes to 151. Administered PRN Tylenol at 1056 crushed though g-tube as per MAR. Medication was ineffective. Resident with behaviors on shift. Resident combative, agitated, and restless. New orders received. Hold Scopolamine patch for 14 days d/t possible hallucinations. Resident combative, agitated and HR elevated in the 130's with intermittent spikes to 140's. RN, RT (Respiratory Therapist) and MD suspected hallucinations from Scopolamine patch and MD ordered to help patch for 14 days. Resident's mother (POA (Power of Attorney)) notified. Mother states, I have scolded the CNA's (Certified Nurse Assistants) about not pulling his arm. I think his arm is in pain from it being pulled. Father called and stated, I have seen his arm being pulled when he is repositioned. That causes him pain and his heart rate to go up. DON (Director of Nursing) notified of mother and father's statements. Provided rounding every 15 minutes throughout the shift. Pt was sent to .ER (emergency room) @ 18:48 (06:48 PM).</p> <p>Respiratory Services note: 05/31/2024 at 18:21: .Throughout shift. Resident's HR high, up and down all day between 110-160. Suspected hallucinations/anxiety from scopolamine patch. Patch taken off this morning. Resident very combative and did not rest all day. Writer also asked for ST (speech therapist) opinion and ST thinks it could be hallucinations as well. RN aware. Management aware. Waited for on call APRN (Advance Practice Registered Nurse)</p> <p>3) Review of the Medication Records revealed the following:</p> <p>- There was an order for scopolamine patch 72 hour 1 Mg (milligram)/3 days with start date of 03/05/2022, and end date of 03/07/2024. Review of Medication Administration Records revealed the last documented application of a scopolamine patch on R1 was 03/07/2024. There was no order for the scopolamine patch that was documented in the progress notes to be on R1 on 05/31/2024.</p> <p>4) Reviewed the facility policy titled Administering Medications. The policy included:</p> <p>2. Medications must be administered in accordance with the orders .</p> <p>7. The individual administering the medication must check the label THREE times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.</p> <p>19. The individual administering the medication must initial the resident's MAR (medication administration record) on appropriate line after giving each medication and before administering the next ones.</p> <p>20. As required ., the individual administering the medication will record in the residents medical record: a. The date and time medication was administered; b The dosage c. The route of administration: .e. Any complaints or symptoms for which the drug was administered; f. Any results achieved and when those results were observed; and g. The signature and title of the person administering the drug.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>There was no documentation in the medical record to identify who, why and when the scopolamine patch was applied. There was no MAR for the nurse to document the application of the scopolamine patch on R1, as there was no order for the medication. This should have triggered the RN to investigate why there was no MAR. One of the uses for scopolamine is to reduce secretions. Side effects of scopolamine include but not limited to allergic reactions, confusion, fast, irregular heartbeat, hallucinations, restlessness, and seizures.</p> <p>Reviewed the facility policy titled Discontinued Medications, which included the statement Discontinued medications must be destroyed or returned to the issuing pharmacy in accordance with established policies.</p> <p>It is unknown why the nursing staff had access to the scopolamine patches for R1.</p> <p>5) Reviewed the facility policy titled Notification of Changes last reviewed/revised February 2024. The policy included:</p> <p>The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician .when there is a change requiring notification.</p> <p>Circumstances requiring notification include: .2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: a. Life-threatening conditions, or b. Clinical complications. 3. Circumstances that require a need to alter treatment. This may include: a. New treatment. b. Discontinuation of current treatment due to: i. Adverse consequences. ii. Acute condition. iii. Exacerbation of a chronic condition. 4. A transfer or discharge of the resident from the facility.</p> <p>Definition: Need to alter treatment significantly means a need to stop a form of treatment because adverse consequences (such as drug reaction), or commence a new form of treatment to deal with a problem .</p> <p>6) On 07/17/24 at 9:45 AM, interviewed the Respiratory therapist (RT)1 on duty 05/31/2024 the shift R1 was transferred to the hospital. Reviewed her progress note that day and she confirmed R1's behavior was very different and confirmed his heart rate (HR) was elevated on and off all day. She said he was very anxious and combative. RT1 said she consulted with the Speech Therapist and he thought the behavior may be related to the scopolamine patch. She said they stood outside the room and observed R1, and he was swatting away at the air, almost like a panic attack when no one was in the room. RT1 said they took the patch off in the morning, and waited to see if that would help. She said she kept talking to the RN, who paged the covering APRN to get the OK to send to hospital. She said Sometimes the HR would come down, and we knew it wasn't bad enough to call 911.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/18/2024 at 10:21 AM, during an interview with DON, she confirmed scopolamine patch required an order. At that time, reviewed R1's Medication Order Summary Report, listing all active medication orders, and the DON confirmed there was no order for scopolamine, and the the last documented application of a scopolamine patch on R1 was 03/07/2024 The DON stated she reviewed the nursing notes to see if she could find a note of a verbal or telephone order that might have been taken and accidentally not entered in the system, but did not find anything. She said the two RN's involved that day are no longer employed at the facility, and she was unable to track who applied the patch and when it was put on. The DON confirmed MD1 was unavailable and the APRN was covering. She said if the staff are unable to reach a provider and one is needed, they should notify the leadership person on call, who would facilitate notification of the Medical Director.</p> <p>On 07/18/2024 11:30 AM during a telephone interview with R1's Physician (MD)1, he said he recalled being contacted about R1 having some tachycardia (rapid heart rate), being restless and having hallucinations, so he ordered removal of the scopolamine patch. MD1 said he was not aware there was no active order for the patch. At that time, he confirmed he left a note informing the facility he would be unavailable the rest of the day, and the APRN would cover. He was not aware the staff were not able to reach the APRN on 05/31/2024.</p>		